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## STAKEHOLDER BILL OF RIGHTS

### DEFINITIONS

For the purposes of this document, the following definitions shall apply:

**Client (Consumer):** "Client" means an individual of any age who is receiving or has received mental health services. As used in these regulations, the term "client" includes those who refer to themselves as clients, consumers, survivors, patients or ex-patients. (9 CCR § 3200.040.)

In addition to those described above, we have expanded the working definition of "Client" to include any individual with personal lived experience of a mental health challenge that has significantly impacted their daily life functions, whether or not they have a formal psychiatric diagnosis or received public mental health services. This expanded definition recognizes individuals from traditionally un-, under-, or inappropriately-served communities who have not interacted with California's Public Mental Health System.

**Local Mental Health Agency:** "Local Mental Health Agency" means a County Mental Health Department, two or more County Mental Health Departments acting jointly, and/or city-operated programs receiving public mental health funds in California (e.g., Berkeley; Tri- City). (See 9 CCR § 3200.090.) The programs/services provided by Counties are limited to a defined geographic area or region, and are not available statewide.

**Mental Health Services Act:** "Mental Health Services Act" means the laws that took effect on January 1, 2005 when Proposition 63 was approved by California voters and codified in the Welfare and Institutions Code. (9 CCR § 3200.220.)

**Public Mental Health System:** "Public Mental Health System" means all publicly -funded mental health programs/services and entities that are administered, in whole or in part, by a Local Mental Health Agency (as defined above) or a State Mental Health Agency (as defined below). It does not include mental health programs and/or services administered, in whole or in part, by federal, state, county or private correctional entities or programs or services provided in correctional facilities. (See 9 CCR § 3200.253.)

**PMHS Information:** "PMHS Information" means all non-private and non-privileged data, figures, calculations, plans, records, reports, summaries, evaluations, opinions, analyses, and interpretations related to public mental health programs, services, outcomes, and/or funding. "PMHS Information" includes all information/data relied upon in or arising from: (1) Community Program Planning processes; (2) Three -Year Program and Expenditure Plans; (3) Local Review Processes; (4) Annual MHSA Program and Expenditure Plan updates; (5) Amendments/changes to MHSA Performance Contracts and/or

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criminal justice & behavioral health  
to prevent incarceration*

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Expenditure Plans; (6) Non-Supplant Certifications and Reports; (7) Cost Reports; (8) Revenue and Expenditure Reports; (9) Performance Outcome Data; (10) Quarterly Progress Reports; (11) Consumer Perception Surveys; (12) Project Reports; (13) Annual Reports; (14) Evaluation Reports; and (15) any other reports or documentation required of public agencies and entities under Title 9, Division 1 of the California Code of Regulations. (*See 9 CCR § 3500, et seq.*)

**PMHS Leadership:** “PMHS Leadership” means the individuals working for PMHS agencies (including statewide agencies and local county- and city-run public mental health systems) who are responsible for entire mental/behavioral health departments or major divisions thereof, and those serving in an administrative, legislative, regulatory, advisory, or oversight capacity in statewide or local mental health agencies (such as commissioners of the Mental Health Services Oversight and Accountability Commission, members of local mental health boards and local MHSA steering committees, etc.) who develop and implement policies that impact clients/consumers receiving services in the PMHS and other stakeholders.

**Stakeholder(s):** While the term “Stakeholder” carries a unique definition under the MHSA (*see 9 CCR § 3200.270*), we are using it in place of the term “Client” (as defined above) throughout this document. This is because many people do not like the word “Client” (or “Consumer”) and prefer not to use this term when describing themselves. Thus, in this narrow context, “Stakeholder” means “Client.”

**State Mental Health Agency:** “State Mental Health Agency” refers to statewide government agencies and public entities (and departments/divisions thereof) that administer, in whole or in part, publicly-funded mental health programs/services. This definition includes the following agencies/entities: (1) the State Department of Health Care Services; (2) the California Mental Health Planning Council; (3) the Office of Statewide Health Planning and Development; (4) The Mental Health Services Oversight and Accountability Commission; (5) the State Department of Public Health; (6) the California Mental Health Services Authority; and (7) any other state agency charged with implementing the programs/services set forth in the Mental Health Services Act.

## **ABBREVIATIONS**

<u>CCR:</u>	California Code of Regulations
<u>LMHA:</u>	Local Mental Health Agency
<u>MHSA:</u>	Mental Health Services Act
<u>PMHS:</u>	California’s Public Mental Health System
<u>SMHA:</u>	State Mental Health Agency
<u>WIC:</u>	California Welfare and Institutions Code

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## STAKEHOLDER BILL OF RIGHTS (2019)

### PREAMBLE (fundamental purposes and guiding principles)

On behalf of Stakeholders throughout California and the individuals and organizations that represent Stakeholders' interests, we hereby adopt this Stakeholder Bill of Rights to:

- Foster transparency, fiscal responsibility, and public accountability within California's Public Mental Health System;
- Protect the rights of mental health Stakeholders receiving services in California's Public Mental Health System;
- Strengthen, support, and expand grassroots, Stakeholder-led public mental health advocacy;
- Promote individual and community empowerment;
- Increase meaningful Stakeholder participation and community inclusion, in public mental health planning and program design, service delivery, and evaluation;
- Facilitate collaboration and communication amongst Stakeholders, community members, Local Mental Health Agencies, State Mental Health Agencies, service providers, legislators, policy-makers, and other state and local entities that influence the Public Mental Health System; and
- Ensure effective and necessary improvements in public mental health policy, programming and services delivery.

### ENUMERATED RIGHTS

**I. Transformation: We, the Stakeholders, have the right to a PMHS that embraces the Recovery Model of Care and is fully committed to all General Standards for programs and services set forth by the MHSA.**

- A. We have the right to collaborative partners in our PMHS Leadership that share the MHSA's vision and values, are committed to openness, transparency, stakeholder engagement, and mutuality to create a PMHS that is truly client-driven.
- B. We have the right to programs and services in our PMHS that are consistent with the philosophy, principles, and practices of the mental health Recovery Model. Such programs and services shall:
  - Embrace the key recovery concepts of hope, personal empowerment, respect, social connections, self-responsibility, and self-determination;
  - Promote consumer-operated services as a way to support recovery;
  - Reflect the diversity of Stakeholder populations served;
  - Plan for each Stakeholder's individual needs;
  - Foster an environment that is non-threatening, culturally competent and affirming, and welcoming to all, regardless of race, ethnicity, culture, language, country of origin, age, gender identity, sexual orientation, disability, or other protected status.

- C. We have the right to public mental health services that are Stakeholder Driven. Stakeholders shall have the primary decision-making role in identifying their needs, preferences and strengths and a shared decision-making role in determining the services and supports that are most effective and helpful for them. Stakeholder Driven programs/services shall use Stakeholders' input as the main factor for planning, policies, procedures, service delivery, evaluation and the definition and determination of outcomes.
- D. We have the right to programs and services that are developed and implemented through Community Collaboration. Stakeholders and families receiving services, other community members, agencies, organizations, and businesses shall work together to share information and resources to shape public mental health policy and create public mental health services that fulfill a shared vision and goals.
- E. We have the right to a PMHS that demonstrates Cultural Competence in all aspects of policy-making, program design, administration, and services delivery. Our PMHS shall take active steps to identify and reduce disparities in engagement, retention, access to services, and treatment effectiveness for individuals of diverse racial/ethnic, cultural (including members of LGBTQ communities), and linguistic populations. Our PMHS shall reflect an understanding of the diverse belief systems concerning mental illness, health, healing and wellness that exist among different racial/ethnic, cultural, and linguistic groups. Our PMHS shall implement policies and practices that understand and address historical bias, racism, and other forms of discrimination upon racial/ethnic, cultural, and linguistic populations, and that work to reduce the effects of bias, racism, and other forms of discrimination on the mental health of individuals. Our PMHS shall promote equal opportunities for administrators, service providers, peer professionals, and others involved in service delivery who share the diverse racial/ethnic, cultural, and linguistic characteristics of the communities and populations served.
- F. We have the right to Linguistic Competence in our PMHS. Organizations and individuals working within our LMHAs shall be capable of communicating effectively and conveying information in a manner that is easily understood by diverse audiences, including individuals with Limited English Proficiency, individuals who have few literacy skills or are not literate, and individuals with disabilities that impair communication. Our LMHAs shall ensure structures, policies, procedures, and dedicated resources enable organizations and individuals to effectively respond to the literacy needs of the populations being served.

## II. **Information: We, the Stakeholders, have the right to full transparency in our PMHS.**

- A. We have the right to unrestricted and unobstructed access to PMHS Information.
- B. We have the right to express our preferences regarding the types of PMHS Information collected, the methods by which PMHS Information is collected, and how PMHS Information is shared with stakeholders and the general public. To the extent possible, all non-private and non-privileged PMHS Information shall be made freely available and accessible to all.
- C. We have the right to receive timely responses to our questions involving PMHS Information that are:

- Specific;
- Thorough and complete;
- Honest and accurate;
- Supported by verifiable facts, evidence, or data; and
- In writing, if we so request.

**III. Education: We, the Stakeholders, have the right to fully understand the meaning and implications of facts and data relevant to our PMHS.**

- A. We have the right to have PMHS Information – including related processes and procedures – thoroughly explained to us in a clear and meaningful way. We have the right to have PMHS Information explained in the language and format we best understand.
- B. We have the right to receive training and guidance from our LMHA to facilitate our effective participation in the deliberative process and help us better understand the functions and operations of our PMHS.

**IV. Representation : We, the Stakeholders, have the right to competent and adequate representation when important decisions are made in our PMHS.**

- A. We have the right to stakeholder representation on deliberative bodies (including boards, subcommittees, workgroups, and advisory panels) that determine or influence how public mental funds are spent and how publicly-funded mental health programs and services are developed, implemented, overseen, evaluated, and revised. We have the right to nominate specific stakeholders of our choice to serve on these bodies.
- B. We have the right to a designated Client Advocate/Liaison in each LMHA. The Client Advocate/Liaison shall have personal lived experience of recovery from a mental health challenge and shall have experience receiving services in the PMHS. We have a right to participate in the selection of candidates for this position. The Client Advocate/Liaison shall serve as a member of our local LMHA's leadership team to represent the collective interests of client/consumer stakeholders at all management-level internal planning, development, implementation, oversight, evaluation, and quality improvement meetings and discussions. The Client Advocate/Liaison shall also participate on interview panels and take part in hiring discussions when candidates for leadership positions within our LMHA are considered.
- C. Our traditionally unserved, underserved, and inappropriately served communities – including, but not limited to, racial/ethnic and LGBTQ populations, transition age youth, older adults, veterans, immigrants, refugees, and homeless individuals – have the right to be actively engaged by our PMHS to participate in important operational, administrative, programming, and funding decisions that directly or indirectly impact these communities and populations.
- D. We have the right to be represented in designated peer support positions in our LMHA. Individuals holding such positions shall have similar personal lived experience as the

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Stakeholder population they serve. Peers who primarily work with adult mental health Clients shall have their own personal lived experience of recovery from a mental health challenge to maintain fidelity to the evidence-based peer support model. Furthermore, such peers shall be empowered by our LMHA to advocate on behalf of the individuals they serve.

**V. Participation: We, the Stakeholders, have the right to shape policy and meaningfully participate in all important programming and funding decisions in our PMHS.**

- A. We have the right to be recognized as essential, co-equal partners in our PMHS. We have the right to be consulted and to have our opinions, preferences, and recommendations actively solicited and fully considered at all stages of program planning, development, implementation, oversight, evaluation, and improvement in our PMHS. We have the right to be involved in decisions about how public mental health funds will be used. We have the right to present our ideas and suggestions before important programming and funding decisions are made in our PMHS and have the right to withhold support for programming and funding decisions that were made without our input.
- B. We have the right to remain informed of significant changes of fact or circumstance that will impact the services and supports provided by our PMHS. We have the right to receive notice and an opportunity to be heard before our PMHS substantially amends existing programming or funding determinations and to be consulted when any such amendments are considered.
- C. We have the right to share our preferences, opinions, experiences, and criticisms related to our PMHS openly and publicly without fear of retaliation or retribution.

**VI. Consideration: We, the Stakeholders, have the right to submit grievances to our PMHS, to have our grievances acknowledged, and to receive thorough and timely responses to our grievances.**

- A. We have the right to a PMHS that effectively responds to the needs of the individuals and communities it serves.
- B. We have the right to hold PMHS leaders accountable for programming decisions, the adequacy, appropriateness, and effectiveness of publicly-funded mental health services, policies and processes, outcomes, and for how these actions (or lack thereof) have impacted individual stakeholders and our communities. We have the right to voice our complaints and file formal grievances in our PMHS when we believe, in good faith, that our rights have been violated. We have the right to have our grievances fully considered and the circumstances addressed in our grievances investigated. We have the right to have our complaints or grievances acknowledged upon their submission. We have the right to a timely and thorough response to our grievance from our PMHS.