

Guide for Consumer
Involvement
in Local Community Planning
for the
Mental Health Services Act



Presented by California Network
of Mental Health Clients

Prepared by Michele D. Curran

Background of MHSA

During 2004 a collaborative of the mental health community, working closely with state policy-makers and influential members of the state's citizenry, was able to qualify as an initiative for the ballot a revolutionary approach to the funding of mental health services and programs. Known at that time as the Mental Health Services Initiative, thousands worked tirelessly to gather the necessary signatures that would put the new funding method before the electorate in November. Upon the certification of the needed numbers of registered voters, this document became Proposition 63. The first Tuesday in November, 2004 had all of the coalition watching television reports and checking with local voting returns. For the first time in many years, the voters of California approved a measure that included a surcharge on the incomes of a targeted group of taxpayers. Now known as the Mental Health Services Act (MHSA), the many provisions of this transforming approach to mental health services and programs went into effect on January 1, 2005.

The Department of Mental Health was charged with a wide variety of tasks: 1.) To develop formulas and baselines for distribution of the monies collected from the tax. 2.) To design the format for each county mental health department to apply for the funds that are allotted for each of the components of the MHSA. 3.) To conduct statewide and regional meetings both to train/inform stakeholders and to elicit ideas and concerns from a wide spectrum of knowledge and experience. 4.) To determine timelines for the applications of funds for each component of the MHSA and to develop materials that further define each of the components. 5.) To share, with a "to-be-established" Oversight and Accountability Commission, the authority to review and approve the county applications for funding in the various service and program sectors of the Act.

In addition, the CA DMH established as a principle of the MHSA: To cultivate a climate in which a "systems change" could occur with total inclusion of clients and family members in planning and policy processes.

The California Network of Mental Health Clients (CNMHC) has played a major role in each of the tiers of the Mental Health Services Act. As part of the design team for the Initiative, CNMHC was able to influence some of the text of the document. The CNMHC has also maintained active partnership with the mental health community in all aspects of MHSA from its writing to its campaign for its passage and to its implementation. Clients throughout the state were resolute in the quest for signatures and in gaining approval from the general public in their local communities. After the passage of the MHSA, clients joined together on both the state and local levels to ensure the adherence of the vision and values as stated in:

- a) the MHSA text;
- b) in the cross-references contained in the MHSA;
- c) and in the CA DMH stakeholder process.

The CA Network of Mental Health Clients is available to all groups desiring more information and technical assistance in the provisions of the Mental Health Services Act and in the participation/inclusion of clients in a meaningful way in all levels of the planning of the various components of the MHSA, starting with the Community Services and Supports (formerly Systems of Care) Plan. The following guide includes materials developed by the CNMHC MHSA Implementation Team, the CA Department of Mental Health, the CA Institute for Mental Health, the CA Association of Social Rehabilitation Agencies, CA Council of Community Mental Health Agencies, and clients from throughout every geographic region of the state.

What is the Mission of the Mental Health Services Act as it Relates to Adults?

Section 7 of the MHSA text states that to Part 3.8 of Division 5 of the Welfare and Institutions Code is added Section 5813.5. This section speaks to services for adults and older adults. Sub-section (d) reads:

Planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers:

- 1) *To promote concepts key to recovery for individuals who have mental illness: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.*
- 2) *To promote consumer-operated services as a way to support recovery.*
- 3) *To reflect the cultural, ethnic and racial diversity of mental health consumers.*
- 4) *To plan for each consumer's individual needs.*

The Overarching Client Values

Each of us must advocate to ensure that this opportunity creates real transformation! Services and programs that are: ♦ Voluntary ♦ Community-based ♦ Holistic ♦ Recovery and consumer-centered values ♦ Supports self-help/peer support services ♦ Client- directed and client staffed

Funding of the Mental Health Services Act

The MHSA imposes an additional 1% tax on that portion of a taxpayer's taxable income in excess of one million dollars. These funds are deposited in the State Treasury in the Mental Health Services Fund. It is estimated the new tax will raise in excess of \$600 million dollars per year. Funding will be made available annually from this fund to counties to accomplish the following (Welfare and Institutions Code Section 3. Purpose and Intent). The CA DMH anticipates that funds from the new tax will be deposited in the Mental Health Services Fund and available by March or April 2005. Funding in amounts necessary to significantly enhance service delivery beyond current levels will probably be available in September or October 2005. These dates are only "best estimates."

Components of the Mental Health Services Act

The CA DMH has identified the six components of the MHSA that need to be woven into an integrated plan at the local level and a comprehensive strategy at the state level. These components will each have a separate funding formula, application process, timeline and review/approval method. Included after each component listed are the Welfare and Institution Code (WIC) Section (§) numbers from the MHSA.

- ♦ Community Program Planning (Local Planning, WIC §§5847, 5848, 5892)
- ♦ Community Services and Supports (System of Care Services, WIC §§5847, 5878.1-5878.3, 18257 and 5813.5)
- ♦ Capital Facilities and Information Technology (WIC §5847)
- ♦ Education and Training Programs (WIC §§5820-5822, 5847)
- ♦ Prevention and Early Intervention Programs (WIC §§ 5840, 5847)

◆ Innovative Programs (WIC §5830, 5847)

The manner in which the CA DMH are proposing that each component will be funded over the three-year introductory period is as follows:

Component	Jan. 1 to June 31, 2005	Next 3 years
Community Program Planning	5% (Due to DMH 3-15-05)	
Community Services and Supports*	Draft regulations published Feb. 16, 2005	55% (1 st year plan can be submitted in June, 2005)
Capital Facilities and Information Technology	45% (Regulations not yet available)	10%
Education and Training Programs	45% (Regulations not yet available)	10%
Prevention and Early Intervention Programs*		20%
Innovative Programs (5% of *)		

The DMH MHSA Vision Statement and Guiding Principles published February 16, 2005 states (excerpts):

Introduction

The Mental Health Services Act (MHSA) includes a clear set of challenging goals for all stakeholders to hold in common as the MHSA becomes reality.¹ Within the context of those common goals, the California Department of Mental Health (DMH) developed, in partnership with stakeholders, a Vision Statement and Guiding Principles to use as it implements the Community Services and Supports component of the MHSA.

Most of the language and concepts included in the Vision Statement and Guiding Principles document were originally presented to MHSA stakeholders on the DMH website and at a public meeting in Sacramento in December 2004. At that time it

was entitled “DMH Vision Statement”. Since then, in response to stakeholder comments and DMH policy clarification, this document has become a Vision Statement and Guiding Principles for DMH to hold for itself and stakeholders as it implements the Community Services and Supports component of the MHSA.

Vision Statement To Guide DMH In The Implementation Of Community Services And Supports

As a designated partner in this critical and historic undertaking, the California Department of Mental Health (DMH) will dedicate its resources and energies to work with stakeholders to create a state-of-the-art, culturally competent system that promotes recovery/wellness for adults and older adults with severe mental illness and resiliency for children with serious emotional disorders and their families. In its implementation responsibilities under the MHSA DMH pledges to look beyond “business as usual” to help build a system where access will be easier, services are more effective, out-of-home and institutional care are reduced and stigma toward those with severe mental illness or serious emotional disturbance no longer exists.

Guiding Principles To Guide DMH In The Implementation Of Community Services And Supports

Beyond the goals in statute for the MHSA as a whole, DMH has developed, with stakeholder input, a set of Guiding Principles. These Guiding Principles will be the benchmark for DMH in its implementation of the MHSA Community Services and Supports component. DMH will work toward significant changes in the existing public mental health system in the following areas:

Consumer and Family Participation and Involvement

1. Significant increases in the level of participation and involvement of clients and families in all aspects of the public mental health system including but not limited to: planning, policy development, service delivery, and evaluation.
2. Increases in consumer-operated services such as drop-in centers, peer support programs, warm lines, crisis services, case management programs, self-help groups, family partnerships, parent/family education, and consumer provided training and advocacy services.
3. Full implementation of an approach to services through which each client and her/his family, as appropriate, participates in the development of an individualized plan of services determined by the individual’s goals, strengths, needs, race, culture, concerns and motivations.

Programs and Services

4. Changes in access and increased geographic proximity of services so that clients will be able to receive individualized, personalized responses to their needs within a reasonable period of time and to the extent needed to enable them to live successfully in the community.
5. Elimination of service policies and practices that are not effective in helping clients achieve their goals. Ineffective treatment methods will be replaced by the development and expansion of new values-driven, evidence-based and

promising practices, policies, approaches, processes and treatments which are sensitive and responsive to clients' cultures and produce more favorable outcomes.

6. Increases in the array and types of available services so children, transition age youth, adult and older adults clients and their families will be able to choose, in consultation with mental health professionals, the kinds of services and the intensity of services that will assist them in attaining the goals in their individualized plans.
7. Integrated treatment for persons with dual diagnoses, particularly serious mental illness and serious substance use disorders, through a single individualized plan, and integrated screening and assessment at all points of entry into the service system.

Age-Specific Needs

8. For children, youth and their families, implementation of specific strategies to achieve more meaningful collaboration with child welfare, juvenile justice, education and primary healthcare, in order to provide comprehensive services designed to enable youth to be safe, to live at home, to attend and succeed in school, abide by the law, be healthy and have meaningful relationships with their peers.
9. For transition-age youth, programming to address the unique issues of this population who must manage their mental health issues while moving toward independence. This should include a person as a point of contact who would follow youth as they transition from the youth systems into the adult system or move out of the mental health system. To meet the needs of these youth, programming needs to include specific strategies for collaboration between the youth and adult systems of care, education, employment and training agencies, alternative living situations and housing and redevelopment departments.
10. For adults, implementation of specific strategies to achieve more meaningful collaboration with local resources such as physical health, housing, employment, education, law enforcement and criminal justice systems in order to promote creative and innovative ways to provide integrated services with the goals of adequate health care, independent living and self-sufficiency.
11. For older adults, implementation of specific strategies to increase access to services such as transportation, mobile and home-based services, comprehensive psychiatric assessments which include a physical and psychosocial evaluation, service coordination with medical and social service providers and integration of mental health with primary care. The ability to reside in their community of choice is a fundamental objective.
12. For all ages, reductions in the negative effects of untreated mental illness including reductions in institutionalization, homelessness, incarceration, suicide, and unemployment.

Community Partnerships

13. Significant increases in the numbers of agencies, employers, community based organizations and schools that recognize and participate in the creation of opportunities for education, jobs, housing, social relationships and meaningful contributions to community life for all, including persons with mental illness. Care must be collaborative and integrated, not fragmented.

Cultural Competence

14. Outreach to and expansion of services to client populations to more adequately reflect the prevalence estimates and the race and ethnic diversity within counties and to eliminate disparities in accessibility and availability of mental health services.
15. Implementation of more culturally and linguistically competent assessments and services that are responsive to a client's and family's culture, race, ethnicity, age, gender, sexual orientation and religious/spiritual beliefs.

Outcomes and Accountability

16. Expanded commitment to outcome monitoring including developing/refining strategies for evaluation of consumer outcomes, and system and community indicators, using standardized measurement approaches whenever possible. Data needs to be readily accessible and viewed as an essential part of program planning.
17. Development and implementation of policy and procedures to ensure that changes in service array in the future are based on intended outcomes. This may necessitate increased training and support for the mental health workforce.
18. Achievement of the MHSA accountability goals necessitates statewide adoption of consistent, effective service delivery approaches as well as standard performance indicators, data measurement and reporting strategies.

Attachment C of Required Contents for County Funding Requests for the Community Services and Supports Plan states that a request for funding must provide documentation in the following areas:

- 1) Community Program Planning must include consumers and families.*
- 2) Community Program Planning must be comprehensive and representative.*
- 3) There must be clear designation of responsibility within the county for Community Program Planning and the planning process must be adequately staffed to be successful and inclusive.*

- 4) *Full participation in Community Program Planning requires training of stakeholders and staff in advance.*
- 5) *Community Program Planning Budget Worksheet.*

County mental health administrations must include clients and family members as full partners from inception of planning through implementation and evaluation of services and supports. This is a clear mandate of the CA DMH and consistent with the text of the MHSA and is applicable to each of the six components of the Act, the first two to be funded being the Community Services and Supports Planning Process and the Community Services and Supports Plan, categorized by age group.

CNMHC Guiding Principles In The Implementation Of The MHSA

Overarching Concern:

The Mental Health Services Act was voted by clients (at the Client Forum 2003) as their highest public policy priority. However, this vote followed a spirited public comment voicing concern that the Act's implementation may not comply with its intent. Would it be used to support the "same old, same old" that hasn't worked and has disempowered clients? Can we guarantee the integrity of the implementation and, if so, how?

Clients continue to support the Mental Health Services Act. The Act ties a new stream of funding to special kinds of model services that deal with the array of social and rehabilitative needs of people with mental disabilities and to a way of delivering the services that values consumer choice, self-determination, and recovery. The language of the Mental Health Services Act does not support the disappointing former methods of doing mental health business, but holds the promise of transforming the kinds of services, their availability, and the way they are delivered in California. The Act supports a mental health system visualized by the President's New Freedom Commission

Report (July, 2003) in which "Consumers of mental health services must stand at the center of the system of care. Consumers needs must drive the care and services that are provided."

Moreover, the services supported by the Mental Health Services Act are voluntary. In Assembly Member Steinberg's (the author of the Mental Health Services Act) own words, "The services funded by the AB 34 programs are not forced or involuntary, and the services funded by the initiative will not be forced or involuntary. "(from www.campaignformentalhealth.org Web Log, June 6, 2004.) The CNMHC membership has long supported the position that "Public policy needs to move in the direction of a totally voluntary community-based mental health system that safeguards human dignity and respects individual autonomy." (Privileges to Rights: People Labeled with Psychiatric Disabilities Speak for Themselves, National Commission on Disability January 20, 2000.) The availability of client respectful voluntary services that value individual autonomy will dramatically reduce the use of forced treatment.

Consumer values are overtly stated in Section 7, 5813.5 (d) of the Mental Health Services Act:

(d) Planning for services shall be consistent with the philosophy, principles and practices of the Recovery Vision for mental health consumers.

- (1) To promote concepts key to the recovery for individuals who have mental illness: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.
- (2) To promote consumer-operated services as a way to support recovery.
- (3) To reflect the cultural, ethnic, and racial diversity of mental health consumers.
- (4) To plan for each consumer's individual needs.

Nevertheless, along with continued support for the Act given its compatibility with consumer values, the concerns continue. What authority will the CA DMH demonstrate to force Counties to comply with the Act? How can we ensure that Counties will not use these new funds to back-fill old systems (that are being cut in the current budgetary crises)? Will the implementation be accountable to the Act?

Overarching Recommendation

Overarching all of the CNMHC's recommendations is the essential involvement of consumers in every aspect of the implementation of the Mental Health Services Act; starting with its planning, moving on to its execution, then to the oversight and evaluation. Clients must participate through contracting (both directly and indirectly) with the CNMHC, consumer staffing of the CA DMH, Planning Council, and Oversight and Accountability Council, both in-house and out-sourced, and volunteer client citizen involvement in State and local planning, oversight, and evaluation bodies. Clients should particularly have maximum participation in four categories: Consumer-Operated Programs; Stakeholder Involvement; Consumers in the Workplace; and reduction in Stigma and Discrimination.

The California Department of Mental Health (CA DMH) should directly or indirectly contract with the CNMHC to assist in implementing all of the consumer related aspects of the Mental Health Services Act, specifically (but not limited to) consumer operated programs, the meaningful and effective involvement of consumers in the implementation of the Act, the hiring of consumers in the mental health workforce as well as training of that workforce, and the reduction of stigma and discrimination campaigns. The CNMHC has been awarded a SAMHSA Statewide Network Grant to create a California Self-Help Technical Assistance and Support Center. This Center will support the development of self-help and peer support groups through assessment, technical assistance, and promotion. With this technical assistance Center as a foundation, the CNMHC is well situated to expand and to provide the leadership for consumer activities and effective consumer participation throughout the State.

Following are recommendations specific to Consumer-Operated Programs, Client Involvement at every level of the Mental Health Services Act implementation, Consumers in the Workplace, and Stigma and Discrimination. These recommendations model the kinds of concerns and responses that will occur as clients take their rightful place as primary participants in the implementation of the Mental Health Services Act. These recommendations represent consumer interests and perspectives. They are not intended to be exclusive of other stakeholder groups. On the contrary, the CNMHC looks forward to working with all of the other mental health stakeholder groups on the overall implementation of Proposition 63, and in particular on specific activities based on the interests and expertise of the various stakeholder groups.

Consumer-Operated Programs Recommendations

CNMHC recommends that:

1. The Department of Mental Health direct, as a local plan requirement, that each County will have, as a section of its plan, a description of how it will utilize consumer-operated programs in the implementation of any services similar to past AB 2034 programs. The Mental Health Services Act cross-references Welfare and Institutions Code §5806 when it describes how the Department of Mental Health shall distribute funds for adults and older adults. Within §5806 (a) (5) is specific reference to provision for peer support or self-help group support where appropriate for the individual.

5813.5 (d) Planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers.

(1) To promote concepts key to the recovery of individuals who have mental illness: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.

(2) To promote consumer-operated services as a way to support recovery.

2. The Department of Mental Health require that local mental health programs specify a percentage of all MHSA funds on consumer-operated programs. Client-run services are emerging best practices and fulfill the purposes of Innovative Programs as defined in Section 5830 (a). Based on individual and group self-determination and choice, these programs are a model for totally voluntary programs. Dealing with the expressed needs of people with mental disabilities, and concretely helping them fulfill these real life needs, they model social and rehabilitative services. Based on the underlying philosophy of peer support and that the best helpers are those who have experienced similar problems, voluntary programs model a non-medical model approach to helping. Studies suggest (and what self-helpers have anecdotally known) that self-help programs serve persons who: will not or cannot use traditional services; may be homeless or at risk of being homeless; have had hurtful or ineffective experiences in traditional programs; have not had access to traditional services. Studies also suggest that self-help programs excel in outcome measurements of increased empowerment and self-esteem.

5830. (a) The innovative programs shall have the following purposes:

1. To increase access to underserved groups.

2. To increase the quality of services, including better outcomes.
4. To increase access to services.

3. The Department of Mental Health contract with the CNMHC to implement consumer-operated programs throughout the state, including; assessment, training and technical assistance, promotion, and evaluation of consumer-operated programs.

Client Involvement At Every level in the Mental Health Services Act Recommendations

CNMHC recommends that:

1. The Department of Mental Health, the Mental Health Planning Council and the Oversight and Accountability commission hire as staff mental health clients to implement the sections of the act that are of utmost importance to consumers, including but not limited to consumer-operated programs, hiring of consumers in the mental health workforce, campaigns to address discrimination and stigma, and meaningful consumer involvement in the implementation of the act. In hiring of consumer staff, the California Network of Mental Health Clients recommends that the Department of Mental Health, the Planning Council and the Commission contract with the California Network of Mental Health Clients to hire the staff that will then be assigned to respective assignments.
2. The Department of Mental Health contract with CNMHC through its Technical Assistance and Support Center to assist the Department in implementing the consumer-operated programs, CADS campaigns, hiring of consumers in the mental health workforce and the meaningful involvement of consumers in the implementation of the act.
3. Each County program develop and implement a plan that includes consumer-operated programs, campaigns to address discrimination and stigma, consumers as part of the mental health workforce, including hiring consumers to help implement the local plan and ensure meaningful consumer involvement.
4. Each County use funds from the act to hire consumers for implementation.
5. In utilizing performance outcomes to determine if counties are meeting the requirements of the act, outcomes measures are determined using consumer involvement. The outcome measures will be determined based on what consumers want and need.

6. The Department of Mental Health have stringent requirements for the content of the county plans and will develop regulations that will ensure that the counties will be required to have consumer-operated programs, campaigns to address stigma and discrimination, consumers employed in the workforce and meaningful consumer involvement in the implementation of the act.

7. Department of Mental Health require each county to have a consumer advisory committee to advise on the development and implementation of the local plan.

Consumers in the Workplace Recommendations

CNMHC recommends that:

1. The Department of Mental Health identify the employing of consumers as a major statewide need that will be reflected in the local plan requirements and regulations, including contracting with consumers to deliver services in rural areas.

2. The Department of Mental Health contract with the CNMHC to provide technical assistance to counties to fulfill its requirements of employing consumers in the mental health workforce. The CNMHC will collaborate with such groups as the California Coalition of Consumer/Survivors in Mental Health Management, (CCC/S) who have experience and expertise on this issue. Technical assistance shall include:

- 1) Training consumers to work in mental health;
- 2) Developing positions for the consumer workers;
- 3) Supporting consumers once they are hired.

3. The Department of Mental Health's 5-Year Education and Development Plan include the employing of consumers in consumer-operated programs, as well as County and Contractor operated programs, including such specialty positions as patients' rights advocates.

4. Consumers working as mental health providers be major recipients of available scholarships and stipends. Scholarships and stipends will be offered to consumers in a variety of educational opportunities including Associates; Bachelors; Masters, or Doctorate Degree, as well as non-traditional educational opportunities such as Certified Psychosocial Rehabilitation Practitioner (CPRP); Certification in Alcohol and Drug Studies (CAADAC); Mental Health Recovery Educator (MHRE or WRAP Trainer).

5. Plan for Loan Forgiveness and Scholarship Programs offered by Education and Training Program Funds have as its highest priority low-income individuals and persons in entry-level positions.
6. CNMHC recommends that a base of 33% of all scholarship and stipend program monies go to consumers.
7. CNMHC recommends that each County develops and implements a consumer-provider training program using existing consumer-developed curriculums as models.
8. To fulfill the intent of WIC §5822 (g) and (h), the Department of Mental Health and the Planning Council will hire staff that have consumer experience.
9. The Department of Mental Health and/or the Planning Council form a consumer oversight committee to implement the hiring of consumers in the workforce. This committee should be staffed by consumers contracted by the Department of Mental Health and/or the Planning Council and employed by the California Network of Mental Health Clients. The composition of the committee should include representatives of CNMHC and local consumers with experience in consumer workforce development.
10. In training consumers to be mental health providers, innovative approaches should be utilized.
11. The employment of consumers take place at all levels throughout the mental health system of care, including: management, administrative, direct service. County hiring plans will include a wide variety of work schedules: full-time, part-time, volunteers, job-sharing, etc.

Stigma and Discrimination Recommendations

CNMHC recommends that:

1. The Department of Mental Health have as a local plan requirement, that each County will report, as a section of its plan, how it will actively combat stigma and discrimination.

2. The Department of Mental Health make available to local mental health programs and interested stakeholders current information and research on effective strategies for combating stigma and discrimination, including national material from the Center for Mental Health Services ADS Center, and state and local efforts including the California Network of Mental Health Clients Bay Area Regional Project on Stigma and Discrimination, and Stamp Out Stigma of San Mateo.
3. The Department of Mental Health identify a minimum percentage of funds from Prevention and Early Intervention Program Revenue that will be spent on Campaigns to Address Discrimination and Stigma. The CNMHC recommends 20% of the Prevention and Early Intervention Program allocation for this effort.
4. In consultation with mental health stakeholders and the Oversight and Accountability Commission, the Department of Mental Health develop a strategic plan on how Sigma and Discrimination will be addressed.
5. The Department of Mental Health contract with CNMHC to assist the Department in carrying out its duties to address discrimination and stigma.

Involvement in the Mental Health Services Act Planning and Policy-Making

State Level Decision-Making

Clients can have an impact on the state level planning and policy process by a variety of activities. It is at the state level that the prescriptive county plan requirements and application FORMS are being developed. The CA DMH has been holding a series of stakeholder meetings that requires pre-registration and teleconferences that do not require pre-registration. The dates, times and locations for these events are posted and updated often on the DMH website (www.dmh.ca.gov). The materials that are being designed by the DMH MHSA team are also posted on this web location. After arriving at the web site, click on the section stating the newest event on the MHSA. Current and past materials will be listed, as will the PowerPoint presentations used during the

teleconferences. One week after each meeting, a summary of that event will also be posted. Email comments can be directed to MHSA@dmh.ca.gov and a response will be given within a few days. Input and questions can be presented via fax (916+653-9194); mail (DMH-MHSA 1600 9th Street, Room 130 Sacramento, CA 95814); and by toll-free phone (800-972-6472).

It is vital that clients respond to each of the documents produced by the DMH. The clients have the most direct and current knowledge of the mental health system as it is; the fullest concept of what holistic, voluntary, client-run services/programs could be; and the ability to look beyond the perimeters set by history and structural limitations.

Regulations established by the CA DMH will directly affect what services and programs counties will/will not develop and implement.

The CA Network of Mental Health Clients encourages all clients to contact the CNMHC office for further information, technical assistance and to share each client's vast expertise. In addition to the statewide MHSA Implementation Team, the CNMHC also has a MHSA training coordinator who can assist clients in presenting trainings in their local community to aid in preparing them to participate at all levels of the MHSA planning and implementation. Contact can be made with CNMHC in the following ways: Email main@californiaclients.org ; the web site is www.californiaclients.org ; the office address is 1722 J Street, Suite 324 Sacramento, CA 95814; the local phone is 916+443-3232 and toll-free is 800-626-7447. Documents of interest include the *Recommendations Regarding the Implementation of the MHSA* (in MS WORD and MS PowerPoint). Other documents are in development and will be available soon.

In addition, there have been on-going trainings and information presentations of the Mental Health Services Act throughout the state sponsored by several agencies. Participation by clients at these events can often “change the conversation” away from filling out the forms to placing the emphasis on “people first”. Your presence and/or interaction at the state level can have a positive impact on re-directing the focus away from bureaucracy and “same old-same old” and turn it to inclusion and systems transformation.

Local /Community Level Decision-Making

Though developing state guidelines is important, how those guidelines becomes reality in each community and county will have the greatest impact on most stakeholders. The text of the Mental Health Services Act specifically states that clients and family members must have “meaningful inclusion” in all levels of planning and policy-making as counties prepare the materials necessary to apply for the available funding.

Community participation is paramount in the success of this “systems transformation”. If the process is truly to be not “business as usual,” then clients, having the most direct knowledge and expertise, must be able to access and have a voice at the planning and policy-making process. The following are steps that each client can pursue in order to be included within his/her community planning structure:

- A. Locate the main office of your county mental health department. Either visit or phone the office, requesting to be referred to the Director’s Office. Once in contact with the administration staff, determine the status of the county’s preparation to go forward with the requirements of the MHSA. Included in this status assessment will be:
 - √ the name and contact information of the staff member or team manager in charge of the Mental Health Services Act planning,

- √ on the county's "Plan to Plan" and request a copy of it. This document will establish the planning process of your county,
- √ when, or if, the county has scheduled the client trainings. The MHSA directives from the CA DMH states that clients and family members must be given trainings prior to the stakeholders meetings and prior to any planning meetings,
- √ on the availability of reimbursement funds for travel to trainings and information meetings and other expenses within and outside of your county. Request stipends and other assistance as needed for participation in the planning process,
- √ if any community meetings have been arranged and, if so, when and where. Ask for the schedule of all of the meetings related to the process. Request any materials that may have been developed for such meetings and for the procedure by which you can respond to the written materials,
- √ to ensure that the proper staff has your name, contact information and understands your interest in being a participant in the planning and policy-making process. If you do not hear back from a staff member within 3 days, make contact again,
- √ on the schedule for the local Mental Health Board/Commission meetings (this is the body that will announce and chair the required Public Hearing of the draft CSS Plan) and request the agenda, reviewing it for agenda items dealing with the MHSA,

√ on the schedule and agenda items concerning the MHSA of the County Board of Supervisors. This is the government entity that must approve the County CSS Plan prior to its submission to the CA DMH for approval.

- B. Clients in your county should “network” and organize as an “interest group”. Coordinate client priorities of issues and develop a “mission statement” of your own. While there will be diverse interests within the group, acting as a coordinated body will give all of the clients a voice that is strong.
- C. Ask to be placed on the county’s main planning/policy committee. While many counties have already filled these positions, some have not. Other counties may have open seats or no limit on numbers of participants on this important group. If you cannot be on the main planning committee, then volunteer to participate on one of the several sub-committees that the process requires. These sub-committees should be open to all interested residents and should be organized according to the topic matter. Sub-committees often are the most important platform for developing the plans for specific areas.
- D. One of the important mottos that has come from the client movement is the phrase “Pairs for Power”. It is suggested that, when possible, clients attend meetings with at least one other client or supporter.
- E. Obtain a copy of the Mental Health Services Act. It can be a tough read, but you should familiarize yourself with the various components of the Act and its goal.
- F. Request information from the CA Network of Mental Health Clients. Materials are available now and new documents are being developed regularly.

- G. Use the web site of the CA Department of Mental Health if possible. Postings are listed frequently and contain the materials needed for background for the teleconferences and meetings. The DMH homepage contains links to many mental health organizations that are also producing materials about the MHSA. It is always helpful to have knowledge of the recommendations and concerns of various constituencies. If you do not have availability of the internet, then contact the CA DMH by phone or mail and request that all materials be sent to you.
- H. Understand the interlink between the MHSA and the current AB 2034 (Steinberg) programs that now exists in 34 areas. The MHSA (sponsored by then Assembly member Darrell Steinberg) refers to the principles of the AB 34 Pilot Programs and to the AB 2034 existing programs throughout the state. The CA DMH uses terminology based on these programs and the criteria for the applications of funding have a direct linkage to the legislation as written in the Welfare and Institution Code.
- I. Seek training and information from a variety of sources. Determine the amount of funding available through your county planning budget for clients and family members to participate in such events and, also, for in-county training and planning meetings.

Counties can use a variety of methods to involve stakeholders. No matter the method, the information gathered from these methods will be used to complete the application for counties MHSA Plan Request for Funding. If you feel that the process is not including clients as full participants in a meaningful role, then contact the appropriate staff member of the CA DMH MHSA team to voice your concern. It is much more effective to have the matter aired during the planning process rather than upon submission of the plan to the CA DMH. Of course, if there seems to be no access for clients in the planning process, then a written statement can be presented at the required Public Hearing, forcing the County Mental Health Department to respond in writing. However, the county is under no legal obligation to alter its plan based on your written comments. If, having no relief by this method, then you

may file a formal complaint to the CA DMH and ask for a meeting with the staff member having oversight of your county.

The Overarching Client Values

Each of us must advocate to ensure that this opportunity creates real transformation!

Services and programs that are:

- ◆ Voluntary
- ◆ Community-based
- ◆ Holistic
- ◆ Recovery and consumer-centered values
- ◆ Supports self-help/ peer support services
- ◆ Client-directed and client staffed