



## E-Learning Toolkit

**ACCESS California** is a program of Cal Voices funded by the California Mental Health Services Act (Prop 63) and by the Mental Health Services Oversight and Accountability Commission (MHSOAC)



WELLNESS · RECOVERY · RESILIENCE

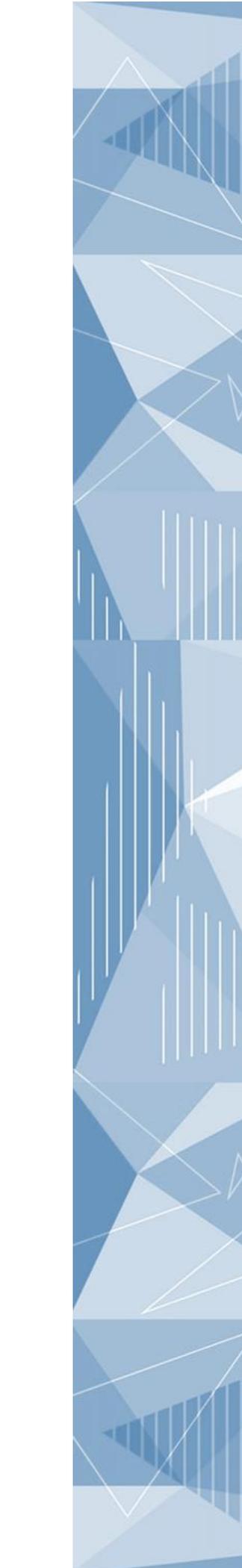


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## ACCESS CALIFORNIA E-LEARNING TOOLKIT OVERVIEW

### Purpose

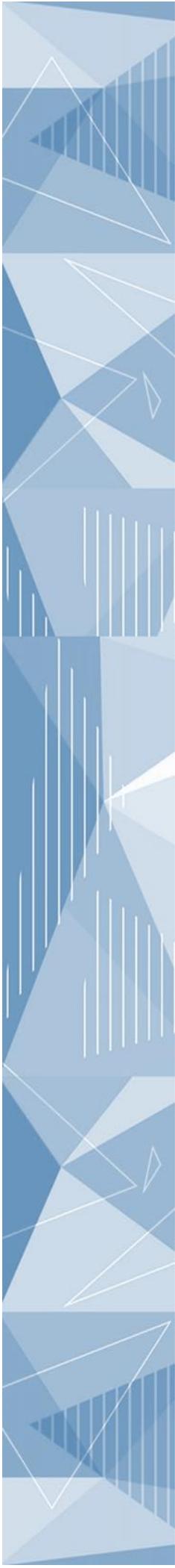
The ACCESS California E-Learning Toolkit provides handouts and worksheets to aid in completing the Local Advocacy 101 and MHSA 101 eLearning modules. These materials can also be used to educate community members about the Mental Health Services Act and the local community planning process, as well as how to develop a public statements.

### Audience

The target populations and audiences for this eLearning Toolkit include:

- **Clients/Consumers** (individuals of any age who are receiving or have received mental health services, including those who refer to themselves as clients, consumers, survivors, patients or ex-patients)
- **ACCESS Ambassadors** (local subject-matter experts who also identify as clients/consumers)
- **Peer Support Workers and Volunteers** (clients/consumers who currently work – or who want to work – in peer support positions within the public mental health system)
- **Peer-run Agencies and Programs** (Agencies and programs that are managed and operated by individuals with lived experience)
- **Communities and the General Public** (local advocates, stakeholders, family members, supporters of clients/consumers, and members of underserved populations)

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## **SECTION 1: THE MENTAL HEALTH SERVICES ACT**

### **Use of Materials**

Materials in this section can be used to:

- Understand and Inform people about what it means for a system to be “client-driven,” “recovery-focused,” and “culturally competent”
- Effectively advocate for their personal and community mental health needs on both the local and state levels
- Guide and/or evaluate the Community Program Planning Process

### **Handouts**

- Handout: MHSA Essential Elements
- Handout: MHSA Program Components
- Handout: ACCESS MHSA Program Planning Guidelines

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## MHSA General Standards

WIC § 5813.5(d); MHSA § 2(e)

The County shall adopt the following standards in planning, implementing, and evaluating the programs and/or services provided with Mental Health Services Act (MHSA) funds. The planning, implementation and evaluation process includes, but is not limited to, the Community Program Planning Process; development of the Three-Year Program and Expenditure Plans and updates; and the manner in which the County delivers services and evaluates service delivery.

### (1) Community Collaboration

A process by which clients and/or families receiving services, other community members, agencies, organizations, and businesses work together to share information and resources in order to fulfill a shared vision and goals. WIC §§ 5830(a)(3), 5866; 9 CCR § 3200.060

### (2) Cultural Competence

Incorporating and working to achieve each of the goals listed below into all aspects of policy-making, program design, administration and service delivery. Each system and program is assessed for the strengths and weaknesses of its proficiency to achieve these goals. The infrastructure of a service, program or system is transformed, and new protocol and procedure are developed, as necessary to achieve these goals.

1. Equal access to services of equal quality is provided, without disparities among racial/ethnic, cultural, and linguistic populations or communities.
2. Treatment interventions and outreach services effectively engage and retain individuals of diverse racial/ethnic, cultural, and linguistic populations.
3. Disparities in services are identified and measured, strategies and programs are developed and implemented, and adjustments are made to existing programs to eliminate these disparities.
4. An understanding of the diverse belief systems concerning mental illness, health, healing and wellness that exist among different racial/ethnic, cultural, and linguistic groups is incorporated into policy, program planning, and service delivery.
5. An understanding of the impact historical bias, racism, and other forms of discrimination have upon each racial/ethnic, cultural, and linguistic population or community is incorporated into policy, program planning, and service delivery.

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6. An understanding of the impact bias, racism, and other forms of discrimination have on the mental health of each individual served is incorporated into service delivery.
7. Services and supports utilize the strengths and forms of healing that are unique to an individual's racial/ethnic, cultural, and linguistic population or community.
8. Staff, contractors, and other individuals who deliver services are trained to understand and effectively address the needs and values of the particular racial/ethnic, cultural, and/or linguistic population or community that they serve.
9. Strategies are developed and implemented to promote equal opportunities for administrators, service providers, and others involved in service delivery who share the diverse racial/ethnic, cultural, and linguistic characteristics of individuals with serious mental illness/emotional disturbance in the community.

WIC §§ 5813.5(d)(3), 5868(b), 5878.1(a); 9 CCR § 3200.100

### **(3) Client Driven**

The client has the primary decision-making role in identifying his/her needs, preferences and strengths and a shared decision-making role in determining the services and supports that are most effective and helpful for him/her. Client driven programs/services use clients' input as the main factor for planning, policies, procedures, service delivery, evaluation and the definition and determination of outcomes.

WIC §§ 5813.5(d)(2)(3), 5830(a)(2) and 5866; 9 CCR §3200.050

### **(4) Family Driven**

Families of children and youth with serious emotional disturbance have a primary decision-making role in the care of their own children, including the identification of needs, preferences and strengths, and a shared decision-making role in determining the services and supports that would be most effective and helpful for their children. Family driven programs/services use the input of families as the main factor for planning, policies, procedures, service delivery, evaluation and the definition and determination of outcomes.

WIC §§ 5822(h), 5840(b)(1), 5868(b)(2) 5878.1; 9 CCR §3200.120

### **(5) Wellness, Recovery, and Resilience Focused**

Planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers: To promote concepts key to the recovery for individuals who have mental illness: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination. To promote consumer-operated services as a way to support recovery. WIC § 5813.5(d); MHS § 7

### **(6) Integrated Service Experience**

The client, and when appropriate the client's family, accesses a full range of services provided by multiple agencies, programs and funding sources in a comprehensive and coordinated manner. WIC §§ 5878.1(a), 5802, 5806(b), 5813.5(d)(4); 9 CCR § 3200.190

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## MENTAL HEALTH SERVICES ACT (MHSA) PROGRAM COMPONENTS

### Community Services and Supports (CSS)

- Programs, services, and strategies to address the unmet needs of adults with Severe Mental Illness (SMI) and children and youth with Serious Emotional Disturbance (SED) Emphasis on eliminating disparity in access and improving mental health outcomes for racial/ethnic populations
  - Full Service Partnership (FSP) - Provide “whatever it takes” for initial populations.
  - General System Development - Improve programs, services and supports for the identified full service populations and others consistent with the target populations
  - Outreach and Engagement - Outreach and engagement of those populations that are currently receiving little or no service
- Funding: 80% of MHSA funds
  - 51% of CSS funds must be for FSPs
  - Reversion period: 3 years

### Prevention and Early Intervention (PEI)

- Services & Programs designed to prevent mental illness from occurring or from becoming more severe and disabling; Address a condition early, low intensity, short duration
  - Universal: Programs and services that target the general public or a whole population group that has not been identified on the basis of individual risk
  - Selective: Programs and services that target individuals or a subgroup whose risk of developing mental illness is significantly higher than average
- Funding: 20% of local MHSA funding
  - 51% of PEI funds must be used to serve individuals age 25 and younger
  - Reversion Period: 3 years

### Workforce Education and Training (WET)

- Programs designed to increase # of qualified diverse individuals working in the mental health field to address shortage individuals available to provide mental health services
  - Training Components
    - Workforce Staffing support
    - Training and Technical Assistance
    - Residency and Internship Programs
    - Mental Health Career Pathway Programs
    - Financial Incentive Programs
- Funding: 10% of local MHSA funds (one-time funding)
  - Reversion Period: 10 years

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## Capital Facilities and Technology

- Buildings/Structures, housing, electronic health records, client access to records, etc. to improve the infrastructure of California's mental health system
  - Capital: Construct, acquire, and/or renovate buildings to provide mental health services
  - Technology: Develop IT system that supports the delivery of mental health services – electronic health records, interoperability with other IT systems, client access to personal health records
- Funding: 10% of local MHSA funds (one-time funding)
  - Reversion period: 10 years

## Innovation

- Develop & Implement promising practices-increase access by underserved groups, increase quality of service, improve outcomes, and promote collaboration
  - Focus = Contribution to learning
  - Must be: New, Adapted, or Adopted
  - Subject to time limitations
- Funding: 5% from CSS and PEI funds
  - Reversion Period: 3 years
  - Plans that are successful can be sustained by CSS funding

## Housing

- Housing assistance to the target populations
  - Rental assistance or capitalized operating subsidies.
  - Security deposits, utility deposits, or other move-in cost assistance
  - Utility payments
  - Moving cost assistance
  - Capital funding to build or rehabilitate housing for homeless, mentally ill persons or mentally ill persons who are at risk of being homeless.
- Funding: One-Time Funding
  - Reversion Period: 10 years

## MHSA PROGRAM PLANNING GUIDELINES FOR LOCAL MENTAL HEALTH AGENCIES ACCESS CALIFORNIA | JANUARY 2018

### ABOUT ACCESS CALIFORNIA

ACCESS California (or "ACCESS" for short) is a statewide consumer-led advocacy program of Mental Health America of Northern California ("NorCal MHA") funded by the Mental Health Services Act ("MHSA") and the Mental Health Services Oversight and Accountability Commission ("MHSOAC").

ACCESS stands for **A**dvancing **C**lient and **C**ommunity **E**mpowerment through **S**ustainable **S**olutions. Our mission is to strengthen and expand local and statewide client/consumer advocacy through individual and community empowerment. Through ACCESS' ongoing research, data collection and evaluation, legislative and policy analysis, advocacy, education, training, outreach, and engagement activities, we implement strategies to elevate the voices, identify the needs, and increase genuine public participation of client/consumer stakeholders to drive truly transformative change in California's Public Mental Health System.

### PURPOSE

This document originated as a supplement the MHSOAC's Innovation Review Outline issued on May 25, 2017 (<http://mhsoac.ca.gov/document/2017-05/mhsoac-commission-meeting-packet-may-25-2017>, p. 115) to incorporate additional factors of concern to client/consumer stakeholders in California's Public Mental Health System ("PMHS"). ACCESS is charged with ensuring Local Mental Health Agencies ("LMHAs") adequately integrate the MHSA's statutory standards (Community Collaboration, Cultural Competence, Client- and Family-Driven and Wellness, Recovery, and Resilience Focused, and Integrated Service Experiences) in the development and implementation of MHSA-funded services. (9 CCR § 3320.) Thus, these guidelines are intended to be applied when evaluating the planning processes undertaken for any MHSA-funded mental health program or service.

ACCESS offers technical assistance to LMHAs to help with the development of their MHSA Plans (and in particular, Innovation Plans), including the incorporation of the guidelines contained herein. ACCESS can review LMHAs' Plans from a client/consumer advocacy perspective, assist in stakeholder outreach, engagement, and recruitment to ensure a robust Community Program Planning Process ("CPP"), and offer guidance on how to integrate recovery-oriented principles, peer support services, and ongoing stakeholder involvement in the development, implementation, oversight, and evaluation of LMHAs' MHSA and Innovation Plans.

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## APPLICATION

ACCESS will utilize these guidelines when providing technical assistance to LMHAs in relation to their MHSA and Innovation Plans and when reviewing and providing public comment on LMHAs' proposed Innovation Plans during MHSOAC meetings.

## ABBREVIATIONS

<u>ACCESS:</u>	ACCESS California, NorCal MHA's MHSOAC-funded statewide advocacy program
<u>CCR:</u>	California Code of Regulations
<u>CPP:</u>	The Community Program Planning process required under the MHSA
<u>LMHA:</u>	Local Mental Health Agency (county- or city-run public mental health systems)
<u>MHSA:</u>	California's Mental Health Services Act, aka "Prop. 63"
<u>MHSOAC:</u>	Mental Health Services Oversight and Accountability Commission
<u>MHSA Plan:</u>	Local Mental Health Agency's Three-Year MHSA Program Plan and updates/addenda thereto
<u>NorCal MHA:</u>	Mental Health America of Northern California; founded in 1946, NorCal MHA is the oldest peer-run consumer advocacy organization in the state
<u>PMHS:</u>	California's Public Mental Health System
<u>WIC:</u>	California Welfare and Institutions Code

## DEFINITIONS

For 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 identified in the MHSA's official definition above, we have expanded our working definitions of "Client" and "Consumer" to include individuals with personal lived experience of a mental health challenge, whether or not they have a formal psychiatric diagnosis or received public mental health services. In doing so, we are broadening our constituency to incorporate individuals from traditionally un-, under-, or inappropriately-served communities who have not interacted with California's Public Mental Health System.

**Stakeholder:** While the term "Stakeholder" carries a unique definition under the MHSA (*see* 9 CCR § 3200.270), we are using it interchangeably with "Client" and "Consumer" throughout this document. This is because many people do not like the terms "Client" and "Consumer" and prefer not to use these terms when describing themselves.

## MHSA PROGRAM PLANNING GUIDELINES

### **THEME ONE: ADVOCACY, MEANINGFUL STAKEHOLDER PARTICIPATION, AND CLIENT-DRIVEN PROGRAMS/SERVICES**

#### **Describe the CPP undertaken to develop the MHSA Plan.**

1. How did the changes/updates to the MHSA Plan originate? Where did the ideas for these changes/updates come from?
  - Did stakeholders offer any alternative programs or services to address the same goals?
  - Did stakeholders express a preference to fund other/different priorities?
2. How was stakeholder feedback solicited and incorporated in the development of the MHSA Plan?
  - What outreach activities, if any, did you perform to engage stakeholders in the CPP?  
For example:
    - How are you using the MHSA planning funds designated under WIC § 5892(c) and 9 CCR § 3300(b) to bring stakeholders to the table?
    - How did you advertise or notify stakeholders of the MHSA planning meetings?
    - What outreach/engagement methods did you use to reach new participants and those from traditionally un-, under-, and/or inappropriately-served populations?
    - What barriers to participation exist for stakeholders in your LMHA?
    - What strategies did you implement to help participants overcome common barriers to participation in the CPP?
  - How many public stakeholder meetings were held and who participated?
    - When and where were the meetings held? (dates, times, locations)
    - How many different client/consumer stakeholders attended these meetings? How many of these stakeholder participants were not LMHA or provider employees?
    - How many stakeholder representatives from traditionally un-, under-, and/or inappropriately-served groups participated?
    - Are any of the participating client/consumer stakeholders recipients of mental health services in your LMHA (currently or previously)?
    - Did your LMHA's designated consumer advocates/liasons participate in these MHSA Planning meetings?
    - Did any peer support staff participate in these MHSA Planning meetings?
    - Did you provide any training to stakeholders pursuant to 9 CCR § 3300(c)(3)(B) to ensure those participating in the CPP had adequate information and understanding to meaningfully participate?

- How did the MHSa Plan change, if at all, based on the stakeholder feedback you received?

*Authorities:* WIC §§ 5846(c)-(d), 5847(b)(4), 5848(a), 5892(a)(6), 5892(c), 5892(e)(3); 9 CCR §§ 3300(b)-(c), 3930(b)(1)

*Resources:* NorCal MHA/ACCESS MHSa 101 and Shared Power trainings; RDA: MHSa Community Program Planning Processes – Technical Evaluation Report (2014)

### **How will stakeholders remain actively involved in the implementation and oversight of your MHSa program(s)?**

1. How will stakeholders remain involved in the oversight, quality improvement, and evaluation of the services/activities described in the MHSa Plan?
2. If changes are necessary to the MHSa Plan, how will you include stakeholder feedback and recommendations in the development of these changes?

*Authorities:* WIC §§ 5813.5(d)(2), 5848(a); 9 CCR §§ 3200.070(3), 3910.015(b), 3910.020(a)(1), 3915(g), 3930(b)(2), 3930(c)(8)(B), 3935(a)

## **THEME TWO: RECOVERY-ORIENTED SYSTEMS, SERVICES, PRACTICES, AND OUTCOMES**

### **How are the services and/or activities you propose to perform under this Plan recovery-oriented?**

1. Which of SAMHSA's 4 Major Dimensions and 10 Guiding Principles of Recovery are addressed by and/or incorporated into the services/programs described in the MHSa Plan?
  - 4 Major Dimensions: (1) Health; (2) Home; (3) Purpose; (4) Community
  - 10 Guiding Principles: (1) Hope; (2) Person-Driven; (3) Many Pathways; (4) Holistic; (5) Peer Support; (6) Relational; (7) Culture; (8) Addresses Trauma; (9) Strengths/Responsibility; (10) Respect
2. How are the services/activities/programs in the MHSa Plan client-driven? How do they incorporate and maximize shared decision-making values?
3. What recovery-based outcome tools and measurements will you use to evaluate the effectiveness of your MHSa program(s)?

*Authorities:* WIC § 5813.5(d); 9 CCR §§ 3320, 3915(b)

*Resources:* SAMHSA's Working Definition of Recovery (2012); NorCal MHA/WISE Recovery 101 training

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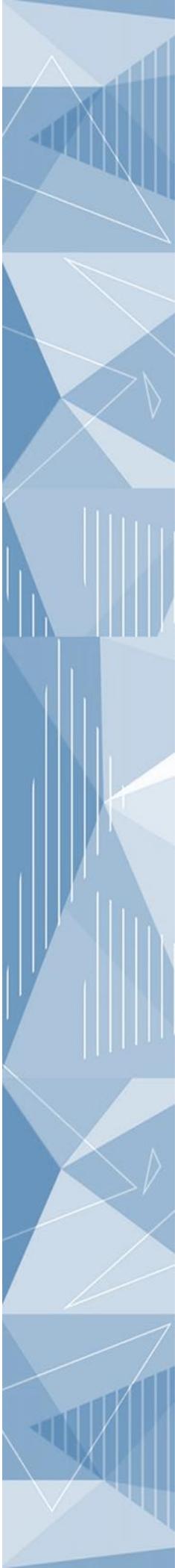
**THEME THREE: EXPANSION AND STRENGTHENING OF PEER SUPPORT SERVICES;  
INCREASED STAKEHOLDER EMPLOYMENT OPPORTUNITIES WITHIN THE PMHS****Are peer support positions included in the MHS Plan?**

1. If not, why?
2. If so:
  - How many positions?
  - Full time or part time?
  - Contracted or hired directly?
  - Living wages and health benefits?
  - Opportunities for continuous learning, professional development, career advancement?
  - Lived experience required or merely desired?
  - Lived experience matches population(s) served?
  - Peers reflect diversity of communities served?
  - What trainings and ongoing education do peers receive to develop and enhance SAMHSA's 12 Core Competencies for Peer Support Workers and to ensure fidelity to the evidence-based peer support model?
  - Are peers supervised/managed by other peer professionals to promote career ladders for peers and to ensure performance expectations and practice guidelines reflect fidelity to the evidence-base and core principles of peer support?
  - What trainings and ongoing education do supervisors, clinicians, etc. who work with peers receive to help peers develop and enhance Core Competencies and ensure fidelity to the evidence-based peer support model and prevent co-optation and marginalization of peers?

*Authorities: WIC §§ 5694, 5813.5(d)(2)-(3), 5822(g)*

*Resources: SAMHSA's Core Competencies for Peers (2015); NorCal MHA/WISE Peer Employer Toolkit; NorCal MHA/WISE Peer Support 101 training*

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## **SECTION 2: LOCAL ADVOCACY**

### **Use of Materials**

Materials in this section can be used to:

- Understand how to meaningfully participate and share power in the public planning process
- Identify local advocacy opportunities
- Organize the contact information of community members, community leaders, decision makers, and other individuals connected or concerned with your issue
- Inform people on how to meaningfully participate and share power in the public planning process

### **Handouts**

- Stakeholder Bill of Rights
- Brown Act Brochure
- Advocacy Opportunities
- Contact List Template

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## STAKEHOLDER BILL OF RIGHTS (2018)

### 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 Local Mental Health Agencies 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)

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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 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

## STAKEHOLDER BILL OF RIGHTS (2018)

### 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 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.

## CLOSED MEETINGS

Closed meetings are the exception and permitted only if they meet defined purposes and follow special requirements (§§ 54953(a), 54954.5, 54962).

## EVEN AT CLOSED MEETINGS...

Special public notice and agenda requirements apply (§§ 54954, 54954.2, 54954.5, 54957.7).

All actions taken and all votes in closed session must be publicly reported orally or in writing (§ 54957.1(b)), and copies of any contracts or settlements approved must be made available promptly (§ 54957.1(b),(c)).

## CLOSED MEETINGS MAY BE HELD FOR: Personnel

Only to discuss the appointment, employment, performance evaluation, discipline, complaints about or dismissal of a specific employee or potential employee (§ 54957). The employee may request a public meeting on any charges or complaints.

But closed sessions are **NOT ALLOWED** for discussing:

- general employment
- independent contractors not functioning as employees
- salaries
- the performance of any elected official, or member of the board
- the local agency's available funds
- funding priorities or budget

## Pending Litigation

Only if open discussion "would prejudice the position of the agency in the litigation." The litigation must be named on the posted agenda or announced in open session unless doing so would jeopardize the board's ability to service process on an unserved party or conclude existing settlement negotiations to its advantage. (§4956.9)

To qualify, the agency must:

- be a party to pending litigation (§ 54956.9(a))
- or expect, based on certain specified facts, to be sued (§§ 54956.9(b)(1),(b)(2))
- or expect to file suit itself (§ 54956.9(c))

## Labor Negotiations

Only to instruct the agency's identified negotiator on compensation issues (§ 54957.6). (Note: school districts are covered by the Rodda Act, Govt. Code §§ 3540-3549.3.)

## Property Negotiations

Only to discuss, with an agency's identified bargaining agent, price or payment terms. The parcel, negotiators and the prospective seller or purchaser must be identified on the agenda. (§ 54956.8) Final price and payment terms must be disclosed when the actual lease or contract is discussed for approval. (§ 54957.1(a))

## Others

License applications for people with criminal records (§54956.7); threats to public services or facilities; (§54957) insurance pooling (§54956.95).

## WHAT TO DO IF:

### A MEETING IS CLOSED THAT SHOULD BE OPEN

- Refuse to leave, and use this Guide to check the law, to protest, and to enforce all notice requirements.
- Leave only if ordered by law enforcement.
- Call your editor or lawyer at once.

### AN ILLEGAL CLOSED MEETING HAS BEEN HELD

- Ask participants what happened, and get reports of actions taken and copies of contracts approved.
- Call FAP, SPJ or CFAC (phone numbers are on the cover of this Pocket Guide).
- Write a story or letter to the editor about it.
- Contact the District Attorney under § 4959, or take legal action under § 54960(a) against violations or a "gag rule" imposed on a body's members.
- A court may: (1) force the agency to make and preserve tapes of closed sessions (§ 54960(b)); (2) declare actions taken null and void (§ 54960.1(d)); (3) award costs and attorneys fees (§ 54960.5).

# A POCKET GUIDE TO OPEN MEETING LAWS IN CALIFORNIA: THE BROWN ACT

A SERVICE OF:

**THE FIRST AMENDMENT PROJECT  
SOCIETY OF PROFESSIONAL  
JOURNALISTS (Nor. Cal.)**

## HOW TO USE THIS GUIDE

This pocket guide is intended to be a quick reference and provide general information to journalists and citizens. It addresses some common public meetings problems, but does not substitute for research or consultation with a lawyer on detailed questions. This guide current as of December 3, 2003.

## FOR MORE INFORMATION OR HELP:

FIRST AMENDMENT PROJECT.....510/208-7744  
[www.thefirstamendment.org](http://www.thefirstamendment.org)

Society of Professional Journalists,  
NORTHERN CALIFORNIA CHAPTER.....415/338-7434  
[www.spj.org/norcal](http://www.spj.org/norcal)

California First Amendment Coalition.....916/974-8888  
[www.cfac.org](http://www.cfac.org)

*Funding provided by the Sigma Delta Chi Foundation  
of the Society of Professional Journalists*

# Brown Act

Govt. Code §§ 54950-54960.5

## THE BASICS

Meetings of public bodies must be “open and public,” actions may not be secret, and action taken in violation of open meetings laws may be voided. (§§ 54953(a), 54953(c), 54960.1(d))

## WHO'S COVERED

- **Local agencies**, including counties, cities, school and special districts. (§ 54951)
- **“Legislative bodies”** of each agency, the agency’s governing body, plus “covered boards,” that is, any board, commission, committee, task force or other advisory body created by the agency, whether permanent or temporary. (§ 54952(b))
- Any **standing committee** of a covered board, regardless of number of members. (§ 54952(b))
- **Governing bodies of non-profit corporations formed by a public agency** or which includes a member of a covered board and receives public money from that board. (§ 54952(c))

## WHO'S NOT COVERED

- **Ad hoc advisory committees** consisting of less than a quorum of the covered board (§54952(b))
- Most other **non-profit corporations**
- All **other government agencies**. State governmental agencies are covered by the Bagley-Keene Open Meeting Act. (Govt. Code §§ 11120-11132)

## WHAT'S COVERED

A “meeting” is any gathering of a majority of the members of a covered board to hear, discuss, or deliberate on matters within the agency’s or board’s jurisdiction. (§ 54952.2(a))

**Note:** No vote or action is required for the gathering to be a meeting, nor must the members meet face to face. (§ 54952.2)

## WHAT MUST HAPPEN

Under the Brown Act an agency must:

- **post notice and an agenda** for any regular meeting, (§§ 54954(a), 54954.2(a)); mail notice at least three days before regular meetings to those who request it, (§ 54954.1); post notice of continued meetings, (§54955.1); deliver notice of special meetings at least one day in advance to those who request it, (§ 54956); and deliver notice of emergency meetings at least one hour in advance to those who request it. (§§54956, 54956.5)
- **notify the media** of special or emergency meetings if requested, (§§ 54956, 54956.5); allow media to remain in meetings cleared due to public disturbance. (§54957.9)
- **hold meetings in the jurisdiction** of the agency except in limited circumstances, (§§ 54954(b)-(e)), and in places accessible to all, with no fee. (§ 54961(a))
- **not require a “sign in”** for anyone. (§54953.3)
- **allow non-disruptive recording** and broadcast of meetings, (§54953.5(a)), and let the public inspect any recording made by the agency of its open meetings. (§54953.5(b)) The agency may destroy recordings it made after 30 days. (§54954.3(b))
- **allow the public to address** the covered board at regular or committee meetings on any item in the agency’s jurisdiction not addressed by the agency at an open earlier meeting. (§54954.3(a))
- **conduct only public votes**, with no secret ballots. (§54953(c))
- **treat documents as public** “without delay,” if distributed to all or a majority of members of a board before or at the meeting, unless they are also exempt under the Public Records Act. (§54957.5)

### Local Rules

Many local jurisdictions, including San Francisco, Contra Costa County, and Oakland, have adopted local “Sunshine” ordinances that grant greater access and openness. Check for local rules.

Other jurisdictions often have rules that *violate* the Brown Act. Challenge such rules or contact the agencies listed on this brochure.

## WHAT IF . . .

- a council member is on a board of a non-profit corporation—is the board covered?
  - YES, if the council both appointed him or her to the board, and funds the corporation. (§54952(b),(c)(1))
- an agency delegates authority to another entity—is the entity covered?
  - YES, if it was created by the agency’s elected body. (§§ 54952(b),(c)(1))
- a council committee meeting has less than a quorum—is it required to meet openly?
  - YES, if it is a standing committee and has either a set meeting schedule or a continuing subject matter jurisdiction. (§ 54952(b))
- members use individual contacts to collectively decide an issue—is that a violation?
  - YES, information communicated to a quorum through a series of contacts, individual phone calls (“daisy chain”), or a third person (“spoke and wheel”) to evade the public is a “meeting” (§ 54952.2(b); 63 Ops.Atty.Gen. 820 (1980); Stockton Newspapers v. Stockton Redevelopment Agy., 171 Cal.App.3d 95 (1985); Common Cause v. Stirling, 147 Cal.App.3d 518 (1983).
- agency members attend a conference called by someone else—is this covered?
  - NO, so long as they do not discuss specific business matters within their jurisdiction (§ 54952.2(c))
- a meeting is held by video/teleconference.
  - YES, if the public’s rights are protected. (§54953(b))
  - Every video/teleconference location must be accessible to the public, and at least a quorum of the members must participate from locations within the body’s jurisdiction. (§ 54953(b))



## **INSTRUCTIONS ADVOCACY OPPORTUNITIES**

### **Step 1: Meetings**

- Identify current public meetings that exist in your county
- Example: Local Mental Health Board, MHSA Community Planning Process, etc.)

### **Step 2: Opportunities for Stakeholders**

- Identify current opportunities that exist for stakeholder participation

### **Step 3: Opportunities for Peer Staff**

- Identify current opportunities that exist for peer staff participation

### **Step 4: Barriers**

- Identify current barriers that exist for stakeholder participation

### **Step 5: Solutions/Improvements**

- Develop strategies that you can use to overcome barriers to participation
- 

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### ADVOCACY OPPORTUNITIES

Identify current meetings, committees, and/or planning processes that exist in your county. Are these meetings, committees, and/or planning processes providing opportunity for meaningful stakeholder input? Are stakeholders approving plans, or are they involved in planning and program design, services delivery, and evaluation?

MEETING NAME	WHAT OPPORTUNITIES EXIST FOR COMMUNITY MEMBERS TO PARTICIPATE?	WHAT OPPORTUNITIES EXIST FOR PEER STAFF TO PARTICIPATE?	WHAT CURRENT BARRIERS EXIST TO STAKEHOLDER PARTICIPATION?	POTENTIAL SOLUTIONS/ IMPROVEMENTS

ACCESS California is a program of Cal Voices funded by the California Mental Health Services Act (Prop 63) and by the Mental Health Services Oversight and Accountability Commission (MHSOAC)



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MEETING NAME	WHAT OPPORTUNITES EXIST FOR COMMUNITY MEMBERS TO PARTICIPATE?	WHAT OPPORTUNITES EXIST FOR PEER STAFF TO PARTICIPATE?	WHAT CURRENT BARRIERS EXIST TO STAKEHOLDER PARTICIPATION?	POTENTIAL SOLUTIONS/ IMPROVEMENTS



## **INSTRUCTIONS CONTACT LIST**

A contact list can help you in organizing the contact information of community members, community leaders, decision makers, and other interested parties.

### **Step 1: List**

- List individuals that you currently know along with their preferred method of contact

### **Step 2: Network**

- Add individuals and organizations that you meet who have a common interest in your issue
- Find out how each individual prefers to be contacted. They will be more likely to respond

### **Step 3: Update**

- Update your contact list annually or as needed
- 

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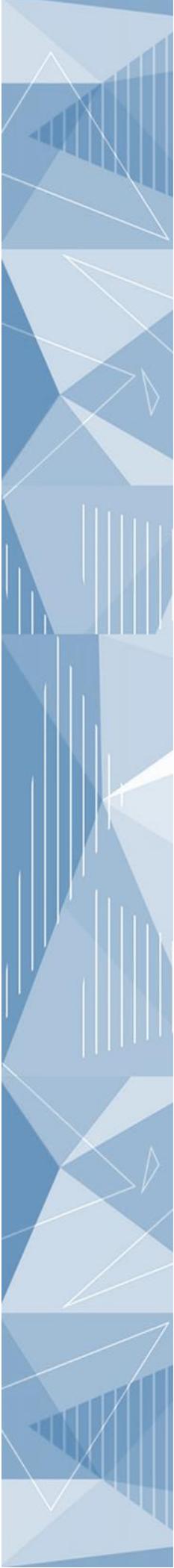
### CONTACT LIST

List individuals that you currently know along with their preferred method of contact. Add individuals and organizations that you meet who have a common interest in your issue. Update as needed.

CONTACT	AGENCY (IF APPLICABLE)	EMAIL	PHONE	WHERE WE MET	EXPERTISE/FOCUS

**ACCESS California** is a program of Cal Voices funded by the California Mental Health Services Act (Prop 63) and by the Mental Health Services Oversight and Accountability Commission (MHSOAC)

CONTACT	AGENCY (IF APPLICABLE)	EMAIL	PHONE	WHERE WE MET	EXPERTISE/FOCUS



## **SECTION 3: RECOVERY-ORIENTED SERVICES**

### **Use of Materials**

Materials in this section can be used to:

- Understand how to meaningfully participate in your own Recovery with shared decision making and person-centered practices
- Identify strength-based language
- Identify a Recovery-Oriented workplace

### **Handouts**

- Dr. Ragins' What is Recovery Based Practice
- Person Centered vs. Illness Centered
- Shared Decision Making
- Strength-based language
- Worksheet: How recovery oriented is your workplace?

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## What is Recovery Based Practice? – Outline

(2010)

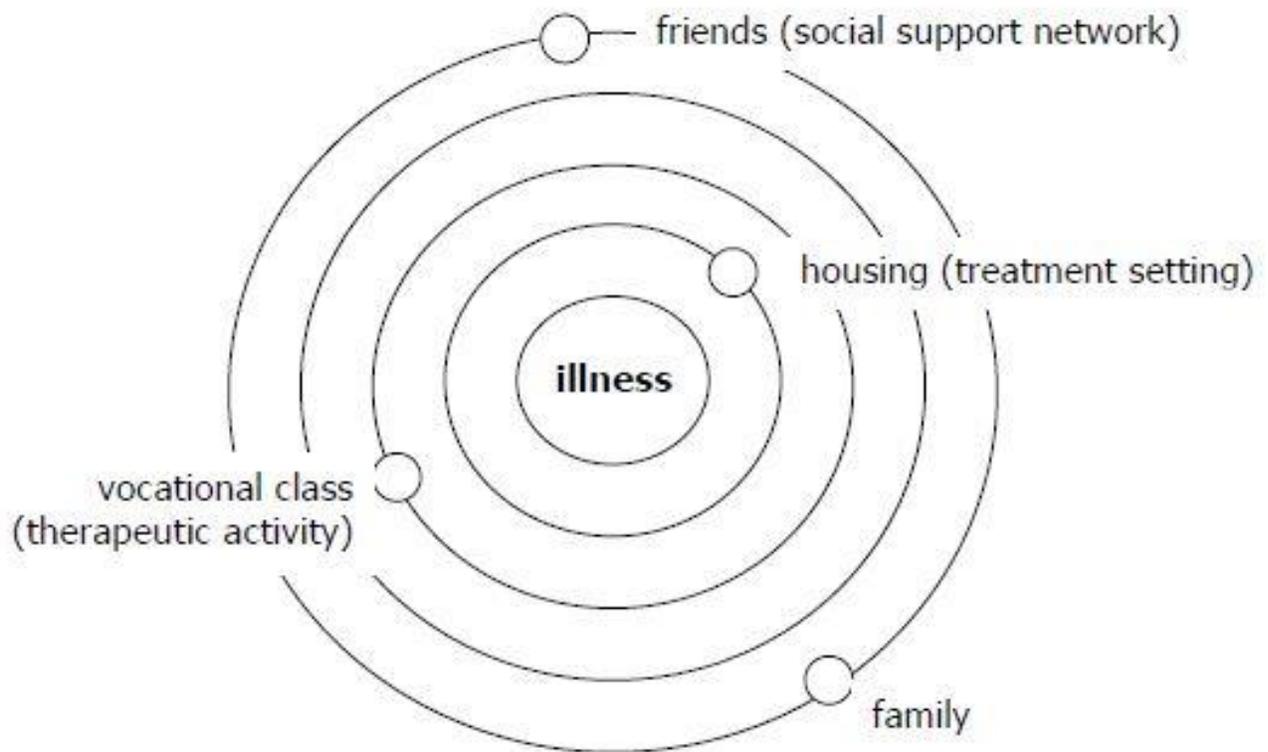
At this point a large array of recovery based practices have been developed, that rivals any model, including the medical model. The vision and principles of the recovery movement can be translated into practices. Programs can be evaluated for how much recovery based practice they are actually doing and funders can have specific expectations. Note that even if all these things are done, a good deal of recovery is about program culture and how things are done, not just what is done.

Here is my “list” of comprehensive recovery based practices:

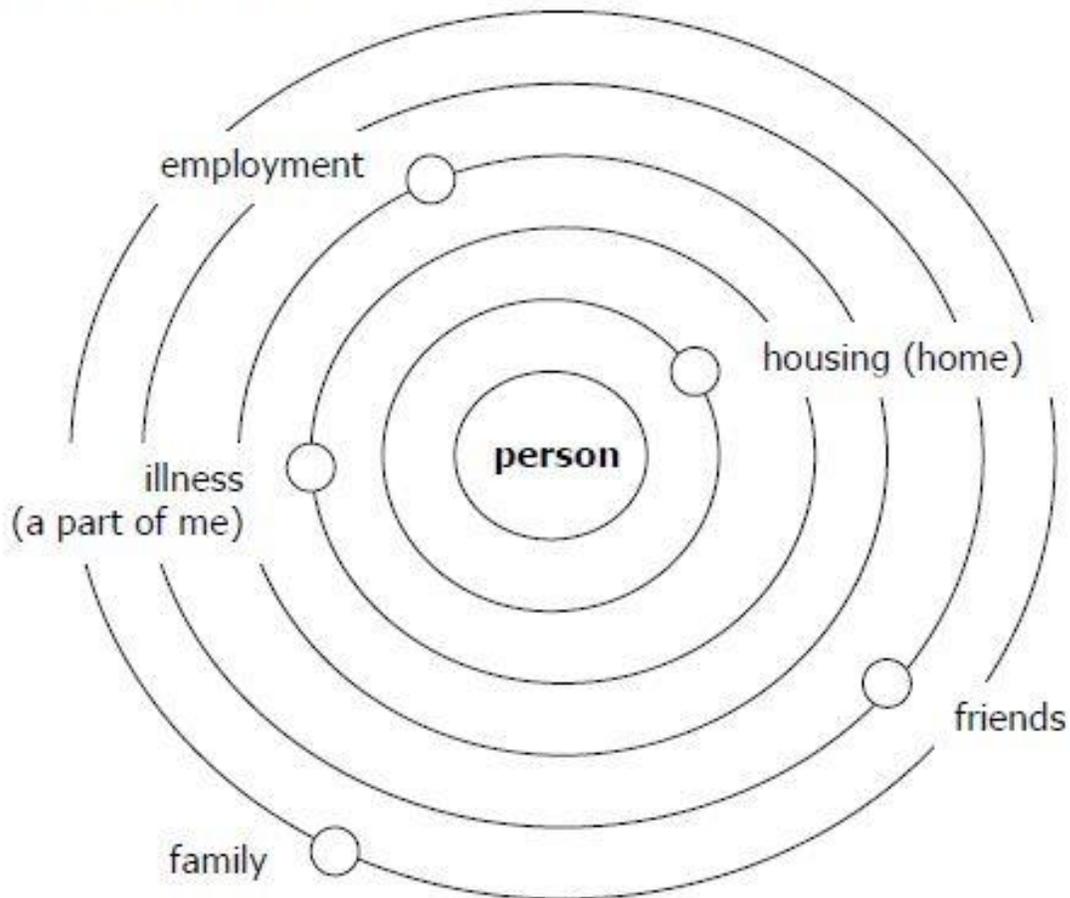
- 1) *Engagement and welcoming* – Focus on relationship and trust building services, not requiring diagnosis or insight or medication, “meeting people where they’re at”, harm reduction, “housing first”, peer engagement, outreach, charity.
- 2) *Person-centered planning and goal-driven services* - Develop a shared story of the person’s life instead of a history of illness, identify strengths to be used in recovery, assist in formulating goals to pursue collaboratively, identify potential barriers and develop shared plans to overcome barriers, develop goal setting skills, use a menu of services supplied by an integrated team and community.
- 3) *Sharing decision-making and building self responsibility* – Develop collaborative relationships, describe service choices in understandable language and as it impacts the consumer’s goals, “client driven services”, advanced directives, assist in learning from consequences of decisions to learn to make new choices – learn from mistakes, define respective roles in achieving goals increasing self responsibility and self reliance
- 4) *Rehabilitation - building skills and supports* –Do things with people instead of for them, use “teachable moments”, in vivo skill building, assist with entitlements, supports, and opportunities, psychiatric rehabilitation and psychosocial rehabilitation, clubhouses and learning roles, peer support.
- 5) *Recovery-based medication services* – Consider treatment optimization approaches that balance judicious use of medications with other treatment, rehab, and recovery interventions, with particular emphasis on patient/client/consumer preference. Align use of medications with the consumer’s goals, instead of symptom control. Taking medication to improve symptoms needn’t precede rebuilding lives. Medications can initially be for “short term” effects until a “customer relationship” is built. Getting off medications happens when they’re no longer needed to attain and maintain goals, not when symptoms are relieved. Medications enable self help coping techniques, rather than competing with them.

- 6) *Peer support and self help* – Cultivate opportunities for outreach and engagement, peer counseling, shared stories and humanity, peer advocacy, peer bridging, acceptance, “giving back”, peer support groups, 12-step, coping skills, self care, WRAP.
- 7) *Adapting and integrating therapy and healing* - Provide therapeutic relationships without excessive structure or rules. Emphasize engagement, relationship building, “corrective emotional experiences”. Create a healing environment – sanctuary, counterculture of acceptance, “therapeutic milieu”, group therapy without walls, Carl Rogers – empathy, authenticity, caring.
- 8) *Trauma-informed care* – Increase trauma awareness, empathetic relationships, trauma healing and recovery, personal safety and boundaries. Avoid retraumatization cycles, and traumatization by staff including reducing coercion, seclusion and restraints.
- 9) *Spirituality and alternative approaches* – For some persons, healing and recovery requires attention to their spiritual life. Faith and communing with others who share similar spiritual beliefs, without proselytizing or requiring participation in formal religious activities, can be a very powerful and supportive adjunct to feeling whole, inclusion of spiritual strengthening practices and healing.
- 10) *Community integration and quality of life support services* – Identify needs and gaps in social supports, and provide benefits assistance, redocumentation, “supported services” – housing, education, employment, medical care, community development, finding “welcoming hearts” in the community, finding a niche, meaningful roles, community inclusion, rights and responsibilities, avoiding “failures of community integration” – hospitalization, homelessness, imprisonment.
- 11) *Graduation and self-reliance* – Build strengths and resilience, protective factors, gifts from their suffering, overcoming fear of losing benefits and illness roles, replacing professional supports with self help and personal supports, developing community treatment resources, “coming out” to fight stigma and discrimination.

## illness centered



## person centered



PERSON CENTERED	ILLNESS CENTERED
The relationship is the foundation	The diagnosis is the foundation
Begin with welcoming – outreach and engagement	Begin with illness assessment
Services are based on personal suffering and help needed	Services are based on diagnosis and treatment needed
Services work towards quality of life goals	Services work towards illness reduction goals
Treatment and rehabilitation are goal driven	Treatment is symptom driven and rehabilitation is disability driven
Personal recovery is central from beginning to end	Recovery from the illness sometimes results after the illness and then the disability are taken care of
Track personal progress towards recovery	Track illness progress towards symptom reduction and cure
Use techniques that promote personal growth and self responsibility	Use techniques that promote illness control and reduction of risk of damage from the illness
Services end when the person manages their own life and attains meaningful roles	Services end when the illness is cured
The relationship may change and grow throughout and continue even after services end	The relationship only exists to treat the illness and must be carefully restricted throughout keeping it professional

## Shared Decision Making

### What is shared decision making?

Shared decision making is a key component of patient-centered health care. It is a process in which clinicians and patients work together to make decisions and select tests, treatments and care plans based on clinical evidence that balances risks and expected outcomes with patient preferences and values.

#### When patients engage in shared decision making they...

- learn about their health and understand their health conditions
- recognize that a decision needs to be made and are informed about the options
- understand the pros and cons of different options
- have the information and tools needed to evaluate their options
- are better prepared to talk with their health care provider
- collaborate with their health care team to make a decision right for them
- are more likely to follow through on their decision

#### What Providers Say About the Value of Shared Decision Making

- Patients are more knowledgeable and better prepared for dialogue
- Helps the patient understand what we are trying to do
- Builds a lasting and trusting relationship
- Both physicians and patients are very satisfied

Source: Adapted from Shared Decision Making video produced by Lekeview Hospital and Stillwater Medical Group. © 2013. Used with permission

### Why is shared decision making important?

In many situations, there is no single "right" health care decision because choices about treatment, medical tests, and health issues come with pros and cons. Shared decision making is especially important in these types of situations:

- when there is more than one reasonable option, such as for screening or a treatment decision
- when no one option has a clear advantage
- when the possible benefits and harms of each option affect patients differently

### What is the benefit of shared decision making?

Shared decision making helps providers and patients agree on a health care plan. When patients participate in decision making and understand what they need to do, they are more likely to follow through.

## How does health IT help shared decision making?

Health IT tools such as interactive decision aids, patient portals, personal health records, and secure electronic messaging can help with shared decision making. For example, patients can access decision aids and relevant patient education materials via a patient portal and communicate with their health care team about the decision via secure messaging. Practices can build triggers into the EHR to remind providers to give patients a decision aid.

### Introducing Shared Decision Making to Patients: Suggested Language for Providers

- *Sometimes things in medicine aren't as clear as most people think. Let's work together so we can come up with the decision that's right for you.*
- *People have different goals and concerns. As you think about your options, what's important to you?*
- *Do you want to think about this decision with anyone else? Someone who might be affected by the decision? Someone who might help sort things out?*

Source: *Six Steps of Shared Decision Making*. © 2012 by Informed Medical Decisions Foundation. Used with permission.

## Tips for Shared Decision Making

The following six steps will help providers with shared decision making. They are adapted from the Informed Medical Decisions Foundation.<sup>1</sup>

1. **Invite the patient to participate:** Inviting patients to participate lets them know that they have options and that their goals and concerns are a key part of the decision making process.
2. **Present options:** Patients need to know the available options.

3. **Provide information on benefits and risks:** Provide balanced information based on the best available scientific evidence. Check back with patients to be sure they understand.
4. **Assist patients in evaluating options based on their goals and concerns:** To understand patients' preferences, ask them what is important to them and what they are concerned about.
5. **Facilitate deliberation and decision making:** Let patients know they have time to think things over, and ask them what else they need to know or do before they feel comfortable making a decision.
6. **Assist patients to follow through on the decision:** Lay out the next steps for patients, check for understanding, and discuss any possible challenges with carrying out the decision.

## Selected Resources

### Decision Aids

Decision aids for a variety of health issues are available at no cost from:

- [Mayo Clinic](#)
- [Ottawa Hospital Research Institute](#)

### Toolkits and Provider Education Resources

These resources offer step-by-step implementation guidelines and skills training:

- [Decision Support Toolkit](#)  
(Dartmouth Center for Shared Decision Making)
- [Implementation Toolkit](#)  
(Ottawa Hospital Research Institute)
- [Decision Support as a Clinical Skill Toolkit](#)  
(Dartmouth Center for Shared Decision Making)

### Patient Resources

(from Informed Medical Decisions Foundation)

Video: [What is Medical Shared Decision Making?](#)

Accompanying patient visit guide: [I Wish I had Asked that!](#)

<sup>1</sup> Source: *Six Steps of Shared Decision Making*. © 2012 by Informed Medical Decisions Foundation. Adapted and used with permission.

## STRENGTH BASED LANGUAGE

### The old worldview hides in our language

Because the illness worldview still predominates, we will need to be very intentional with our language: It is how we best express our new worldview. So now is a good time to start rethinking how you refer to yourself and others. Although we will not prescribe terms or language that we all must use, we will challenge each other to consider language that strengthens our wellness worldview and avoid language that may undermine it. Old habits die hard and so do old worldviews, so let's challenge each other respectfully, but challenge each other nonetheless.

**The Power of Worldview:** The power of how we see things is sadly revealed in the way people interpret a person's behavior simply on the basis of their perception of that person as *normal* or *diagnosed*:

You as "Normal"	Me as "Diagnosed"
If you are overly excited, you're happy	If I'm overly excited, I'm manic
If you imagine the phone ringing all day, you're just stressed out	If I imagine the phone ringing, I'm psychotic
If you're crying and sleeping all day, you're sad and need some time off	If I'm crying and sleeping all day, I'm depressed and need to get up
If you're afraid to leave the house at night you're cautious	If I'm afraid to leave the house at night, I'm paranoid
If you speak your mind and express your opinions, you're assertive	If I speak my mind and express my opinions, I'm aggressive
If you don't like something and mention it, you're being honest	If I don't like something and mention it, I'm being difficult
If you get angry, you're upset	If I get angry, I'm dangerous and need to get medicated or restrained
If you overreact to something, you're sensitive	If I overreact to something, I'm out of control
If you don't want to be around other people, you're taking care of yourself and relaxing	If I don't want to be around other people, I'm isolating and avoiding
If you talk to strangers, you're being friendly	If I talk to strangers, I'm being inappropriate
If you speak bluntly to others, you're being rude	If I speak bluntly to others, I have a behavior problem
If you don't follow orders, you don't like being told what to do	If I don't follow orders, I'm being noncompliant
If your house is messy, you probably don't like housework	If my house is messy, I need to learn some ADLs (Activities of Daily Living)
If you ask someone out, it's a date	When I ask someone out, it's an outing to learn social skills
<b>For all these behaviors you are considered to be a human being having a normal emotional response</b>	<b>For many of these behaviors, I'm told to take a pill, or hospitalized</b>

(Thanks to Elaine Popovic and Debbie Sesula)

And the difference between **You** and **Me** is our labels.

**The Power of Language:** Language has the power to stigmatize and demean, or respect and uplift. Some people who receive mental health or substances abuse services use the term “consumer” to refer to themselves and others, while others prefer to be called “survivors.” Some people now prefer the term “peer” while others simply prefer to be referred to as a “person” or a “person who receives services” or “individual living with a mental health condition.”

However, as people who are truly seeking wellness, let’s consider the power that language has before we make our personal choices. Let’s look at words that can hurt or help people.

<b>Words that stigmatize, demean and pathologize and invite discrimination:</b>	<b>Words that uplift us: that recognize and respect our shared humanity and strength:</b>
Manipulation	Survival mode; overwhelmed and trying to get needs met
Low functioning, under developed	Coping, fighter flight
Case, Patient, client consumer	Person receiving services, person, individual living with a mental health condition
Decompensating	Becoming ill, things are breaking down; things aren’t working
Non-compliant (or compliant)	Independent, autonomous, taking personal responsibility, freely exercising rights
Frequent flyer	Trying to get it right. Giving lots of opportunities to help
Unmotivated	Not ready, not helpful
“A _____.” (fill in the blank with any diagnosis)	“A person who has been given the diagnosis of _____.”
Depressed	Sad, down in the dumps, worn out, need time to get well, anger/ fear
Symptomatic	Experiencing big feelings, intense feelings
Cutter	Experiencing pain through self-harm
Grandiose	Thinking big, expressing hopes and dreams, ambitious

**ACCESS California** is a program of Cal Voices funded by the California Mental Health Services Act (Prop 63) and by the Mental Health Services Oversight and Accountability Commission (MHSOAC)



WELLNESS · RECOVERY · RESILIENCE

**HOW RECOVERY-ORIENTED IS YOUR WORKPLACE?**

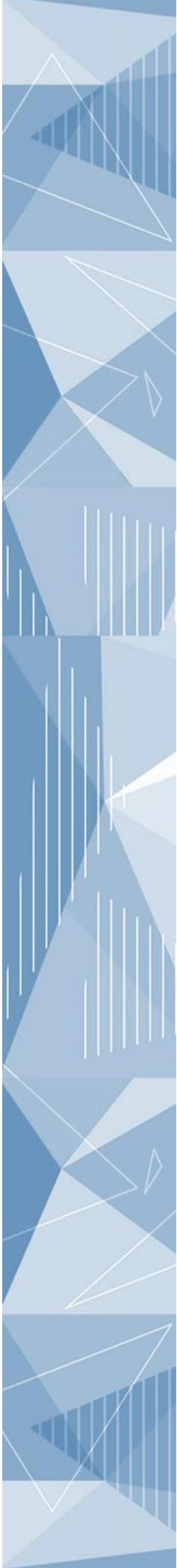
<i>The mental health system I work in and people I work with ...</i>	<b>Strongly Agree</b>	<b>Agree</b>	<b>Neutral/ Not Sure</b>	<b>Disagree</b>	<b>Strongly Disagree</b>
Provide services that focus on reducing clients' disability and improving quality of life for clients and their supporters					
Encourage the individuality of staff and clients					
Promote accurate and positive portrayals of psychiatric disability, while actively fighting discrimination					
Focus on individual strengths and people's unique contributions					
Use language of hope and possibility					
Offer a variety of options for treatment, rehabilitation, and support					
Help people develop valued social roles, interests, and hobbies					
Effectively engage stakeholders in treatment and services					
Actively involve service users, family members, and other natural supports in the development and implementation of programs and services					
Encourage stakeholder participation and advocacy activities					
Build buy-in and facilitate connections amongst groups representing various interests					

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WELLNESS • RECOVERY • RESILIENCE

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## **SECTION 4: HOST A GROUP E-LEARNING SESSION**

### **Use of Materials**

Materials in this section can be used to:

- Prepare for a group ACCESS California E-Learning session
- Advertise the E-Learning Session

### **Handouts**

- Group Session Preparation Checklist
- Fillable Flyer Template

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## TRAINING PREPARATION

### PREPARATION

- Determine which E-Learning module you will be discussing
- Select a date/time
- Identify a meeting location
  - Is public transportation nearby?
  - Is parking available?
  - Room set-up
  - Equipment needs
    - Computer
    - Projector
    - Speakers
- Develop an invitation/announcement
- Disseminate invitation/announcement
- Identify and prepare materials
  - Sign-In Sheet (if applicable)
  - Handouts

---

### FOLLOW-UP

- Are there items that need to be followed up on with meeting participants?
  - Who is responsible?
  - How will follow-up be communicated to the group?
- Let ACCESS know how it went
  - Email us at [access@norcalmha.org](mailto:access@norcalmha.org)

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# MENTAL HEALTH SERVICES ACT 101

## GROUP E-LEARNING SESSION



Mental Health Services Act (MHSA) 101 focuses on the MHSA's core principles, values, and essential elements, as well as MHSA's five services components (CSS, PEI, WET, INN, CAP FAC) and the funding structures. Participants will learn about California's Public Mental Health system, the history of the Consumer Movement, relevant aspects of the client/consumer culture in California, and the political origins of the MHSA. This learning session will also touch on proposed California laws that may influence mental health policy, access, and services.

### DATE & TIME

### LOCATION

ACCESS California is a program of NorCal MHA. Our mission is to strengthen and expand local and statewide client/consumer advocacy through individual and community empowerment.

### REGISTER:



[wiseup.work](https://wiseup.work)



[/NorCalMHA](https://www.facebook.com/NorCalMHA)



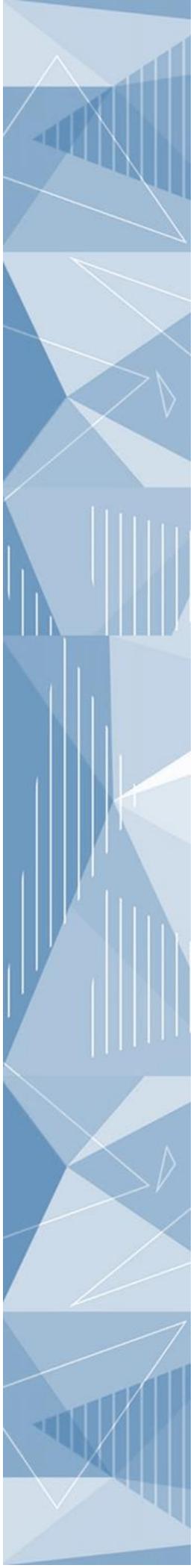
WELLNESS • RECOVERY • RESILIENCE

NorCal  
MHA

MHSOAC

Mental Health Services  
Oversight & Accountability Commission

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## **SECTION 5: ACCESS PROGRAM RESOURCES**

### **Use of Materials**

Materials in this section can be used to:

- Inform people about ACCESS California
- Reach out to ACCESS to get assistance with identifying local advocacy opportunities
- Reach out to ACCESS to report a violation in the Community Program Planning Process

### **Handouts**

- Handout: ACCESS brochure
- Handout: ACCESS Helpline/Ombudsman
- Handout: What is a Peer?

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## ACCESS Themes

Our program activities are structured around three specific themes, all of which advance client/consumer empowerment and inclusion, and reflect and reinforce the foundational principles and values of the Mental Health Services Act (MHSA), which include:

- Client-driven services
- Community collaboration
- Cultural competence
- Integration of services, including mental health, primary care, and co-occurring services
- Wellness, recovery, and resiliency

**Advocacy:** Meaningful stakeholder participation

**Recovery:** Implementation of recovery-oriented systems and services

**Peer Support:** Expansion of peer support services within the Public Mental Health System

## Ombudsman & Advocacy Helpline

Are you looking for more information on local, statewide, or federal mental health laws and policies?

Want to start advocating in your community but not sure where to start?

Reach out to ACCESS California's Advocacy Helpline! Our dedicated staff will help you. We can even connect you with local ACCESS Ambassadors near you.

**CALL** the 24-hour message line:



**(707) 572 - 4357**

## ACCESS California

720 Howe Ave, Suite 102  
Sacramento, CA 95825

Office Phone: 916-376-7736  
Fax: 916-400-3338  
E-mail: [access@norcalmha.org](mailto:access@norcalmha.org)



**ACCESS**  
California A PROGRAM OF  
CAL VOICES

[www.accesscalifornia.org](http://www.accesscalifornia.org)

**ACCESS California** (Advancing Client and Community Empowerment through Sustainable Solutions) is a program of Cal Voices funded by the California Mental Health Services Act (Prop 63) and by the Mental Health Services Oversight and Accountability Commission (MHSOAC)

**CAL VOICES**  
ADVOCACY · RECOVERY · PEER SUPPORT

a continuation of  
**NorCal**  
MHA  
Mental Health Act



**MHSOAC**  
Mental Health Services  
Oversight & Accountability Commission





- Get connected to the statewide network
- Get the latest and up-to-date information on consumer stakeholder advocacy efforts
- Get the support you or your organization needs from the ACCESS Team

**(707) 572-HELP**  
**707-572-4357**

## ACCESS California

720 Howe Ave, Suite 102  
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Office Phone: 916-376-7736  
Fax: 916-400-3338  
E-mail: [access@norcalmha.org](mailto:access@norcalmha.org)  
[www.accesscalifornia.org](http://www.accesscalifornia.org)

**“WE ALL KNOW THE POSSIBILITY OF TRANSFORMATION OF MENTAL HEALTH SERVICES IS ROOTED IN THE STAKEHOLDER PROCESS.”**

California Behavioral Health Directors Association

## About ACCESS California

ACCESS (Advancing Client and Community Empowerment through Sustainable Solutions) California is a client/consumer-led statewide advocacy program funded by the Mental Health Services Oversight and Accountability Commission (MHSOAC) and a program of Cal Voices, a continuation of Mental Health America of Northern California (NorCal MHA).

## Our Mission

To strengthen and expand local and statewide client/consumer stakeholder advocacy in California's Public Mental Health System through individual and community empowerment.

It starts with



## What We Do

### Research

- Data Collection and Evaluation
- Legislative and Policy Analysis
- State of the Community Report

### Outreach

- Statewide Advocacy Conference
- Statewide Directory
- Quarterly Newsletter

### Education

- Consumer Stakeholder Training
- Workforce Integration Support
- Technical Assistance for Counties and Providers
  - \* Innovation Plan Feedback
  - \* Recovery-Based Treatment Tools
  - \* Strengthening and Expanding Peer Support Programs

### Advocacy

- Local and Statewide Mental Health Advocacy
- Monitoring Mental Health Bills
- Network of Consumer Advocates (ACCESS Ambassadors)
- Ombudsman & Advocacy Helpline

# Ombudsman Advocacy Helpline

**(707) 572 - HELP**

[www.accesscalifornia.org/helpline](http://www.accesscalifornia.org/helpline)

Are you looking for advocacy opportunities in your local public mental health system?

Do you need support advocating?

Has a violation occurred in your local Community Program Planning Process??

Give our Advocacy Helpline a call! The Advocacy Helpline is a 24 hour message line. Our Outreach Team will call you back within 2 business days to assist you with your situation.

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## What is a Peer?

Put simply, a peer is a person we identify with in some capacity. This can include anything from age to gender to sexual orientation to shared language. In behavioral health, a peer is usually used to refer to someone who shares the experience of living with a mental health condition. In that narrow context two people living with a mental illness are peers, but in reality most people are far more specific about whom they would rely on for peer support. Trust and compatibility are extremely important factors.

Peers are people in recovery from mental health conditions  
**They are living proof that recovery is possible**



Peer support is the “process of giving and receiving encouragement and assistance to achieve long-term recovery.” Peer supporters “offer emotional support, share knowledge, teach skills, provide practical assistance, and connect people with resources, opportunities, communities of support, and other people” (Mead, 2003; Solomon, 2004).

## Peer Supporters support others in recovery

They utilize their:

- lived experience
- formal skills
- knowledge of systems



To provide support through:

- advocacy
- education
- mentoring
- motivation

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Peer Supporters (also known as peer providers, peer support specialists, navigators, peer advocates, peer counselors, to name a few) can play many roles in supporting people living with mental illness, such as:

- Facilitating education and support groups
- Linking people to services as they transition from hospitals or jails into the community
- Working one-on-one as role models, mentors, coaches and advocates
- Supporting people in developing advanced directives and creating Wellness Recovery Action Plans (WRAP).

## Benefits of Peer Support

Peer support is considered a best practice by the Substance Abuse and Mental Health Services Administration (SAMHSA).

Research shows peer support services can have a big impact on the individuals receiving services they support by:

- Reducing symptoms and hospitalizations
- Increasing social support and community participation
- Decreasing lengths of hospital stays and costs of services
- Improving well-being, self-esteem, and social functioning
- Encouraging more thorough and longer-lasting recoveries

Peers go by many names and can work in many different settings. Many peers have additional training and certifications that demonstrate their skills and knowledge. Combined with their lived experience and ability to engage and connect with individuals receiving services, peer supporters are a dynamic and growing group that continue to transform lives and systems.



## Peer support changes lives.



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