W·I·S·E
Workforce Integration Support and Education

2019 CONSUMER ADVOCATE LIAISON PRACTICE MANUAL

A guide to influencing decisions that improve the lives of Adult Clients in California's Public Mental Health System.

CAL VOICES
ADVOCACY • RECOVERY • PEER SUPPORT

a continuation of NorCal MHA Mental Health America

WELLNESS • RECOVERY • RESILIENCE

OSHPD Office of Statewide Health Planning and Development

WISE is a program of Cal Voices funded by the California Mental Health Services Act (Prop 63) and administered by the Office of Statewide Health Planning and Development (OSHPD).

HAVE YOU HEARD?

NorCal MHA has changed its name to Cal Voices!

Why the Name Change?

- Our former name – Mental Health America of Northern California – was too long, which made it difficult to say and remember.
- The shortened version of our former name – NorCal MHA – no longer reflected our agency's scope. We've held statewide advocacy and training contracts for over a decade, so we don't operate exclusively in Northern California anymore. Essentially, we outgrew the "NorCal" in our name and it was time for an update.

Why Cal Voices?

- Cal Voices is short and sweet, making it easy to say and remember, and it doesn't rely on any complicated acronyms.
- Cal Voices is broad enough to encompass all the work we do locally, regionally, and statewide, which includes consumer advocacy, legislative and policy analysis, mental health research, best practices development and promotion, recovery-oriented programming, direct peer support services, education and training, etc.
- Cal Voices is flexible enough to remain relevant to any new activities we may take on in the future.

Will Cal Voices Remain an MHA Affiliate Organization?

- Yes, we will continue our affiliation with MHA National. Other local and regional MHAs have enacted similar name changes while maintaining their MHA affiliation.

When Did the Name Change Take Effect?

- Our name change was approved by the California Secretary of State in October 2019. It's officially official!

Anything Else?

- Staff will continue to receive all emails sent to their @norcalmha.org email addresses even after we've established their new Cal Voices email accounts.
- Our existing website, norcalmha.org, will redirect visitors to our new Cal Voices website once it's up and running.

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Mental Health America

INTRODUCTION

"Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has."

~Margaret Mead

The 2019 Consumer Advocate Liaison (CAL) Practice Manual was created by Cal Voices' (formerly NorCal MHA) Workforce Integration Support and Education (WISE) Program. The guidance and resources provided are intended to inform Public Mental Health Service (PMHS) Employers and Consumer Advocate Liaisons throughout California.

The information and resources are intended to provide a historical context to the role, paint a clear picture of the knowledge, skills and abilities Consumer Advocate Liaisons bring to the Public Mental Health System, and provide tools and tips on how to strengthen these vital positions to the local mental health systems (counties) across California.

Cal Voices is a client/consumer run organization providing advocacy, self-help and recovery-oriented services to mental health clients and the public mental health system for over 70 years. As a result, we have an intrinsic understanding of the unique history and culture that mental health clients in California undergo. First, mental health clients experience the profound stigma of a diagnosis of a serious mental health condition and/or substance use disorder, and are presently or have been a recipient of some public mental health services or government assistance. Additionally, some common experiences for mental health clients includes: potential turbulent relationships with family, marginal employment opportunities, lack of access to affordable housing and challenges of daily living. Most of us have also experienced a significant level of isolation and loneliness. For some clients, such challenges may culminate in lost years of productivity (employment), and/or loss of personal fulfillment. These losses can be difficult to share with others and cause barriers toward integrating into a new life of recovery.

Therefore, the Consumer Advocate Liaison represents and advocates for the interests and concerns of consumers. The position supports its county program development, and provides voice, and representation on behalf of the local Mental/Behavioral Health Departments in existing and new initiatives. When counties incorporate these Liaisons into their counties they have taken one step forward, by ensuring that their system is being driven by those they are serving.

THE MENTAL HEALTH BELL: A SYMBOL OF HOPE

Cast from shackles which bound them, this bell shall ring out hope for the mentally ill and victory over mental illness.

—Inscription on Mental Health Bell

During the early days of mental health treatment, asylums often restrained people who had mental illnesses with iron chains and shackles around their ankles and wrists. With better understanding and treatments, this cruel practice eventually stopped.

In the early 1950s, Mental Health America issued a call to asylums across the country for their discarded chains and shackles. On April 13, 1953, at the McShane Bell Foundry in Baltimore, Md., Mental Health America melted down these inhumane bindings and recast them into a sign of hope: The Mental Health Bell.

Maryland Gov. Theodore McKeldin and Mrs. A. Felix DuPont in 1953 pour the metal made from melted chains used to restrain people with mental illnesses to create the Mental Health Bell.

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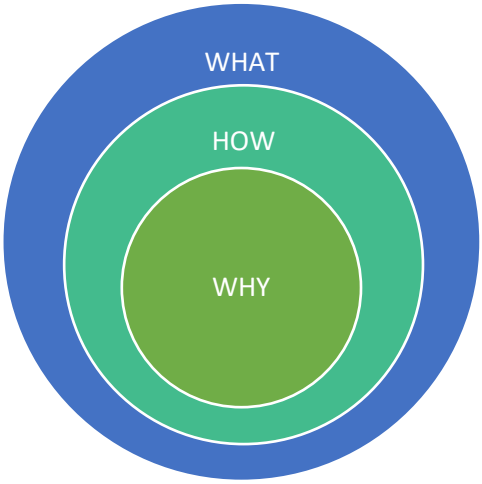
START WITH WHY?



WHY
Why do you do what you do?

HOW
How do you do what you do?

WHAT?
What do you do?

We naturally communicate from the outside-in, we go from the clearest thing to the fuzziest thing. We tell people WHAT we do, we tell people HOW we do are different or special and then we expect a behavioral like funding, a vote or support.

The problem is that WHAT and HOW do not inspire action. Facts and figures make rational sense, but we don't make decisions purely based on facts and figures. Starting with WHAT is what commodities do.

Starting with WHY is what LEADERS do. LEADERS INSPIRE. -SIMON SINEK

When Consumer Advocate Liaisons start with WHY, they need to ask themselves a series of questions:

1. What do Public Mental Health Clients in my county want/need?
2. Who can make it happen?
3. What do the decision/policy makers need to hear?
4. Who do the decision/policy makers need to hear it from?
5. How can I make sure they hear it?
6. What resources do I have at my disposal to make this happen?
7. What resources do I need to ensure public mental health clients in my community are heard and have their needs met?
8. What will be our Advocacy Plan?
9. How can we tell if our Advocacy Plan is working?

BACKGROUND

In 1995, Sacramento County was the first county in the state of California to create a Consumer Advocate Liaison position. This was incredibly innovative, and took place a decade before California passed Proposition 63; today, known as the Mental Health Services Act (MHSA). Sacramento County's Mental Health Board made a formal recommendation to their Behavioral Health Director to create a Leadership position for an individual with lived experience of recovery from a mental health condition to serve as a member of the County's leadership team, representing the collective interests of client/consumer stakeholders at all management-level internal planning, development, implementation, oversight, evaluation, quality improvement meetings, and discussions to represent the voice of public mental health clients..

Additionally, Sacramento County's Mental Health Board was adamant that the Consumer Advocate/Liaison position be contracted out to a Peer Run community-based organization (CBO). This was a critical position to take due to the fact that the Consumer Advocate Liaison may have differing priorities, positions, and/or concerns than that of Sacramento County's leadership. Fortunately, the Mental Health Director at this time was in full support and had the foresight to see how meaningful this position would be. In 1995, Sacramento County's Board of Supervisors approved the funding for a Consumer Advocate Liaison and Cal Voices was awarded the contract. We have been imbedded within Sacramento County for over 20 years and still hold the Client and Family Advocate Liaisons contract. These are two separate positions as they represent two separate and unique stakeholder populations. Although, our Consumer Advocate Liaison is employed by Cal Voices, the position has an office at the County's Behavioral Health Department and is a member of the County's and Cal Voices management team.

Today, due to the passage of the MHSA most counties have now created a Consumer Advocate Liaison position. However, not all Liaisons are as imbedded within the County leadership teams as in Sacramento County. Furthermore, some Advocates are County employees and do not have autonomy from their leadership. This poses a problem, as there is a need for separation when placed there to advocate for system change. Often times, the client's voice and choice is not represented in a meaningful and truly collaborative way. According to the World Health Organization:

> Advocacy groups need independence from the government in order to achieve their goals. While a good relationship and even financial support from government can be very useful to both parties, there is often a need for outside advocacy. History has repeatedly shown that government that government can seriously violate human rights, including those of people with mental disorders. In many instances where this has happened the independence of nongovernment organizations has been essential in enabling them to advocate for the rights of those affected and to promote change.[1]

[1] Mental Health Policy and Service Guidance Package pg.23, World Health Organization 2003

DEFINING ADVOCACY

"We must always take sides. Neutrality helps the oppressor, never the victim. Silence encourages the tormentor, never the tormented."

~ Elie Wiesel

The dictionary defines an advocate as someone who publicly supports or recommends a particular cause or policy and a person who pleads a case on someone else's behalf.[2]

According to UNICEF, the concept of "Advocacy" can be defined as:

> Advocacy is a core process for addressing inequity and disparities. Advocacy addresses inequity by bringing the issue of mental health disparities to the forefront of the agenda for decision makers, by building awareness, visibility and public momentum behind the issue, and by improving access, cost and quality of programs and services for mental health clients.[3]

In many cases, mental health clients have experienced hospitalization, and a personal loss of power over some or even every aspect of their lives. Additionally, most mental health clients navigate prescription medication changes while also trying to educate and advocate for themselves about the potential side effects from the medication. These collective experiences create a unique culture and can make adjustment back into the community daunting. One of the most pervasive collective experiences shared by mental health clients is our own self-stigmatization; a sense of fear and shame; and a sense of enduring hope that someday we may recover and regain our peace of mind.

UNICEF goes on to clarify that:

> Central to this approach is gaining a deep understanding of the root causes of the problem an enabling an environment so that the problem can be addressed. This involves strengthening the accountability of decision makers to public mental health clients, and supporting mental health clients in claiming their rights. Advocacy addresses underlying causes of problems to achieve equity, and addresses issues of equity to solve underlying causes of the problems.[4]

2 Soanes, Catherine, and Angus Stevenson, editors, Concise Oxford English Dictionary, 11th ed., Oxford University Press, NewYork, 2004, p. 19.)
3 UNICEF Advocacy Toolkit, 1st Edition, 2010 (p 3.)
4 UNICEF Advocacy Toolkit, 1st Edition, 2010 (p.3)

UNICEF goes on to explain that Advocacy requires "gaining a deep understanding of the root causes of the problem" and creating "an environment so that the problem can be addressed."[5] This involves strengthening the accountability of decision makers to public mental health clients, and supporting mental health clients in claiming their rights. Advocacy addresses underlying causes of problems to achieve equity.

The Consumer Advocate Liaison Defined:

The Consumer Advocate Liaison is someone with personal lived experience of recovery from a mental health challenge. This is a requirement! Ideally, the individual will have lived experience receiving public mental health services in California, this makes them a Peer.

The Consumer Advocate Liaison, represents and advocates for the interest and concerns of consumers from multicultural backgrounds, accessing public mental health services in their county. The Consumer Advocate Liaison supports county program development and provides a bridge, voice, and representation on behalf of their Division of Behavioral Health in community settings, and in existing and new initiatives. Some of the essential characteristics that the Consumer Advocate Liaisons bring to their county is a knowledge of concepts pertaining to wellness and recovery, peer support, cultural and linguistic humility, and knowledge of the Mental Health Services Act as well as public mental health systems.

Additionally, the Consumer Advocate Liaison fosters communication and cooperation to facilitate close working relationships between Public Mental Health Clients, Community Based Organizations, the Public Mental/Behavioral Health Department, and community stakeholders that are impacted by mental health.

I am an advocate for awareness, the truth, and a person's right to know. I believe that in the absence of the truth, all of us stand helpless to defend ourselves, our families and our health, which is the greatest gift we have.

~ Erin Brockovich

ADVOCACY IN CALIFORNIA'S PUBLIC MENTAL HEALTH SYSTEM POST-MHSA

"The time is always right to do the right thing. "

~ Martin Luther King Jr.

FACT!

Under the Welfare and Institution code there are funds available to counties to pay for ADVOCACY.

WIC § 5830(c)(2)

County mental health programs shall develop plans for innovative programs to be funded pursuant to paragraph (6) of subdivision (a) of Section 5892.

(c) An innovative project may affect virtually any aspect of mental health practices or assess a new or changed application of a promising approach to solving persistent, seemingly intractable mental health challenges, including, but not limited to, any of the following:

(2) Advocacy

WIC § 5892(a)(6)

(a) In order to promote efficient implementation of this act, the county shall use funds distributed from the Mental Health Services Fund as follows:

(6) Five percent of the total funding for each county mental health program for Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850), shall be utilized for innovative programs in accordance with Sections 5830, 5847, and 5848.

Since the passage of the MHSA many counties have created a Consumer Advocate Liaison (CAL) position; today, designated CAL's are employed in most county mental health departments throughout California. They have personal lived experience of recovery from a mental health challenge and usually have experience receiving services in the PMHS. They serve as a member of the county's leadership team, representing the collective interests of client/consumer stakeholders at all management-level internal planning, development, implementation, oversight, evaluation, and quality improvement meetings and discussions. The Consumer Advocate/Liaison also frequently participates on interview panels and hiring discussions when candidates for county mental health leadership positions are considered

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MHSA Recap

In 2004, the voters of California sent an unequivocal message to public mental health agencies throughout the state: The Public Mental Health System (PMHS) was broken, too many people were falling through the cracks and suffering needlessly, and something drastic needed to be done to reverse course. Upon the Mental Health Services Act's (MHSA) passage over a decade ago, client/consumer communities across the state rejoiced at the prospect of a truly client-driven mental health system that is responsive to the needs of the people it serves and fully accountable to the public. The MHSA was intended to transform the public mental health system, not only through the generation of new revenue to fund the expansion of services, but also by requiring unprecedented levels of stakeholder input and involvement at all levels of program planning, development, and oversight.

Before the MHSA, many Californians living with a mental illness lacked access to the essential services and community supports necessary to recover and maintain their mental wellness. New and innovative methods of addressing mental health challenges had no reliable funding source to be implemented. The MHSA established a 1% tax on all personal income over $1,000,000 to expand public mental health care. The Act provided an opportunity to design new and adapt old mental health services. System transformation was sought through the expansion of services and an improved continuum and integration of care. Counties are now receiving MHSA funding in an attempt to provide "whatever it takes" treatment for people with serious mental health challenges.

In May of 2011 the Mental Health Services Oversight and Accountability Commissions, Client and Family Leadership Committee (CFLC) produced a Policy Paper and the premise of this paper is that outcomes improve when informed by the perspectives of persons with lived mental health experience and expertise and paper reiterated that the purpose of the MHSA, "is not about including clients and family members in planning, policy, and service delivery just for inclusion's sake."[65]

The policy paper went on to say:

> To be successful mental health systems must be guided and informed by: (1) individuals with a life experience of mental health challenges who have significant roles at all levels of the. System, and (2) individual, family, system and community outcomes including the cost effectiveness of services for mental health and its community partners. It is critical that clients and family members have active roles in ongoing local and statewide efforts to evaluate mental health services, analyze client and system outcomes, and ensure that the findings are used to inform future funding and program decisions.[6]

[5] MHSOAC, client driven, family focused transformation of the mental health system through the ca MHSA.2
[6] MHSOAC, client driven, family focused transformation of the mental health system through the ca MHSA.2011

Despite these mandates, the collective client stakeholder voice both in local communities and across the state has waned since the early days of the MHSA. Stakeholders we have surveyed feel increasingly marginalized and perceive few opportunities to meaningfully participate in important decisions about public mental health policies and services that directly affect them. Far too many local mental health boards, MHSA Steering Committees and other stakeholder advisory bodies function as mere formalities, effectively rubberstamping whatever proposals are brought before them by the agencies they are meant to guide and oversee, without significant discussion or thoughtful deliberation about what they are being asked to approve. Judging by their actions, Counties and even state-level mental health agencies - seeking to minimize red tape and advance internal priorities - seem more interested in the appearance of stakeholder involvement than in ensuring stakeholders serving on these bodies are truly knowledgeable about the complex issues at stake, aware of actual client and community needs, and understand the important procedural aspects of local and statewide public meetings where critical decisions are made.

CONSUMER ADVOCATE LIAISON: WHAT

Consumer Advocate Liaisons provide advocacy on behalf on individuals receiving services within CA PMHS.

- **Required:** Personal lived experience (as an adult) of recovery from a mental health challenge
- **Desired:** Personal lived experience as the direct recipient of public mental health services in any California county

IN THIS SECTION, WE WILL COVER:

1. Recovery in California's Public Mental Health System: An Overview of the Issues
2. What is Recovery
3. What Do People Need to Recover
4. What are Recovery-Oriented Systems of Care
5. What are Recovery-Based and Client-Driven Services

1. RECOVERY IN CALIFORNIA'S PUBLIC MENTAL HEALTH SYSTEM: AN OVERVIEW OF THE ISSUES

Upon its passage in November 2004, California's former Department of Mental Health (DMH) declared the Mental Health Services Act (MHSA) "a unique opportunity to transform the California community mental health system."[7] In implementing and overseeing the newly-passed MHSA, the DMH pledged to work toward significant changes in the existing Public Mental Health System (PMHS) in the following areas:

- Consumer and Family Participation and Involvement
- Programs and Services
- Age-Specific Needs
- Community Partnerships
- Cultural Competence
- Outcomes and Accountability
- Taking a Comprehensive Viewpoint[8]

Several key provisions in the MHSA's statutes and regulations impose requirements on Counties to create recovery-oriented adult systems of care, deliver recovery-based and client-driven adult mental health services, and to collect and analyze meaningful recovery outcomes in MHSA-funded programs.

The MHSA imposes the following mandates for all County mental health services provided in the adult and older adult systems of care (and particularly those services funded as a part of the MHSA's Community Services and Supports (CSS) component):

WIC § 5813.5(d)(1-4)

> Planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for Mental health consumers:
>
> (1) To promote concepts key to the recovery for individuals who have mental illness: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.
>
> (2) To promote consumer operated services as a way to support recovery.
>
> (3) To reflect the cultural, ethnic, and racial diversity of mental health Consumers.
>
> (4) To plan for each consumer's individual needs.[9]

[7] http://web.archive.org/web/20060518021631/http://www.dmh.ca.gov/DMHDocs/docs/letters05/05-01.pdf (p. 1)
[8] https://web.archive.org/web/20100528002603/http://www.dmh.cahwnet.gov/Prop_63/MHSA/docs/Vision_and_Guiding_Principles_2-16-05.pdf (pp. 1-5)
[9] WIC § 5813.5(d) (emphasis added)

The MHSA's General Standards, which are codified in the California Code of Regulations state:

9 CCR § 3320

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, as defined in Section 3200.060.

(2) Cultural Competence, as defined in Section 3200.100.

(3) Client Driven, as defined in Section 3200.050.

(4) Family Driven, as defined in Section 3200.120.

(5) Wellness, Recovery, and Resilience Focused.

(6) Integrated Service Experiences for clients and their families, as defined in Section 3200.190.[10]

To ensure Counties would sufficiently enact the MHSA's vision for total system transformation, the former DMH required counties to embed and continually address these General Standards throughout Counties' entire MHSA Program and Expenditure Plans.[11]

The California Code of Regulations defines "Client Driven," the MHSA's third General Standard, as follows:

§ 3200.050. Client Driven

"Client Driven" means that 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.[12]

The DMH further explained the MHSA's mandate that planning, implementation, evaluation, and delivery of MHSA-funded programs and services be "Client Driven":

Adult clients identify their needs and preferences which lead to the services and supports that will be most effective for them. Their needs and preferences drive the policy and financing decisions that affect them. Adult services are client-centered; with providers

[10] 9 CCR § 3320 (emphasis added)
[11] https://web.archive.org/web/20100528131402/http://www.dmh.cahwnet.gov/DMHDocs/docs/letters05/05-05CSS.pdf (p. 4)
[12] 9 CCR § 3200.050 (emphasis added)

working in full partnership with the clients they serve to develop individualized, comprehensive service plans. Individualized, comprehensive service plans help overcome the problems that result from fragmented or uncoordinated services and systems.
Many adults with serious mental illness have limited influence over the services they [...] receive. Increasing opportunities for clients to have greater choices over such things as types of service, providers, and how service dollars are spent, facilitates personal responsibility, creates an economic interest in obtaining and sustaining recovery, and shifts the incentives towards a system that promotes learning, self-monitoring, and accountability. Increasing choice protects individuals and encourages quality.[13]

[13] https://web.archive.org/web/20100528131402/http://www.dmh.cahwnet.gov/DMHDocs/docs/letters05/05-05CSS.pdf (p. 5)

2. WHAT IS RECOVERY

MENTAL HEALTH SERVICES ACT DEFINITION

Beyond the recovery-related mandates listed in the sections of the Welfare and Institutions Code and California Code of Regulations cited above, the Mental Health Services Act (MHSA) statutes and regulations do not define the concept of "Recovery," nor do they elaborate on the meaning of the "Recovery Vision" cited in WIC § 5813.5(d). However, upon the MHSA's passage, the DMH offered this definition to Counties for the purposes of MHSA program planning:

> Recovery refers to the process in which people who are diagnosed with a mental illness are able to live, work, learn, and participate fully in their communities. For some individuals, recovery means recovering certain aspects of their lives and the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or elimination of symptoms. Focusing on recovery in service planning encourages and supports hope.[14]

OTHER DEFINITIONS

According to Boston University's Center for Psychiatric Rehabilitation, "[w]hile there is no consensus on the definition of recovery, people describe it as a process of empowering individuals with hope and self-esteem to find new meaning and purpose in their lives."[15]

Unlike the Medical Model, which is disease-focused and looks at recovery in terms of reduced symptomology and ongoing illness management, "[the] Recovery [Model] does not imply curing the mental illness, but learning to work within and beyond the limits of the disability so that individuals' personal rights of friendships, homes, families, satisfying jobs, access to education, and decent pay can become realities."[16]

In 2012, SAMHSA published its Working Definition of Recovery, which defines the concept as:

> A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.[17]

14 https://web.archive.org/web/20060521134818/http://www.dmh.ca.gov/mhsa/docs/Adults/Proposition%2063%20Begins%201-13-05%20final.pdf (p. 10)
15 https://cpr.bu.edu/resources/newsletter/recovery-center
16 Id
17 https://store.samhsa.gov/system/files/pep12-recdef.pdf

3. WHAT DO PEOPLE NEED TO RECOVER

SAMHSA'S WORKING DEFINITION OF RECOVERY

SAMHSA's Working Definition of Recovery identified four major dimensions that support a life in recovery:

1. **Health:** Overcoming or managing one's disease(s) or symptoms—for example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem— and for everyone in recovery, making informed, healthy choices that support physical and emotional wellbeing.
2. **Home:** A stable and safe place to live.
3. **Purpose:** Meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society.
4. **Community:** Relationships and social networks that provide support, friendship, love, and hope.[18]

The Working Definition also included ten guiding principles of recovery:

1. **Recovery emerges from hope**. The belief that recovery is real provides the essential and motivating message of a better future—that people can and do overcome the internal and external challenges, barriers, and obstacles that confront them. Hope is internalized and can be fostered by peers, families, providers, allies, and others. Hope is the catalyst of the recovery process.
2. **Recovery is person-driven**. Self-determination and self-direction are the foundations for recovery as individuals define their own life goals and design their unique path(s) towards those goals. Individuals optimize their autonomy and independence to the greatest extent possible by leading, controlling, and exercising choice over the services and supports that assist their recovery and resilience. In so doing, they are empowered and provided the resources to make informed decisions, initiate recovery, build on their strengths, and gain or regain control over their lives.
3. **Recovery occurs via many pathways**. Individuals are unique with distinct needs, strengths, preferences, goals, culture, and backgrounds— including trauma experience — that affect and determine their pathway(s) to recovery. Recovery is built on the multiple capacities, strengths, talents, coping abilities, resources, and inherent value of each individual. Recovery pathways are highly personalized. They may include professional clinical treatment; use of medications; support from families and in schools; faith-based

18 https://store.samhsa.gov/system/files/pep12-recdef.pdf

approaches; peer support; and other approaches. Recovery is non-linear, characterized by continual growth and improved functioning that may involve setbacks. Because setbacks are a natural, though not inevitable, part of the recovery process, it is essential to foster resilience for all individuals and families.

4. **Recovery is holistic**. Recovery encompasses an individual's whole life, including mind, body, spirit, and community. This includes addressing: self-care practices, family, housing, employment, transportation, education, clinical treatment for mental disorders and substance use disorders, services and supports, primary healthcare, dental care, complementary and alternative services, faith, spirituality, creativity, social networks, and community participation. The array of services and supports available should be integrated and coordinated.
5. **Recovery is supported by peers and allies**. Mutual support and mutual aid groups, including the sharing of experiential knowledge and skills, as well as social learning, play an invaluable role in recovery. Peers encourage and engage other peers and provide each other with a vital sense of belonging, supportive relationships, valued roles, and community. Through helping others and giving back to the community, one helps one's self. Peer-operated supports and services provide important resources to assist people along their journeys of recovery and wellness. Professionals can also play an important role in the recovery process by providing clinical treatment and other services that support individuals in their chosen recovery paths.
6. **Recovery is supported through relationships and social networks**. An important factor in the recovery process is the presence and involvement of people who believe in the person's ability to recover; who offer hope, support, and encouragement; and who also suggest strategies and resources for change. Family members, peers, providers, faith groups, community members, and other allies form vital support networks. Through these relationships, people leave unhealthy and/or unfulfilling life roles behind and engage in new roles (e.g., partner, caregiver, friend, student, employee) that lead to a greater sense of belonging, personhood, empowerment, autonomy, social inclusion, and community participation.
7. **Recovery is culturally-based and influenced**. Culture and cultural background in all of its diverse representations—including values, traditions, and beliefs—are keys in determining a person's journey and unique pathway to recovery. Services should be culturally grounded, attuned, sensitive, congruent, and competent, as well as personalized to meet each individual's unique needs.
8. **Recovery is supported by addressing trauma**. The experience of trauma (such as physical or sexual abuse, domestic violence, war, disaster, and others) is often a precursor to or associated with alcohol and drug use, mental health problems, and related issues. Services and supports should be trauma-informed to foster safety (physical and emotional) and trust, as well as promote choice, empowerment, and collaboration.

9. **Recovery involves individual, family, and community strengths and responsibility**. Individuals, families, and communities have strengths and resources that serve as a foundation for recovery. In addition, individuals have a personal responsibility for their own self-care and journeys of recovery. Individuals should be supported in speaking for themselves. Families and significant others have responsibilities to support their loved ones. Communities have responsibilities to provide opportunities and resources to address discrimination and to foster social inclusion and recovery. Individuals in recovery also have a social responsibility and should have the ability to join with peers to speak collectively about their strengths, needs, wants, desires, and aspirations.
10. **Recovery is based on respect**. Community, systems, and societal acceptance and appreciation for people affected by mental health and substance use problems— including protecting their rights and eliminating discrimination—are crucial in achieving recovery. There is a need to acknowledge that taking steps towards recovery may require great courage. Self-acceptance, developing a positive and meaningful sense of identity, and regaining belief in one's self are particularly important.[19]

[19] https://store.samhsa.gov/system/files/pep12-recdef.pdf

4. WHAT ARE RECOVERY-ORIENTED SYSTEMS OF CARE

In California, the Mental Health Services Act (MHSA) mandates adoption of a recovery-oriented system of care. Evidence reveals that peer support programs have positive impacts on people in their recovery while also providing valuable advocacy support to the public mental health service system. ACCESS California has a unique opportunity to move the ball forward in the recovery movement by elevating diverse, client advocacy efforts towards the establishment of consistent recovery outcome measures throughout California's public mental health system. Ensuring California's Public Mental Health System (PMHS) establishes a comprehensive recovery orientation is essential to achieving positive outcomes associated with an individual's recovery and improved quality of life.

The MHSA was intended to transform the entire PMHS. In 2005, Darrell Steinberg and Rusty Selix, two of the MHSA's co-authors, released a joint statement describing the Act thusly: "[T]he first and foremost thing that everyone needs to recognize is that [the MHSA] is not increased funding for the old mental health system that we have known for the past decades. Instead, it is a complete transformation to a new system."[20]

In light of the MHSA's explicit endorsement of the "Recovery Vision" for adult mental health services at WIC § 5813.5(d) and the Act's six General Standards enumerated at 9 CCR § 3320(a), this new system is presumably one that is recovery-oriented. What does a recovery-oriented system look like?

If we think about a "system" as a type of culture, then recovery-based system transformation really refers to a cultural shift within the PMHS from one that predominantly adheres to Medical Model traditions, values, thinking, and practices to one that embraces recovery as the ultimate goal of all public mental health services.

In 2005, immediately after the MHSA's passage, Dr. Mark Ragins, a pioneer in the field of recovery medicine and a co-founder of MHA-LA's highly successful Village program (upon which the MHSA's adult CSS component is based) said this about the recovery-based system transformation required under the MHSA:

> Unless we truly incorporate the Recovery Vision in our programs we will not succeed. The most successful innovative programs have created a new culture: a recovery culture. The traditional treatment culture may have been successful in the asylums and university hospitals where it was developed, but it is ill suited to our present needs. The major goals of this act – reaching out to underserved populations, employment, inclusion of consumers and their families, social responsibility and outcomes, integration of treatment

[20] https://web.archive.org/web/20060521134818/http://www.dmh.ca.gov/mhsa/docs/Adults/Proposition%2063%20Begins%201-13-05%20final.pdf (p. 10)

> and support services, reduction in stigma – cannot be addressed effectively within the traditional treatment culture, but they can be achieved within a recovery culture. In other words, the Recovery Vision is the tool that can finally make the dream of deinstitutionalization a proud reality.[21]

How prescient he was! Throughout history, the public has looked to the medical community to cure us from a multitude of ills, with patients telling doctors' their problems as they assessed, examined, ordered tests, sought diagnoses and forecast long-term prognoses and outcomes. Rarely did this culture incorporate the perspectives of its patients or accept differing points of view. This is particularly the case with mental health disorders. Yet, despite decades of medical approaches to mental illness, we find that persistent mental health disorders continue to cause millions disabling symptoms limiting our ability to regain our prior employment, relationships and social role in society.

Dr. Ragins further noted in 2005:

> There is a lot of talk about transforming our mental health system into a consumer-driven, recovery-based system, but very little talk about transforming staff to work successfully in this new system. Recovery programs, to this point, tend to rely on creating small counter-cultures with dynamic leadership, staff that are different or want to change, and new non-professional and consumer staff. Transforming existing programs with existing staff requires a proactively guided process of staff transformation to succeed.[22]

He went on to identify 12 specific aspects of system transformation that must occur before the MHSA's vision and potential could be fully realized:

1. Looking Inward and Rebuilding the Passion: Recovery work requires staff to use all of themselves in passionate ways to help people. It can't be done effectively in a detached, routine way. Recovery staff tend to be happier, more full of life, and more actively engaged. To achieve this, as staff, we need to remember why our hearts brought us to this field in the first place. … Staff with hope, empowerment, responsibility, and meaning can help people with mental illnesses build hope, empowerment, responsibility, and meaning. Administrative leadership must treat its staff well before further transformation can occur.
2. Building Inspiration and Belief in Recovery: Staff spend the vast majority of our time and emotions on people who are doing poorly or are in crisis. We neglect success stories of those we help and our roles in supporting these successes. Staff need to be inspired by hearing people tell their stories of recovery, especially the stories of people we have worked with and known in darker times. We need to be familiar with the extensive research that documents recovery and the concept of the "clinicians' illusion" that gets in the way of us believing in this research.
3. Changing from Treating Illnesses to Helping People with Illnesses Have Better Lives: Recovery staff treat "people like people," not like cases of different illnesses. To achieve

[21] https://web.archive.org/web/20060521134818/http://www.dmh.ca.gov/mhsa/docs/Adults/Proposition%2063%20Begins%201-13-05%20final.pdf (p. 10)
[22] https://web.archive.org/web/20060521134818/http://www.dmh.ca.gov/mhsa/docs/Adults/Proposition%2063%20Begins%201-13-05%20final.pdf (p. 22)

this, we need to fight the numerous ways in which the pervasive culture of medicalization is reflected in the infrastructure. Goal setting needs to reflect quality of life, not just symptom reduction. Quality of life outcomes need to be collected. Treatment must be life-based, not diagnosis-based. Assessments must describe a whole life, not an illness with a psychosocial assessment on a back page. Progress notes need to reflect life goals, not just clinical goals.

4. Moving from Caretaking to Empowering and Sharing Power and Control: Staff have generally adopted a caretaking role toward people with a mental illnesses. We act protectively, make decisions for them because of their impairments, even force them to do what we think is best for them at times. Recovery practice rejects those roles, although many staff and consumers are comfortable with them. Analogous to how parents must stop being caretakers for our children to become successful adults, staff must stop being caretakers for the people we work with to recover.
5. Gaining Comfort with Mentally Ill Co-Staff and Multiple Roles: Recovery requires breaking down the "us vs. them" walls. People with mental illnesses must be included as collaborators, co-workers, and even trainers. To work alongside them as peers (not as segregated, second-rate staff) is probably the single most powerful stigma reducing and transforming experience for staff. For people with mental illnesses to recover and attain meaningful roles beyond their illness roles, staff need to take on roles beyond our illness treatment roles.
6. Valuing the Subjective Experience: Staff have been taught to observe, collect, and record objective information about people to make reliable diagnoses and rational treatment plans. Recovery plans are collaborative. To achieve a partnership, staff must appreciate not just what's wrong with a person, but how that person understands and experiences what's happening. Knowing what it would be like to be that person, what they're frightened of, what motivates them, what their hopes and dreams are, are all part of a subjective assessment.
7. Creating Therapeutic Relationships: Recovery work emphasizes therapeutic work more than symptom relief. Our present system relies on illness diagnosis, treatment planning, prescription, and compliance. Staff can be interchangeable, professionally distant, even strangers, as long as the diagnosis, plan and compliance are preserved. Recovery work relies on the same foundations as psychotherapy: (1) an ongoing, trusting, collaborative, working relationship, (2) a shared, explanatory story of how the person got to this point, and (3) a shared plan of how to achieve the person's goals together.
8. Lowering Emotional Walls and Becoming a Guiding Partner: People repeatedly tell us that we are the most helpful when we are personally involved, genuinely caring, and "real." Psychotherapeutic and medical practice traditions, ethical guidelines, risk management rules, and personal reluctance are barriers to lowering emotional walls. Staff needs lots of discussion and administrative support to change because of these strong contrary forces. To best support people on their path of recovery, staff need to act not as detached experts giving them maps and directions, but as guides, becoming involved and walking alongside them, sharing the trip.

9. Understanding the Process of Recovery: Staff are familiar with monitoring progress as a medical process. We follow how well illnesses are diagnosed and treated, symptoms are relieved, and function is regained. We alter our interventions and plans based on our assessment of this process. Recovery work monitors a different process – the process of recovery. Analogous to the grief process found in hospices, this process can be described by four stages: (1) hope – believing something better is possible, (2) empowerment – believing in ourselves, (3) self-responsibility – taking actions to recover, and (4) attaining meaningful roles apart from the illness. Where hospice staff help people die with dignity, recovery staff help people live with dignity.
10. Becoming Involved in the Community: Recovery tries to help people attain meaningful roles in life. These roles will require them to be reintegrated into the community, to be welcomed and to be valued, and to find their niches. Recovery cannot be achieved while people are segregated from their communities. To support this, staff must work in the community. This is a substantial change for most staff and may trigger personal insecurities.
11. Reaching Out to the Rejected: Recovery is being promoted, not just as a way of helping people who are doing well do even better, but also as a way of engaging with and helping people who do not fit well in the present system. Recovery programs have proven success with people with dual diagnoses, homeless people, jail diversion people, "non-compliant" people, people with severe socio-economic problems, and people lacking "insight." All of these people have different serious obstacles to engagement and treatment. Because staff may bring our own prejudices against them, a "counter-culture of acceptance" needs to be created to work with them. This often requires both an attitudinal change in staff and training in specialized skill sets. System transformation will not be considered a success if we continue to reject these people in need.
12. Living Recovery Values: "Do as I say, not as I do" is never a good practice. When the walls and barriers are reduced and emotional relationships are enhanced in a good recovery program, it's even harder for staff to hide. We must live the values of recovery and be actively growing ourselves if we expect to be effective recovery workers. In recovery, the same rules and values apply to all of us.[23]

One thing is certain: leadership buy-in is essential to fostering a system of care that is recovery-oriented. Therefore, engaging system advocates, providing training, education and outreach opportunities for meaningful involvement can assist in moving the system forward towards a recovery orientation. System change occurs by engaging diverse stakeholders, as well as leadership impacted most by transformative efforts. A truly recovery-oriented system of care involves a framework whereby services and supports are coordinated and delivered in a person centered and community defined atmosphere. Such a system includes services that include both prevention and treatment, peer support and community defined services, and allow for flexibility to meet a person's needs.

[23] Id. (pp. 23-24)

5. WHAT ARE RECOVERY-BASED AND CLIENT-DRIVEN SERVICES

Despite sound evidence challenging the traditional medical model of care for individuals with mental health disorders,[24] it has taken decades for sincere belief in recovery to gain credibility in the medical community and California's Public Mental Health System. The movement sprung from a grassroots community of individuals who experienced recovery from a mental health condition themselves and began using their agency to help transform a broken system. In fact, the roots of the Recovery Movement occurred as a result of clients, patients, survivors becoming involved in their own treatment process, through self-advocacy and in turn discovering the power that peer support made in their lives. These victories in people's lives all had something in common in that they were directed by the clients themselves. In short, the quintessential thread through all first-person narrative accounts of recovery is that services must be client directed in order to be recovery-oriented.

On the most basic level, recovery-based services are those that place the client's individual needs and preferences at the forefront of each and every treatment plan, not just in the array of programs offered, but in the ways in which these services are actually delivered.

Recovery-Oriented IS	**Recovery-Oriented IS NOT**
Person-Centered ▪ Broad focus ▪ Looks at "all of you" ▪ Goal-driven ▪ Services help a person rebuild their whole life	Illness-Centered ▪ Narrow Focus ▪ Looks at your diagnosis ▪ Symptom-driven ▪ Services treat and illness or eliminate/ reduce symptoms
Client-Driven ▪ Inside-out ▪ Individualized ▪ Collaboration and partnership	Professionally-Driven ▪ Outside-in ▪ Formulaic ▪ Compliance and coercion
Strengths-Based ▪ Building on what's right ▪ Developing resilience ▪ Independence and personal empowerment ▪ Positive reframing	Deficits-Based ▪ Fixing what's wrong ▪ "Idiot compassion" ▪ Reliance on professionals or "the system" ▪ Pathologizing

[24] https://www.madinamerica.com/wp-content/uploads/2011/12/vermont2.pdf (p. 144)

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CONSUMER ADVOCATE LIAISON: HOW

"You may have to fight a battle more than once to win it."
~Margaret Thatcher

Shared Power and Collaborative Decision Making

Meaningful change cannot take place in the public mental health system without the inclusion of all parties that impact client services and experiences. For too long, many advocates have viewed "the system" as a monolithic and malevolent entity without seeking to understand the constraints and impediments that the county and community-based organizations regularly face. Rather than looking for areas of commonality, some consumer advocates have focused on our perceived differences, undermining clients' ability to work within and change it from within. For this reason, it is imperative that Consumer Advocate Liaisons take a different approach.

Public Mental Health Services must move well past the Medical Model's focus on illness management by incorporating at the very least these aspects into the culture of their systems, their services, practices and delivery models, outcomes tracking and measurement activities.

1. Expansion of Peer Services at all levels of the system
2. Measure Recovery Outcomes
3. Invest in Programs that produce meaningful recovery outcomes

IN THIS SECTION, WE WILL COVER:

1. Consensus Decision Making
2. Building an Advocacy Strategy
3. Providing Education And Support
4. Client's Bill Of Rights
5. Strengths And Challenges
6. Conditioning
7. Strengthening The Role Of The Consumer Advocate Liaison

1. CONSENSUS DECISION MAKING

"So, open your mouth lad! For every voice counts!"

~ Dr. Seuss

Consensus decision making is an alternative to the commonly practiced non-collaborative decision-making processes. Robert's Rule of Order, for instance, is a process used very effectively by many organizations. The goal of Roberts Rules is to structure the debate and passage of proposals that win approval through a majority vote. However, the process does not emphasize the goal of full agreement, nor does it foster whole group collaboration and the inclusion of minority concerns in resulting proposals. Critics of Roberts Rules believe that the process can involve adversarial debate and the formation of competing factions. These dynamics may harm group relationships and undermining the ability of the group to cooperatively implement a contentious decision.

Consensus decision making is also an alternative to "top-down decision making, commonly practiced in hierarchical groups. Top-down decision making occurs when leaders of a group make decisions in a way that does not include the participation of all interested stakeholders. The leaders may (or may not) gather input, but they do not open the deliberation process to the whole group. Proposals are not collaboratively developed, and full agreement is not a primary objective.

Consensus decision making addresses the problems of both Robert's Rules of Order and top-down models. The goals of the consensus include:

1. Better Decisions: through including the input of all stakeholders the resulting proposals can best address all potential concerns
2. Better Implementation: A process that includes and respects all parties, and generates as much agreement as possible sets the stage for greater cooperation in implementing the resulting decisions
3. Better Group Relationships: A cooperative, collaborative group atmosphere fosters great group cohesion and interpersonal goals

Below are some of the most important factors that improve the chances of successfully consensus making:

1. Clear Common Purpose
2. High Levels of Trust
3. Participants well trained in the consensus process | Participants willing to put the best interest of the group before their own
4. Participants willing to spend sufficient time in meetings
5. Skillful facilitation and agenda preparation

*The information above is an excerpt from http://windekindcommons.com/introduction/consensus-decision-making/

2. BUILDING AN ADVOCACY STRATEGY

"If you fail to plan, you are planning to fail!"
~ Benjamin Franklin

STEP ONE: CREATE A PLAN

Start by asking yourself a series of questions:

- What is working well in my county?
- What are my counties areas for growth?
- What are the unmet needs of public mental health clients?
- What is the problem/s?
- What is my goal?
- What do I know?
- What do I need to know?
- What do I need to find out?
- How do I go about getting the information that I need?
- Are there other people that can help me?

STEP TWO: GATHER INFORMATION

Do your own community research. Ask clients and community stakeholders the same questions you asked yourself in step one.

As a Client Advocate Liaison, you know from first-hand experience that individuals who are receiving services in our PMHS experience the profound stigma of a diagnosis, of a serious mental health condition. These individuals often times feel powerless and defeated. Often, individuals are unaware of their rights and/or have a feeling that they are not worthy to have "the" right. Due to these false internal narratives that take place in their heads, it is important for the Client Advocate Liaison to be that pillar of hope for the "hopeless" and bring your county's client stakeholders to the forefront.

How do consumer advocate liaisons gather information?

Consumer Advocate Liaisons possess invaluable lived experience as current or former PMHS clients and act as our go-to resource within their County on issues related to local mental health advocacy, client empowerment, education, community engagement, stakeholder needs and concerns, and mental health policy and planning activities. Client Advocate Liaisons also link the identified needs of public mental health clients to their local leaders, providers, and various stakeholder groups to further their advocacy efforts.
Client Advocate Liaisons:

- Create and engage in ongoing opportunities to arm community stakeholders with important mental health policy information
- Assist community stakeholders in expressing their concerns, needs, and wants in appropriate, meaningful settings
- Identify local client advocacy needs and community-wide trends related to mental health policy
- Share relevant information and findings with County Leadership
- Represent the needs and wants of their local communities at public meetings, based upon their collaboration with local clients and other stakeholders
- Support stakeholders in advocating for themselves at public meetings where important decisions are made
- Promote awareness of the MHSA's General Standards and requirements for meaningful stakeholder involvement in the CPP process

Tip: In an effort to gather meaningful information from your community stakeholders, you may want to consider conducting preliminary stakeholder focus groups, and creating a needs assessment survey based on the recurring themes that are identified through this exercise. You may have it broadly disseminated throughout the system. You may also partner with your County Quality Improvement team. This is a great way to foster a collaborative working relationship and models a commitment from the county. This will provide you with both qualitative and quantitative data to better support your findings, and support you with the following:

- Inform you of your stakeholder's perceptions
- Identify overarching needs
- Create long term and short-term goals based on the identified needs

Identify:

- How can I get the information I need?
- Who are the decision makers?
- Are there other people that can help me?

STEP THREE: ACTIVATE AND STAY SOLUTION FOCUSED

Ask yourself:

- What are some possible solutions to this problem/issue? (be specific)
- What are some barriers to these solutions?
- What do I expect the other side to do?

Build your case once you discover what the clients in your county want and you have identified who can get their needs met; now you may begin building your advocacy plan.

Ask yourself about the strengths of your Advocacy Plan:

- Has an established policy or procedure been ignored?
- Is the mission and vision of an organization not being upheld?
- Is a contractor in violation of withholding services?
- Are the necessary services and supports available for individuals to reach and maintain their recovery goals?
- What the county/organization has to gain from ensuring their identified needs are met?

In order to be able to effectively advocate, you must have a clear understanding of the facts that you know, and also a firm grasp of what information you might need to gather. And, always stay humble as there are quite possibly many unknown unknowns.

Continually educate yourself around county and programs policies that apply to the community issues/concerns you have identified, and:

- Communicate clearly and effectively with a wide range of organizations, government agencies, groups, professions, and individuals from different educational, economic, and cultural backgrounds
- Build coalitions among groups with differing needs and objectives
- Demonstrate equality in relationships with clients and capacity for self-awareness
- Organize and motivate volunteers, consumers, and community members
- Model effective coping techniques and communication skills
- Use language that is non-judgmental and non-clinical
- Demonstrate advocacy and teamwork skills
- Display professionalism in appearance, language, and conduct
- Demonstrate culturally-sensitive and appropriate interaction
- Apply self-help and support principles and techniques to problems and issues

3. PROVIDING EDUCATION AND SUPPORT

In an effort to maximize collaboration and effectuate positive change throughout the county's public mental health system, Consumer Advocate Liaisons need to provide ongoing training and education to their stakeholders and their audience must be not be limited to clients/consumers. County Leadership, Community Based Organizations, Providers, and communities need educational resources and support that will help them effectively engage and include clients/consumers at all levels throughout the public mental health system.

Consumer Advocate Liaisons encourage clients/consumers to advocate for their own mental health needs, and create systems, services, and outcomes that are truly client-driven and recovery-oriented.

Thus, the Client Advocate Liaisons teach these populations how to successfully collaborate and share power with clients/consumers.

Client Advocate Liaisons (CAL) promotes the expansion of meaningful recovery concepts, consumer-operated services, consumer cultural humility, and a PMHS that is truly client-driven. To accomplish this, Client Advocate Liaisons actively train, educate, and engage with both clients and county leadership to help them recognize, participate in, and expand stakeholder advocacy opportunities within their own local mental health systems. CAL's are informing both stakeholders and PMHS leadership about the MHSA's statutory and regulatory mandates as they relate to recovery-oriented systems and services, community collaboration, the MHSA's CPP process, client-driven services, and effective outreach and engagement to clients with severe mental health challenges and to traditionally unserved, underserved, and inappropriately-served populations.

The training and educational support tailored for client/consumer stakeholder's intent is to support individuals receiving services and strengthen their communities to effectively advocate for their own needs. CAL's are there to empower their community stakeholders and strive to build capacity in an ongoing effort to support client stakeholders and provide them with the necessary skills for them to carry on independently. CAL's keep hope alive and empower individuals and systems to foster independence for those receiving public mental health services and moving away from paternalistic and deficit-based care.

An example of some trainings and support that Consumer Advocate Liaisons may provide to County Leadership, Community Based Organizations, Providers, and Community Stakeholders are:

- What it means for a system to be client driven, recovery oriented and model cultural humility
- How to effectively engage with stakeholders and encourage their advocacy efforts

- How to meaningfully include and share power with stakeholders
- How the public mental health system works, including applicable federal and state mental health laws
- How to successfully integrate peer support workers and volunteers at all levels of the public mental health system

This training and support should be designed to:

1. Increase awareness of public mental health issues and needs;
2. Provide understanding on effective methods of engaging the client community;
3. Reduce stigma and discrimination and increase inclusiveness in systems and communities;
4. Implement transformative change in the public mental health system;
5. Increase client participation in local planning and policy discussions.

4. CLIENT'S BILL OF RIGHTS

Public Mental Health Clients have often been led to believe that they don't have rights or should be afraid to exercise them. Some rights are governed by laws or rules, while others are not. Therefore, the term "rights" can sometimes be confusing. It is important to understand the differences in the types of rights that individuals receiving services have so that you can determine the best advocacy strategy.

To do this, let's first identify different types of rights.

- Laws: Some rights that we have are legal rights, and therefore may be enforceable in a court of law or through a formal grievance procedure. There can be Federal, State, or local laws. For example, a federal law called the Health Insurance Portability and Accountability Act of 1996 (HIPAA) makes it illegal in most instances for a health care provider to share your private health care information with others. Therefore, according to this law, you have the right to private health care records.

- Contracts: The majority of California Counties contract out their public mental health services to community-based organizations (CBO's). You want to familiarize yourself with the services that your counties mental health providers are contracted to provide and meet with the clients to ensure they have access to ALL of these services. If clients feel their rights to services outlined in the contract are being denied then you have a case to bring to county leadership.

- Policies: Sometimes there are rules or policies that outline the individuals receiving services rights. The rules or policies may not be law, but may be governed by law or may simply be a set of guidelines. Familiarize yourself with your counties policies and procedures and familiarize them with the stakeholder bill of rights (located in the appendix).

The bottom line is that Consumer Advocate Liaisons primary objective is to represent the voice of public mental health clients within their county. The Consumer Advocate Liaison is there to be the voice for those that have historically been voiceless. Therefore, it is critical for the Liaison to have an Advocacy Plan. According to UNICEF:

> Creating an advocacy plan helps to understand the situation, stakeholders and their relative power, and how change happens; identify target audiences, the right messages, and the right messenger to deliver the message; identify processes, opportunities and entry points; recognize capacity and gaps; and finally set goals and interim outcomes, develop and action plan, and monitor and evaluate results.[25]

[25] UNICEF Advocacy Toolkit, 1st Edition, 2010 (p. 15)

Every CAL will take a unique approach to their advocacy plan and have unique areas of focus. However, each CAL will ensure that the common interests of client stakeholders first and foremost.

It is recommended that CAL's focus its research and data collection activities on analyzing and measuring the following factors in their counties PMHS:

- The extent to which clients, community stakeholders, and PMHS leadership understand and have effectively operationalized the MHSA's mandates for community collaboration, recovery-oriented adult systems of care, and recovery-based client-driven services;
- The extent of client participation in the planning, development, and oversight of local mental health services;
- The quality and appropriateness of local mental health services and the ease of accessing them;
- Whether their county is providing recovery-oriented mental health services and the level to which they have integrated evidence-based recovery practices within their adult systems of care; and
- The barriers that hinder County's ability to implement recovery-oriented systems of care, provide recovery-based and client-driven services, and capture and utilize meaningful recovery outcomes data for MHSA-funded programs.

In seeking this information, CAL's not only engage with clients and community stakeholders, CAL's also invite public mental health agencies and providers to participate in our research and data collection efforts, which helps us determine the extent to which each group's perceptions diverge and gather important insights from the various entities that comprise the PMHS. It is imperative that CAL's not only gather information from the target population (current and former PMHS clients), but also from the government entities and organizations which provide and oversee the quantity and quality of services available, influencing clients' recovery experiences and outcomes. These agencies have unmet needs of their own that significantly impact client care. Therefore, CAL's works with providers, local mental health agencies, and community stakeholders to identify these needs and better understand how they impact various aspects of services delivery within the PMHS. Only after understanding the fuller picture, can CAL's effectively advocate for realistic changes both consumers and Counties are likely to embrace.

Cool heads prevail:

- When addressing concerns such as the one above, be mindful of your body language and the tone of your voice. Assume good intent.
- Depending on the relationships you have with the CBO you may want to talk to the director first and educate them on the concerns that have been brought to your attention. Then take it up the ladder to the mental health director if you are not seeing be addressed in a meaningful way.

5. STRENGTHS AND CHALLENGES

The Consumer Advocate Liaison (CAL) is a unique position having the distinct responsibility of marrying the medical and recovery model of care.

Reputation/Responsibility: We hate to be the ones to break it to you but Stigma is alive and well; YES, even in the mental health field. Can you believe that our Psychiatrists, Psychologists, Social Workers and Marriage and Family Therapists do not have Recovery Practices as part of their curriculum? You heard us right, they have no educational/foundational knowledge of RECOVERY! So, it's up to the CAL's to bridge the gaps in knowledge. As the esteemed Dr. Mark Ragins says, "you can't just put wellness and recovery on the door to make it so."

STRENGTHS

Let us begin to unwrap the unique Strengths that the Consumer Advocate Liaisons brings to California Counties.

The Consumer Advocate Liaison has obtained facts, information, and the knowledge acquired through their unique lived experience of having to navigate the complexities of the public mental health system and from the personal responsibility it took, and hard work that is necessary to live a life in recovery. The CAL is the evidence that individuals receiving Public Mental Health Services (PMHS) have the ability to, and often do recovery.

The CAL ensures that county leadership, public mental health clients and community stakeholders are familiar with the power and importance of the consumer movement, client directed services, and the principles of wellness and recovery and peer support.

Additional strengths and knowledge CAL's provide to the PMHS:

- Theories, principles, goals and objectives of self-help support needs to adult consumers
- Cultural humility and the disparities faced by underserved communities when accessing services in the public mental health system
- The structure and function of California's public mental health system
- Multiple types of programs and consumer needs within a county behavioral health system
- Principles, methods and techniques of community organization and development
- Program planning and design, budget development, and program evaluation
- Key elements, values, and goals of the Mental Health Services Act (Prop. 63)
- Available community resources
- The complex public and/or private agency services available for individuals' mental health needs, including community- and recovery-based resources and culture-specific supports
- The relationships among government agencies, public and private community organizations and groups, and private enterprises affecting consumers and stakeholders within their County

The Consumer Advocate Liaison has the ability to:

- Communicate clearly and effectively with a wide range of organizations, government agencies, groups, professions, and individuals from different educational, economic, and cultural backgrounds
- Build coalitions among groups with differing needs and objectives
- Demonstrate equality in relationships with clients and capacity for self-awareness
- Organize and motivate volunteers, consumers, and community members
- Model effective coping techniques and communication skills
- Use language that is non-judgmental and non-clinical
- Demonstrate advocacy and teamwork skills
- Display professionalism in appearance, language, and conduct
- Demonstrate culturally-sensitive and appropriate interaction
- Apply self-help and support principles and techniques to problems and issues
- Work productively with minimal oversight and instruction
- Demonstrate personal responsibility and sound independent judgment
- Support the County's Mental/Behavioral Health Division in consumer liaison related work with different levels of County government

CHALLENGES

"Oppressed groups are frequently placed in the situation of being listened to only if we frame our ideas in the language that is familiar to and comfortable for a dominant group. This requirement often changes the meaning of our ideas and works to elevate the ideas of dominant groups."

-Patricia Hill Collins

1. **Lack of Preparation.** While lived experience is a minimum qualification, it is not the sole requirement for CAL positions. When CAL performance expectations are undefined and/or poorly communicated, CAL's do not receive adequate onboarding, orientation, and training to acquaint them with their positions and duties. If PMHS employers do not sufficiently prepare existing staff for the inclusion of CAL's, new CAL's are greeted with low expectations, assignment of menial tasks unrelated to advocacy. Hostility (both subtle and overt) from other workers who fear CAL's will encroach upon their jobs or undermine the delivery of professional care.

2. **Lack of Understanding.** PMHS employers that do not understand the CAL role hire CAL's who also lack this understanding. CAL's without a strong foundation in recovery concepts and self-help support principles hinder the effective delivery of advocacy, training and education services and risk becoming "mini clinicians" when working with clients. If peer support principles are not consistently reinforced through workplace practices and if recovery-based outcomes are not measured, CAL's begin to conform their activities to the

data being captured rather than strictly adhering to their roles or placing the needs of clients first. Non-peer staff who don't understand the CAL role assign duties to CAL's that no one else wants to do, leaving CAL feeling "dumped" upon and under-utilized.

CAL's who have received public mental health services and/or other government assistance are frequently double-stigmatized: first based on the disclosure of their mental health or substance use disorder and second because of their poverty and reliance on government aid programs. These common experiences of public mental health clients can make adjustment back into the community daunting, especially when these same individuals are seeking employment in the very same settings that they associate with past traumas.

3. **Lack of Support.** Like PMHS employers, CAL's also lack ongoing guidance and support related to their job duties and peer identities. It is essential that peers interact with one another on a regular basis to share common workplace experiences, strengthen their professional identities, and learn new job skills. As mentioned above, many CAL's do not have mentors or role models within their own organizations and are not given opportunities to seek them out in professional settings. Thus, if CAL's are struggling in their roles and their supervisors do not understand their needs, peers feel isolated and alone.

4. **Lack of Advocacy & Structural Barriers.** When leadership roles are lacking and peers are relegated to the confines of their assigned programs without representation in management or a voice at the table when important matters are decided, their workplace needs go unaddressed. CAL's report feeling that workplace leaders do not advocate for their interests, so their pay, benefits, and working conditions are unlikely to ever improve. Counties' annual EQRO reports address whether peers have a direct line of communication with organizational leadership, but there is no enforcement or follow up (until the next EQRO report) to ensure this requirement is being met. No such external evaluation and reporting mechanism exists for private CBOs. Additional structural barriers include county personnel and risk management departments that refuse to deviate from standard hiring practices for peer positions, and institutionalized stigma that results in different treatment and practices applicable only to peer staff (prohibiting peer access to client data; walling off peers from important activities and information because peers are more "risky;" identification as peer treated as a black mark when applying for other positions, etc.).

6. CONDITIONING[9]

Part of the reason some of us fail to take control lies in our individual conditioning. Many of us have been conditioned to accept less than we can have and be less than we can be.

That point is well made by a story I heard from my partner, Dick Winwood, who once took his daughter, Sarah, to a traveling circus. Dick was surprised to find eight elephants, each tethered only by a small rope attached to a ring on an iron leg shackle. Each of the small ropes, in turn, was tied to a much larger rope that was staked to the ground. Any one of those elephants, as big and strong as each was, could easily have walked away to explore the shopping mall across the highway. Dick wondered why these intelligent and curious creatures would not *want* to be free and roam around.

Later, he did some research to learn why elephants stay tethered when they have the power to move about. He learned that when they are very young, those elephants are chained by the leg to immovable stakes. For several weeks they struggle to free themselves. But, little by little, over a period of three to four weeks, the elephants are conditioned to believe that they can't move about freely when they are tied to the right rear leg. From the moment this conditioning takes hold, you can tie them with a string and they won't move. The elephants at the circus didn't roam about because they *believed* they couldn't. The tethers *in their minds* were stronger than any chain or rope.

Now, we're not elephants. But in many subtle ways we've been conditioned to believe certain things about ourselves and our environment. And we need to erase two effects of this conditioning from our lives if we want control and inner peace.

These two effects are defined by the following statements:

1. *There are events we can't control, but we believe we can.* We waste time worrying about the weather, or futility trying to control or manipulate spouses or employees or our children.
2. *Conversely, there are events we can control, but we believe we can't.* Many people, for example, feel they are locked into careers they really don't like, but in reality, this is usually self-imposed bondage.

[26] Hyrum W. Smith, 1994: The 10 Natural Laws of Successful Time and Life Management: Proven Strategies for Increased Productivity and Inner Peace: pg. 24

7. STRENGTHENING THE ROLE OF THE CONSUMER ADVOCATE LIAISON

The Consumer Advocate Liaison role is a responsibility not to be taken lightly. You must model recovery, professionalism and show up every day knowing that it took hundreds of years, a civil rights movement and legislation demanding client driven systems for you to have a seat at the table. The pressure is real, but you got this. As a Consumer Advocate Liaison, it is crucial that the county, community-based organizations and communities that you work with trust and value what you have to say. Sometimes you may feel like the elephant in the room but sometimes that is the most important role in the room.

> The expression "elephant in the room" (usually "the elephant in the room") or "the elephant in the living room"[1][2] is a metaphorical idiom in English for an important or enormous topic, problem, or risk that is obvious or that everyone knows about but no one mentions or wants to discuss because it makes at least some of them uncomfortable or is personally, socially, or politically embarrassing, controversial, inflammatory, or dangerous.[3][4]
>
> It is based on the idea/thought that something as conspicuous as an elephant can appear to be overlooked in codified social interactions and that the sociology/psychology of repression also operates on the macro scale. Various languages across the world have words that describe similar concepts.[27]

[27] Google>elephant in the room

APPENDIX

Appendix 1: Sample Consumer Advocate Liaison Job Announcement

Appendix 2: MHSA General Standards

Appendix 3: MHSA Program Components

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Appendix 5: Committees and Meetings

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APPENDIX 1: SAMPLE CONSUMER ADVOCATE LIAISON JOB ANNOUNCEMENT

LOCATION: [COUNTY] , CA | DEADLINE TO APPLY: [DATE]

[Agency] is a 501(c)(3) public benefit organization dedicated to improving the lives of residents in the diverse community of [County], California through advocacy, education, research, and culturally relevant peer support services. In all its programs, [Agency] works with individuals and families with mental health challenges to promote wellness and recovery, prevention, and improved access to services and supports.

POSITION OVERVIEW

[Agency] is seeking a full-time ([#] hours per week) Consumer Advocate/Liaison. This position reports directly to [Agency] Executive Director and is embedded within the [County] Division of Behavioral Health. As such, the Consumer Advocate/Liaison occupies a unique role that requires highly specialized knowledge and skills, including the ability to work independently while maintaining close ties to [Agency], organizational leadership.

The Consumer Advocate/Liaison represents and advocates for the interests and concerns of consumers from multicultural backgrounds accessing public mental health services in the County. The position supports [County] program development and provides a bridge, voice, and representation on behalf of the Division of Behavioral Health in community settings in existing and new initiatives. Knowledge of concepts of wellness, recovery, peer support, cultural and linguistic competence, public mental health systems, and the Mental Health Services Act are essential characteristics of this position.

Applicants must have personal lived experience of recovery from a mental health challenge. Individuals with experience receiving public mental health services in any California county, who are bilingual/bicultural, and/or members of underserved groups (e.g., racial/ethnic minorities; LGBTQ community members, etc.) are strongly encouraged to apply.

MINIMUM QUALIFICATIONS

Applicants who do not possess these minimum qualifications will not be interviewed:

- Personal lived experience of recovery from a mental health challenge
- The ability to consistently work a minimum of [#] hours each week and adhere to an assigned schedule
- The ability to occasionally work during the evenings and on weekends, as business needs dictate
- A high school diploma or its equivalent (Associate's or Bachelor's degree preferred)
- Intermediate computer literacy skills, including proficiency in word processing and email applications
- A current and valid Class "C" California Driver License

- Immediate access to reliable personal transportation throughout the workday
- Auto insurance coverage that meets the minimum legal requirements in California
- A clean criminal history, as evidenced by a California DOJ background screening
- Strong written, verbal, and interpersonal communication skills
- Any combination of training, education, and experience necessary to perform the Job Duties for this position, and likely to provide the required Knowledge and Abilities as described herein

JOB DUTIES

- Coordinates and communicates with [Agency], organizational leadership and program managers to strengthen and expand recovery and peer support principles in the provision of public mental health services
- Provides support to [County] Behavioral Health Director at assigned community meetings and projects to strengthen the voice and perspectives of consumers receiving and seeking services
- Actively participates in county mental health system planning and project development
- Provides technical assistance and consumer perspectives for the Division's Management Team and other identified planning and project teams
- Advocates for and elevates the needs of clients/consumers receiving services in [County] adult system of care
- Fosters the involvement of clients/consumers and other stakeholders on local boards and committees
- Trains and mentors' clients/consumers by sharing knowledge of existing supports and services, providing information and supports around recovery plans and principles
- Serves as a liaison for clients/consumers to [County] Division of Behavioral Health Services
- Provides feedback and information regarding the needs of clients/consumers through surveys, focus groups and other reports
- Develops strategies to help clients/consumers connect to benefits, entitlements, and other resources
- Provides encouragement, motivation and support to clients/consumers
- Plans, organizes, and executes special events in the community
- Conducts peer support groups and recovery-oriented group activities
- Assists clients/consumers in building and maintaining personal support networks
- Plans and evaluates advocacy support services
- Assesses the advocacy, mental health treatment, and educational needs of consumers and mental health stakeholders
- Researches and evaluates existing and available resources for consumers in [County]
- Analyzes and evaluates data and formulates recommendations to Division Management
- Develops program recommendations for the Division of Behavioral Health to meet the identified needs of consumers and stakeholders
- Coordinates and facilitates collaborative efforts among public, private, and non-profit groups and organizations to meet consumer needs
- Provides leadership, advocacy, and coalition building on behalf consumers and other stakeholders
- Researches mental health and related supportive social service policies, procedures, programs, organizational structures, existing and proposed legislation and regulations, and

related issues
- Serves on program development committees and task forces as liaison to the County; acts as liaison to various agencies and organizations
- Attends a variety of meetings, trainings, and events with provider agencies and county mental health staff
- Writes complex documents including proposals, budgets, and reports that are part of County program initiatives
- Facilitates meetings and makes group presentations
- Conducts data collection and family and client satisfaction surveys
- Ensures confidentiality is maintained at all times in accordance with Federal, State, County, and agency standards
- Performs all other duties as assigned

KNOWLEDGE AND ABILITIES

The ideal candidate will demonstrate KNOWLEDGE of:

- The Consumer movement, client-directed services, and principles of wellness, recovery, and peer support
- Theories, principles, goals and objectives of self-help support needs to adult consumers
- Cultural competency and the disparities faced by underserved communities when accessing services in the public mental health system
- The structure and function of California's public mental health system
- Multiple types of programs and consumer needs within a county behavioral health system
- Principles, methods and techniques of community organization and development
- Program planning and design, budget development, and program evaluation
- Key elements, values, and goals of the Mental Health Services Act (Prop. 63)
- Available community resources
- The complex public and/or private agency services available for individuals' mental health needs, including community- and recovery-based resources and culture-specific supports for older adults
- The relationships among government agencies, public and private community organizations and groups, and private enterprises affecting consumers and stakeholders within the County

Successful candidates will have the ABILITY to:

- Communicate clearly and effectively with a wide range of organizations, government agencies, groups, professions, and individuals from different educational, economic, and cultural backgrounds
- Build coalitions among groups with differing needs and objectives
- Demonstrate equality in relationships with clients and capacity for self-awareness
- Organize and motivate volunteers, consumers, and community members
- Model effective coping techniques and communication skills
- Use language that is non-judgmental and non-clinical
- Demonstrate advocacy and teamwork skills
- Display professionalism in appearance, language, and conduct
- Demonstrate culturally-sensitive and appropriate interaction
- Apply self-help and support principles and techniques to problems and issues

- Work productively with minimal oversight and instruction
- Demonstrate personal responsibility and sound independent judgment
- Support [County] Behavioral Health Division in consumer liaison related work with different levels of County government
- (Desired) Speak fluently in one of the county's threshold languages

PHYSICAL AND MENTAL REQUIREMENTS

This position requires employees to:

- Consistently work [#] hours each day, [#] hours each week, and adhere to an assigned work schedule
- Drive to/from various locations within the County
- Sometimes work in the evenings or on weekends, as business needs dictate
- Occasionally travel to conferences and trainings held in distant locations
- Perform moderate typing and engage in daily computer use
- Sit/remain stationary for the majority of the day
- Speak to others via telephone, in person, and in public settings
- Read, understand, and summarize information both verbally and in writing
- Make decisions and engage in ongoing problem-solving activities

COMPENSATION AND BENEFITS

Employment at Your Organization is strictly at/will and this position is dependent upon continued program funding.
Salary begins at $xx,xxx annually, and may increase depending on experience. This is a full-time ([#]-hour per week) position. Full-time positions receive employer-paid medical, dental, and vision benefits, along with paid holidays and up to 150 hours (four weeks) of paid time off each year. Full-time employees may also enroll in our group life insurance and 403(b) retirement plans.

APPLICATION INSTRUCTIONS: PLEASE READ CAREFULLY

To apply for this position, you must apply online on or before [DATE]. Please note:

- **No late applications.** The agency will not accept applications submitted after [DATE], unless we have officially extended this deadline.
- **Do your homework.** We want to hire the right person, not a warm body. Learn about our agency, who we are, and what we do before you apply. Check out our website (www.yourorganization.org) and read about our programs. Your application will tell us whether you really want to work for the agency or just want a job.
- **Be prepared.** Keep a copy of this job announcement with you when you complete the online application, as several questions will ask you to respond to specific information listed in this announcement.
- **Take your time.** When reviewing your application, we will consider how your responses reflect your qualities as a potential employee. The ability to follow instructions, attention to detail, thoughtfulness, thoroughness, accuracy, spelling, and grammar all matter. Slow down and make your responses count.

APPENDIX 2: MHSA GENERAL STANDARDS

MHSA General Standards

WIC § 5813.5(d); 9 CCR § 3320

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.
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); MHSA § 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

APPENDIX 3: MHSA PROGRAM COMPONENTS

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
    - Financial Incentive Programs
    - Residency and Internship Programs
    - Mental Health Career Pathway Programs
- Funding: 10% of local MHSA funds (one-time funding)
  - Reversion Period: 10 years

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

APPENDIX 4: 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 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) 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

CCR:	California Code of Regulations
LMHA:	Local Mental Health Agency
MHSA:	Mental Health Services Act
PMHS:	California's Public Mental Health System
SMHA:	State Mental Health Agency
WIC:	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. <u>Transformation</u>: 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. <u>Information</u>: 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. <u>Education</u>: 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. <u>Representation</u> : 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. <u>Participation</u>: 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. <u>Consideration</u>: 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.

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APPENDIX 5: COMMITTEES AND MEETINGS

MEETING	DESCRIPTION
Meetings with Division of Behavioral Health Services Director	The Consumer Advocate Liaison (CAL), meets regularly with the Behavioral Health Services (BHS) Director to discuss issues, trends and projects.
County Mental Health Board	The Mental Health Board is a subcommittee of the County Board of Supervisors, which meets to discuss the county's mental health programs, including reviewing and approving plans and updates. The CAL's have a designated time on this meeting's agenda to provide updates about their activities.
Division of Behavioral Health Services Management Team	The CAL attends the weekly/monthly meeting of the BHS Management Team Meeting. This is a meeting of leadership from the Division's Adult and Children's Departments: Mental Health Services Act (MHSA), Mental Health Services, Alcohol and Drug Services, Cultural Competence, Quality Management, Medical Directors and Inpatient, and the BHS Director. This group meets to discuss ongoing system-wide issues and new programs, and to hear a report from the BHS Director. The CAL's have a designated time on the agenda to provide a report, which may include information about current projects, trends in community input or new legislation.
Cultural and Linguistic Competence Committee	The Cultural and Linguistic Competence Committee is a monthly meeting of BHS Staff, contracted providers and community members representing and serving diverse populations. The committee meets to discuss outreach to diverse communities and culture-specific programs, and to review data and reports related to cultural competence. The CAL attends to make recommendations for outreach, data collection and interpretation from the client/consumer perspective.
Performance Improvement Project (PIP) for EQRO Committee	The Performance Improvement Project (PIP) Committee meets to design and implement Performance Improvement Projects (PIPs) for the County's annual External Quality Review Organization (EQRO) review. PIPs are used to evaluate programs designed to improve a specific process in the mental health system. The CAL makes recommendations for how to collect and interpret data related to the PIP.

High Intensity Provider Meeting	The Division of BHS meets monthly with its contracted providers of high-intensity services (Full Service Partnership (FSP) programs), to review clinical and business matters. The CAL attends to stay informed of system-wide trends and issues and to provide expertise, such as informing contracted agencies of training opportunities, legislation and consumer/community input.
Moderate Intensity Provider Meeting	The BHS meets monthly with its contracted providers of moderate-intensity outpatient services, to review clinical and business matters. The CAL attends to stay informed of system-wide trends and issues and to provide expertise, such as informing contracted agencies of training opportunities, legislation and consumer/community input.
Management Team	The CAL attends their employers (if contract through the county) monthly Management Team meeting and management trainings to stay current on agency policies and procedures and to learn from the agency's various county and statewide initiatives related to advocacy, peer support, workforce development and programs focused on specific populations.
Older Adult Coalition	BHS meets monthly with its staff and contracted providers who serve the older adult population. The meeting features presentations about programs, services or legal updates related to older adult mental health. The CAL attends to build expertise related to serving this population and to serve as a resource for service providers of adult consumers.
Employment Partners Collaborative	The Employment Partners Collaborative is a meeting of mental health service providers and employment programs for individuals with mental health challenges. The meeting features presentations about programs related to benefits, employment training and education for consumers. The CAL attends to provide expertise related to consumer employment and to gain knowledge about local programs.
Quality Improvement Committee (QIC)	Quality Improvement Committee (QIC) meets monthly with BHS staff representing various roles (i.e.: leadership, MHSA, Cultural Competence, monitors of contracted providers) and agencies providing mental health services to review data and procedures related to collecting data. The CAL attends to provide program updates and to make recommendations related to data collection and interpretation.
Mental Health Services Act Steering Committee	The Mental Health Services Act Steering Committee is composed of representatives from BHS and various stakeholder groups, including consumers and family members. The committee meets to hear public comment and review proposals and updates related to MHSA funding. The CAL attends to give public comment from the consumer

	perspective and to advocate that peer support and advocacy be incorporated into all MHSA programs.
Mental Health Support Group	The CAL facilitates a peer support group for consumers and family members twice per month and provide training to community members with lived experience to become group facilitators.
Advocate Liaison Meeting with Adult and Children's Division Managers	The CAL meets quarterly with Executive Management to discuss system-wide issues and to prepare to co-facilitate a quarterly meeting with contracted providers.
Utilization Review	The Utilization Review Committee is a group of BHS and contracted provider staff who meet to review and update procedures related to clinical documentation. The CAL attends to gain knowledge about quality management processes and to provide expertise on issues related to documentation, such as making recommendations for training peers in documentation.
Expert Pool	The CAL facilitates a quarterly Expert Pool meeting for consumers, family members, peer advocates and others in the community. The meeting is an educational forum featuring two to three presentations by individuals representing programs related to mental health in the community or about issues commonly faced by individuals with mental health challenges.
Contract Monitoring with BHS	The CAL meets monthly with their contract monitor from BHS to discuss progress on deliverables, client and family success stories and system issues they identify through their work with community members.
Adult and Children's Division Staff	The Adult and Children's Staff Meeting is an opportunity for a large group of BHS mental health administrative staff and leadership to share success stories and provide updates about numerous programs. There is a designated time for the CAL to provide updates about their activities and to report out issues in the community.
Opioid Coalition	The County Opioid Coalition is a large, open meeting of stakeholders representing disciplines such as public health, behavioral health and criminal justice. Each meeting has a theme related to treatment of opioid addiction in the community, i.e. opioid use and pregnancy and parenting. The CAL attends to provide expertise as a representative of adult mental health consumers.

Client Stakeholder Meetings	The CAL works with the Division to plan and recruit for current clients of local mental health services to participate in stakeholder meetings to discuss the services they receive. The CAL facilitates these meetings with support from BHS staff and reviews the input with leadership.
Town Hall	The CAL helps plan open community stakeholder meetings with BHS staff and reviews feedback gathered with leadership.
Interviews	The CAL regularly participates in hiring panels for BHS Staff.
Proposal Reviews	The CAL participates in committees to review funding proposals for County projects.

APPENDIX 6: ADVOCACY OPPORTUNITIES

ADVOCACY OPPORTUNITIES

Please 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?	Level of involvement 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?	Level of involvement in planning and program design, services delivery, and evaluation

APPENDIX 7: ADVOCACY WORKSHEET

ADVOCACY WORKSHEET

Doing Your Homework

Do you really understand the issue?

- How common/widespread is the problem?
- How did we get here?
- What has already been done and why?
- What hasn't been tried and why?
- What might work and why?
- What competing interests may be at stake?

At what venue will you make your public statement?

- ___ Mental Health Board
- ___ Committee of MH Board
- ___ MHSA Steering Committee
- ___ Subcommittee of MHSA Steering Committee
- ___ County Board of Supervisors
- ___ City Council
- ___ MHSOAC
- ___ DHCS
- ___ OSHPD
- ___ CalMHSA
- ___ CA Senate
- ___ CA Assembly
- ___ Other

What authority/influence does this body have to address the issue?

Who is the body accountable to? How?

Why is this the most appropriate forum to make your statement?

When, where, and at what time will the meeting take place?

Is the issue you're speaking about on the agenda?

How much time do you have to speak?

What are the political backgrounds/leanings of the members?

- What do they care about?
- What's their level of opposition to or support for the issue?
- How have they voted on similar issues in the past?
- What arguments might be most convincing to each member?

Are there any procedural rules this body follows that you need to keep in mind?

- Brown Act/Bagley-Keene Act
- City or county ordinances
- Bylaws/articles

Making Your Point

Who are you and where are you from? (1 sentence)

What is the issue? What happened? What changed or might change? (1 sentence)

What is your ask? What **exactly** do you want the body to do? (1 sentence)

How is the issue impacting you, people close to you, people like you, and/or the community at large? (2-3 sentences)

Why is the current situation not working/proposed action ineffective? (1-2 sentences)

What is the possible solution? (1-2 sentences)

Why is the solution better than the status quo/proposed action? (3-4 sentences)

Restate your ask/exactly what you are asking the body to do. (1 sentence)

Thank the body. (1 sentence)

APPENDIX 8: WHAT IS A PEER?

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

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.

APPENDIX 9: GLOSSARY OF BEHAVIORAL HEALTH, MEDI-CAL, AND MHSA TERMS

1115 Waiver: Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs. The purpose of these demonstrations, which give States additional flexibility to design and improve their programs

1370: Mentally incompetent to stand trial.

5150: Provision of the California Welfare and Institutions Code defining standards for the involuntary treatment, typically for inpatient psychiatric hospitalization of persons with mental illness. It is frequently used to refer to a 72-hour involuntary hold in an inpatient psychiatric facility

5250: Provision of the California Welfare & Institutions code that places a 14-day intensive treatment limit on persons held involuntarily on a 5150.

5350: Provision of the California Welfare and Institutions Code providing for appointment of a conservator for any person who is gravely disabled as a result of mental disorder or impairment by chronic alcoholism.

5355: Provision of the California Welfare & Institutions Code providing for appointment of a Conservator.

5585 Provision of the California Welfare & Institutions Code providing for a 72-involuntary hold for a minor.

AAP: American Academy of Pediatricians

AB: California Assembly Bill

AB 100: The California Assembly Bill signed into law on March 24, 2011. It ends the requirement that the California Department of Mental Health (DMH) and the Mental Health Services Oversight and Accountability Commission (MHSOAC) annually review and approve county MHSA plans and updates. A.B. 100 also states that counties are not required to annually update the three-year MHSA plan, and that MHSOAC, instead of DMH, may offer technical assistance to counties as needed. The State, rather than DMH, will administer the Mental Health Services Fund. A.B. 100 also authorizes the one-time transfer of $862 million in MHSA funding to other areas of mental health services, including special education pupils, EPSDT, and Medi-Cal Specialty Health Managed Care. In addition, A.B. 100 states that the Legislature expects the State to consult with MHSOAC to devise an effective means of ensuring that counties comply with MHSA.

AB 109/AB 117: Signed into law in 2011, provides California's blueprint for reducing the number of inmates in California's 33 state prisons by 137.5 percent by May 2013 as ordered by the U.S. Supreme Court. A.B. 109 calls for sentencing new, non-serious, non- violent or non-sexual offenders to county jail instead of state prison.

AB 1421: Laura's Law is a California law passed in 2002 that allows for court-ordered outpatient treatment for individuals who have a serious mental illness and recent history of psychiatric hospitalizations, incarcerations or threats or attempts of serious violent behavior toward self or others. Each county has the option as to whether to implement Laura's Law.

AB 2034: The California Assembly Bill that amended the California Welfare and Institutions Code and provides funding to address the issues of the homeless and their unmet needs. Counties and cities that operate independent public mental health programs provide health services and outreach to mentally ill adults who are homeless or at risk of becoming homeless. Many of the clients receiving services provided under the mandates of AB 2034 and AB 34 (passed in 1999) reside in housing arrangements that do not require licensure by Community Care Licensing. Funding for AB 2034 was discontinued by Governor Schwarzenegger in 2008.

AB 34: The California Assembly Bill that, beginning on November 1, 1999, provided $10 million to provide services to homeless mentally ill individuals and mentally ill individuals at risk of incarceration in the three counties of Los Angeles, Sacramento, and Stanislaus. In 2000, based on the early results demonstrated by this program, the legislature provided an additional $55 million to expand these services to include 31 more counties and 40 additional providers throughout the state of California.

AB 3632: Under the federal special education law, Individuals with Disabilities Education Act of 2004, children with disabilities are entitled to a free appropriate public education with the assistance of services. One of these related services are psychiatric services. A child who qualifies for special education, has an Individualized Education Program (IEP) and who requires psychiatric services may receive services at no cost. AB 3632 requires the coordination of these psychiatric services to be between the School District and County Mental Health. The School District is responsible for providing the psychiatric service's as long as school counseling and guidance services are meeting the child's need. To the extent that the services needed are beyond the scope of the School District then County Mental Health becomes responsible. A child may be referred by the School District to County Mental Health for an assessment to receive AB 3632 services when certain criteria are met. (See also SELPA)

Access: The extent to which an individual who needs care and services is able to receive them. Access is more than having insurance coverage or the ability to pay for services. It is also determined by the availability of services, acceptability of services, cultural appropriateness, location, hours of operation, transportation needs, and cost.

Access Team: A service that conducts telephone screenings for persons requesting mental health services and that links these individuals to appropriate mental health resources.

ACSW: Academy of Certified Social Workers

Admin Days: Time spent by a hospitalized patient waiting for transfer to another facility.

Administrative Costs: Costs of operating and managing programs. These costs cannot be tied to the provision of specific services.

Advocate: a person who pleads another's cause, a person who speaks or writes in support of something.

Affordable Care Act (ACA): The Patient Protection and Affordable Care Act (PPACA), commonly called the Affordable Care Act or "Obamacare," is a United States federal statute signed into law by President Barack Obama on March 23, 2010. Together with the Health Care

and Education Reconciliation Act, it represents the most significant regulatory overhaul of the U.S. healthcare system since the passage of Medicare
and Medicaid in 1965.

AOD: Alcohol and other drugs.

Appropriate Services: Services designed to meet the specific needs of each individual and family.

APS: Adult Protective Services

ASO: Administrative Services Organization. In 1998 the California Mental Health Directors Association identified an organization to manage the provision of mental health services for minors eligible for full scope Medi-Cal benefits placed out-of-county.

Assessment: A professional review and evaluation of an individual's mental health needs and conditions to determine the most appropriate course of treatment, if indicated, and may ascertain eligibility for specific entitlement or mandated programs.

Assisted Outpatient Treatment (AOT): Court-ordered outpatient treatment for individuals with severe mental illness who meet certain criteria and are resistant to accepting mental health services.

At Risk Mental State (ARMS): The condition of individuals who are at risk for developing a psychotic illness and are experiencing signs or symptoms indicative of high risk for psychotic illness. These individuals have not yet been diagnosed with a psychotic illness.

Best Practice: An effective method of treatment as established by a body of knowledge that may include scientific, practical or anecdotal elements.

Behavioral Healthcare: Continuum of services for individuals at risk of, or suffering from, mental, addictive, or other behavioral health disorders.

Behavioral Therapy: Focus on behavior-changing unwanted behaviors through rewards, reinforcements, and desensitization. Desensitization, or Exposure Therapy, is a process of confronting something that arouses anxiety, discomfort, or fear and overcoming the unwanted responses. Behavioral therapy often involves the cooperation of others, especially family and close friends, to reinforce a desired behavior.

Beneficiary: A client covered by Medi-Cal.

Biopsychosocial Model of Care: both a philosophy of clinical care and a practical clinical guide. Philosophically, it is a way of understanding how suffering, disease, and illness are affected by multiple levels of organization, from the societal to the molecular. At the practical level, it is a way of understanding the individual's subjective experience as an essential contributor to accurate diagnosis, health outcomes, and humane care.

Board and Care Home: (Also called adult care home or group home.) Residence which offers housing and personal care services for 3 to 16 residents. Services such as meals, supervision, and transportation are usually provided by the owner or manager. May be single family home. (Licensed as adult family home or adult group home.)

BOS: Board of Supervisors.

Budget: Estimate of proposed expenditures prior to actually incurring the expenditures. May or may not reflect actual expenditures. Should be developed using the best information available at the time the budget is developed.

CalWorks: California Work Opportunity and Responsibility to Kids, a program that provides cash aid and services to eligible California families.

CAMHPRO: California Association of Peer Run Organizations

Capital Facilities/Technological Needs (CF/TN): One of the five funding components of the Mental Health Services Act.

Care Coordinator: A person who ensures that patients receive all needed health care services. Within governmental programs, care coordinators also help patients remove barriers to access, and help link patients to other needed services in the community (such as financial assistance, housing, social services, etc.). Sometimes plans or insurance companies use the term care coordinator for a case manager who is also concerned with controlling health care costs

Caregiver: A person who has special training to help people with mental health problems. Caregivers include family members of adults and older adults, as well as family members of children.

CARF: Commission on Accreditation of Rehabilitation Services

Case Manager: An individual who organizes and coordinates services and supports for individuals with mental illness and their families.

CBHDA: California Behavioral Health Directors Association

CCP: Coordinated Care Plan

CCR: California Code of Regulations

CDSS: California Department of Social Services.

Certified Peer Specialist (CPS): A designation earned by consumers who provide services in the mental health system.

Change Agent: individuals who represent consumers, families, county and contracted administrative agencies. They work as a team to help each other and partner with leadership to help the whole system change.

CID: Critical Incident Debriefing

CIBHS: California Institute for Behavioral Health Services

Client: An individual who receives alcohol, drug, and/or mental health services.

CMS: Centers for Medicare and Medicaid Services (formerly HCFA)

COD: Co-Occurring Disorder

Cognitive Behavioral Therapy (CBT): a type of psychotherapy in which negative patterns of thought about the self and the world are challenged to alter unwanted behavior patterns or treat mood disorders such as depression.

Cognitive Enhancement Therapy (CET): a cognitive rehabilitation training program for adults with chronic or early-course schizophrenia or schizoaffective disorder who are stabilized and maintained on antipsychotic medication and not abusing substances.

Community-Based Organization (CBO): Usually refers to nonprofit or for-profit provider of alcohol, drug and/or mental health services, but may also refer to any local non-government organization.

Community Clinic: A clinic operated by a tax-exempt nonprofit corporation that is supported in whole or part by donations, grants, government funds, gifts, bequests, or contributions. Charges to the patient are based on the ability to pay using a sliding fee scale. These clinics provide essential services to primarily uninsured and underserved individuals.

Community-Defined Evidence: Practices that have a community-defined evidence base for effectiveness in achieving mental health outcomes for underserved communities. It also defines a process underway that will develop specific criteria for by which effectiveness may be documented using community-defined evidence that will eventual give the procedure equal standing with current evidence- based practices.

Community Health Center: A nonprofit organization that provides primary and preventive health care services for uninsured and underserved individuals in collaboration with other community providers.

Community Services and Supports (CSS): (1) A general reference to community-based mental health services and support programs, which includes a variety of services, a wide range of intensities and purpose. This term often refers to a continuous 'system of care' model able to respond to a variety of user needs. (2) A specific funding "stream" or component of the Mental Health Services Act administered by the California Department of Mental Health.

Complaint: In the Medi-Cal grievance procedure, an oral expression of dissatisfaction with services.

Compliance: Accurately following the government's rules on billing system requirements and other federal and/or state regulations.

Compliance Program: A self-monitoring system of checks and balances to ensure compliance with applicable laws relating to an organization's business practices.

Comprehensive, Continuous, Integrated System of Care (CCIS): a vision-driven system "transformation" process for re-designing behavioral health and other related service delivery systems to be organized at every level. (Minkoff & Cline, 2004, 2005).

Conservatorship: See "LPS Conservatorship" and "Probate Conservatorship."

Consumer: Any individual who does receive or could receive mental health, alcohol, drug and other care services to improve the quality of his or her life.

Consumer-Driven: A client-centered system of mental health care tailored to an individual's needs, preferences, and timetables that views providers and family as partners, not controlling partners.

Consumer-Run Services: Mental health treatment or support services that are provided by current or former mental health consumers. Includes social clubs, peer-support groups, and other peer-organized or consumer-run activities.

Contingency Management or Systematic use of Reinforcement is a type of treatment used in the mental health or substance abuse fields. Clients' behaviors are rewarded; generally, adherence to or failure to adhere to program rules and regulations or their treatment plan.

Continuum of Care: A term that implies a progression of services that a child moves through, usually one service at a time. More recently, it has come to mean comprehensive services.

Co-Occurring Conditions/Disorder: Two or more disorders present in one individual simultaneously. Often refers to an individual with both a mental health condition and a substance abuse disorder (alcohol and/or drug dependence or abuse). May also refer to other combinations of disorders.

Coordinated Services: A multi-agency approach to providing care for children incorporating a *plan of care* that typically involves organizations such as mental health, education, juvenile justice, and child welfare. *Case management* is used to coordinate services.

Cost Report: An annual document prepared by each county that shows the actual costs of various services and programs using accepted accounting methods. The cost report is used as the basis for determining the amount of Medi-Cal funding to which a county is entitled. Also referred to as Short-Doyle/Medi-Cal cost report.

County Executive Office: Administrative Office of the executive branch of a County government.

CPT: Current Procedural Terminology, a system for coding physician procedures developed by the AMA to file claims with Medicare.

Criminogenic: Producing or tending to produce crime or criminals.

Crisis Intervention Training (CIT): Established in Memphis in 1987, Crisis Intervention Training programs educate and prepare law enforcement professionals who come into contact with people with severe mental illnesses. CIT helps in identifying the signs and symptoms of these illnesses and in responding effectively and appropriately to people who are experiencing a psychiatric crisis..

Crisis Residential Treatment Services: Short-term, round-the-clock help provided in a non-hospital setting during a crisis.

Crisis Respite Facility: a voluntary, short-stay residential facility for individuals experiencing significant behavioral health challenges but who do not require inpatient services.

Crisis Stabilization Unit (CSU): a program that provides very short-term treatment and observation in an effort to resolve a mental health crisis without involuntary hospitalization. Sometimes referred to as a "23-hour bed" program.

Crisis Triage Team: A program that provides interventions for individuals experiencing mental health crises below the level of acuity that may lead to an involuntary hold.

CSI: Client and Service Information System

CSOC: Children's System of Care

CSP: Client Service Plan

Cultural Competence/Multi-Culturalist: The practice of continuous self-assessment and community awareness on the part of service providers to ensure a focus on the cultural, linguistic, socio-economic, educational and spiritual experiences of consumers and their families/support systems relative to their care.

CWS: Child Welfare Services, a program run by a County Department of Social Services.

CY: Calendar Year

DA: District Attorney

Day Treatment: Treatment that includes special education, counseling, parent training, vocational training, skill building, crisis intervention, and recreational therapy lasting at least four hours per day.

Dialectical Behavior Therapy (DBT): a cognitive-behavioral treatment approach with two key characteristics: a behavioral, problem-solving focus blended with acceptance-based strategies, and an emphasis on dialectical processes.

Direct Service Costs: Costs of providing services to clients.

DBH: California Department of Behavioral Health

DO: Danger to others

DR: California Department of Rehabilitation.

Drop-in Center: A social club offering peer support and flexible schedule of activities; may operate on evenings and/ weekends.

Drug Medi-Cal: Drug Medi-Cal is a treatment funding source for individuals who are Medi-Cal eligible. Services funded by Drug Medi-Cal are listed in Title 22, California Code of Regulations (CCR), Section 51341.1. (d)(1-6).

Drug Medi-Cal Organized Delivery System Waiver (DMC-ODS): In 2015 the Centers for Medicare and Medicaid Services (CMS) has approved California's Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver amendment that provides a continuum of care modeled after the American Society of Addiction Medicine (ASAM) criteria for substance use disorder treatment services.

DS: Danger to self (one of the criteria for an involuntary hold)

DSM: Diagnostic and Statistical Manual of Mental Disorders

Dual Diagnosis: Often used to indicate the co-occurrence of mental health disorders and substance abuse disorders (alcohol and/or drug dependence or abuse), although may also refer to other combinations of disorders.

Early Childhood Mental Health (ECMH): Programs that serve children 0-5 and their families.

Early Intervention: Usually joined in phrase with the term Prevention, it means providing services or treatment early on at the onset of an illness with the goal of reducing the duration and severity of the disorder.

Electronic Health Record (EHR): A digital version of a patient's paper chart. EHRs are real-time, patient-centered records that make information available instantly and securely to authorized users.

Emerging Best Practices: Those treatments and services with a promising, but less thoroughly documented, evidentiary base.

EMS: Emergency Medical Services

EMT: Emergency Medical Technician

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT): Services that are Medicaid's comprehensive and preventive child health program for individuals under the age of 21. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) legislation and includes periodic screening, vision, dental and hearing services. In addition, section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary health care service listed at section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the state's Medicaid plan to the rest of the Medicaid population.

Evidence-Based Practices (EBP): Services supported by research or suggested by other evidence that are typically person-centered, individualized, and congruent with the recovery model of care.

Expenditure: An actual incurred cost.

External Quality Review Organizations (EQRO): Examine health plans to determine compliance with Centers for Medicare and Medicaid Services (CMS) requirements and provide quality assurance oversight.

Eye Movement Desensitization and Reprocessing (EMDR): a one-on-one form of psychotherapy that is designed to reduce trauma-related stress, anxiety, and depression symptoms associated with posttraumatic stress disorder (PTSD) and to improve overall mental health functioning.

Face sheet: printout of client history with mental health services, including contracted providers.

Family Behavior Therapy (FBT): Outpatient behavioral treatment aimed at reducing drug and alcohol use in adults and youth along with common co-occurring problem behaviors such as depression, family discord, school and work attendance and conduct problems in youth.

Family-Centered Services: Help designed to meet the specific needs of each individual child and family.

Family-Driven: A system of care that involves the family of a youth/consumer in the process of assessment, identifying treatment options and developing a treatment plan that is based on and adapted to the youth/consumer's individual needs.

Family Member: An individual who is now or was in the past, either the primary caregiver or a concerned and involved person who provides a significant level of support to a person who is living with a mental illness.

Family/Consumer Involvement: One of the five major guiding principles of the MHSA that calls for client- and family- driven mental health system for older adults, adults, and transition-age youth and a family-driven system of care for children and youth.

Family Support Services: Help designed to keep the family together while coping with mental health problems that affect them. Examples include consumer information workshops, in-home supports, family therapy, parenting training, and crisis services and respite care.

FEP: First-Episode Psychosis

FFP: Federal Financial Participation

First Onset/Break: The first time an individual meets DSM criteria for a psychotic illness.

FSA: Family Service Agency

Full Service Partnership (FSP): One of three categories of MHSA Community Services and Supports (CSS) funding for programs that provide all necessary services and supports for designated populations. Full Service Partnerships provide the most intense level of services under MHSA funding.

Full-Time Equivalents (FTEs): The number of staff positions calculated assuming a full fiscal year (2,080 hours) after allowing for vacation time, sick leave, holidays, etc.

Fully Served: People who have been diagnosed with serious mental illness and children who have been diagnosed with serious emotional disorders, and their families, who are receiving mental health services through an individual service plan in which both the client and service provider agree that they are obtaining all of the services they want and need to achieve their wellness/recovery goals.

FY: Fiscal Year. July 1 through June 30.

GD: Gravely disabled

General System Development: one of three categories of MHSA funding denoting funds used to improve programs, services and supports for the identified initial full service populations and for other clients consistent with the populations described in the proposal.

Grievance: Any written communication of dissatisfaction.

Health-Based Intervention: Mental health programs and interventions designed to be used within a healthcare setting to assisted trained healthcare providers in identifying, screening, assessing and treating or referring individuals with, or at risk for, mental health problems.

Historical/Intergenerational Trauma: Memories passed from one generation to the next.

HMO: Health maintenance organization; an entity that provides, offers or arranges for coverage of designated health services needed by members for a fixed, prepaid premium. HMOs offer prepaid, comprehensive health coverage for both hospital and physician services. The HMO is paid monthly premiums or capitated rates by the payers, which include employers, insurance companies, government agencies, and other groups representing covered lives.

Home-Based Services (In-Home Supports): Help provided in a family's home either for a defined period of time or for as long as it takes to deal with a mental health problem. Examples include parent training, counseling, and working with family members to identify, find, or provide other necessary help. The goal is to prevent the child from being placed outside of the home.

Housing Services: Assistance to clients/patients in finding and maintaining appropriate housing arrangements.

HRSA: U.S. Health Resources and Services Administration, an agency of the US Department of Health and Human Services that directs national health programs to ensure quality health care to underserved, vulnerable, and special-need populations and promote appropriate health professions workforce capacity and practice, particularly in primary care and public health.

ICD: International Classification of Diseases is provided by the Centers for Medicare and Medicaid Services and the National Center for Health Statistics for medical coding and reporting in the U.S.

IEP: Individualized Education Program

ILP: Individual Learning Plan

IMPACT: (Improving Mood--Promoting Access to Collaborative Treatment) is an intervention for adult patients who have a diagnosis of major depression or dysthymia, often in conjunction with another major health problem.

Independent Living Services: Assistance, skills training and supportive services designed to maximize the client's ability to function
in the community.

Indicators: Measures that help quantify the achievement of an outcome.

Individual Service Plan (ISP): Person-directed plan of care developed with the assistance of the interdisciplinary team to prevent institutionalization and facilitate an individual's ability to fully participate in the community, taking into account the individual's preferences.

Innovation: A funding component of MHSA that supports time-limited demonstration projects that promote learning about new approaches to behavioral health service delivery.
Institution for Mental Disease:

Institution for Mental Disease (IMD): A designation of the Federal Government to distinguish skilled nursing facilities (SNF) that primarily care for people with psychiatric diagnoses from those that provide care for people with primarily medical illnesses. Any SNF with 51% or more of its population with a psychiatric diagnosis is considered to be an IMD.

Integrated Services: The range of community and supportive services available to a consumer that are coordinated, centered on the person being served rather than a particular problem, program or service site, reflective of common values and focused on the delivery of services.

IOM: Institute of Medicine

IST: Incompetent to Stand Trial

Juvenile Justice Involvement: Children and youth with signs of behavioral/emotional problems at risk of or having had contact with any part of the juvenile justice system and cannot be appropriately served with MHSA Community Services and Supports programs.

Katie A: Katie A. v. Bonta is a federal class action lawsuit filed on behalf of California foster youth and children at risk of out-of-home placement. Initially filed in July 2002, the lawsuit sought to improve access to intensive home and community-based mental health services offered through Medi-Cal, California's Medicaid program. After several years of litigation and negotiation, the parties reached a landmark settlement in September 2011.

Laura's Law: (see AB 1421)

LGBT: Lesbian, Gay, Bisexual and Transgender.

LCSW: Licensed Clinical Social Worker.

Little Hoover Commission: An independent and bipartisan state oversight agency that investigates California state government operations and, through its reports, makes regulatory and legislative recommendations on a wide variety of issues.

Lived experiences: Refers to the unique experiences and perspectives of mental health consumers and family members.

LPS (Mental Health) Conservatorship: A legal arrangement making one adult (called the conservator) responsible for a mentally ill adult (called the conservatee). These conservatorships are only for adults with mental illnesses listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Maintenance of Effort: A required contribution in order to receive funding. In the case of the MHSA, the maintenance of effort is based on a prior level of funding used for mental health services.

Managed Care: A system of health care in which patients agree to visit only certain doctors and hospitals, and in which the cost of treatment is monitored by a managing company.

Managed Care Organization (MCO): An organization that combines the functions of health insurance, delivery of care, and administration.

Medicaid: A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. In California, Medicaid is called "Medi-Cal."

Medi-Cal: California's Medicaid program. It provides health care coverage for more than six million low-income children and families as well as elderly, blind, or disabled individuals. Medi-Cal is jointly funded by the state and federal government and administered by the California Department of Health Services. People enroll in Medi-Cal through their county social services department.

Medical Model: the term coined by psychiatrist R. D. Laing in his *The Politics of the Family and Other Essays* (1971), for the "set of procedures in which all doctors are trained." This set includes complaint, history, physical examination, ancillary tests if needed, diagnosis, treatment, and prognosis with and without treatment.

Medical Necessity: Health care services and supplies finding and maintaining appropriate housing arrangements.

Medicare: The federal health insurance program for people 65 years of age or older, certain younger people with disabilities; e.g., those receiving SSDI, and people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called ESRD).

Medi-Medi: Enrollment in both Medi-Cal and Medicare.

Medically Necessary: A service or treatment that is appropriate for a client's diagnosis and which, if not rendered, would have an adverse affect on the client's condition.

Mental Health: How a person thinks, feels, and acts when faced with life's situations. Mental health is how people look at themselves, their lives, and the other people in their lives; evaluate their challenges and problems; and explore choices.

Mental Health Disorder: A diagnosable illness that significantly interferes with an individual's cognitive, emotional or social abilities.

Mental Health Integration: The combining of mental health prevention, assessment, intervention, treatment and referral into the primary health care system to prevent the development of serious emotional disorders and mental illness and to increase access to mental health services for underserved populations.

Mental Health Plan (MHP): California Welfare & Institutions Code Section 5775: "the State Department of Mental Health shall implement managed mental health care for Medi-Cal beneficiaries through fee-for-service or capitated rate contracts with mental health plans, including individual counties, counties acting jointly, any qualified individual or organization, or a nongovernmental entity.

Mental Health Problem: Diminished cognitive, emotional or social abilities, but not to the extend that the criteria for a mental disorder are met.

Mental Health Services Act (MHSA): Mental Health Services Act. It became law in California on January 1, 2005**.** It is designed to provide new resources for the expansion of mental health services, without reductions of current State allocation or cost/risk share agreements. The MHSA is intended to transform mental health care by mandating all services be: outcome-driven and based on consumer and family involvement; developed and monitored with a collaborative of community partners; delivered with cultural competency focused on eliminating ethnic and racial disparities in services.

Mental Health Services Oversight and Accountability Commission (MHSOAC): Mental Health Services Oversight and Accountability Commission. In November 2004, California voters passed Proposition 63, the Mental Health Services Act. The law calls for the establishment of the Mental Health Services Oversight and Accountability Commission (MHSOAC). Section 10 of the MHSA (Welfare and Institutions Code Section 5845) established the Mental Health Services Oversight and Accountability Commission (MHSOAC) and defined the creation and composition of the Commission. The MHSOAC oversees the Adults and Older Adults Systems of Care Act; Human Resources; Innovative Programs; Prevention & Early Intervention Programs; and the Children's Mental Health Services Act. The Commission replaced the advisory committee which had been established pursuant to Welfare and Institutions Code Section 5814.

Mental Health Treatment Court (MHTC): program funded by the state through a four year grant that began in 1999.

MET: See Motivational Enhancement Therapy

MFT: Marriage and Family Therapist.

MHA: Mental Health Association

MHP: Mental Health Plan or Mental Health Professional

MIA: Medically Indigent Adults program for people who are uninsured and who are not eligible for other health care coverage. MIA does not cover mental health care.

Milieu Therapy: a type of treatment that involves changing this environment in the hope that it will encourage a client to develop new coping strategies. This treatment will usually involve a long-term residential stay within a therapeutic community, but it can involve adapting the home life to create a more supportive environment.

Mobile Crisis Services: A crisis service that is delivered where and when the crisis occurs, ensuring that persons in psychiatric crisis are served by mental health professionals whenever possible.

Moral Reconation Therapy: a systematic treatment strategy that seeks to decrease recidivism among juvenile and adult criminal offenders by increasing moral reasoning.

Motivational Enhancement Therapy: an adaptation of motivational interviewing (MI) that includes normative assessment feedback to clients that is presented and discussed in a non-confrontational manner.

Motivational Interviewing (MI): a goal-directed, client-centered counseling style for eliciting behavioral change by helping clients to explore and resolve ambivalence.

MOU: Memorandum of Understanding

NAMI: National Alliance on Mental Illness

Natural Supports: Supports that occur within the larger community not part of mental health services; e.g., church, AA clubs.

New Freedom Mental Health Commission: Established by President George W. Bush in April 2002 to recommend ways to eliminate inequality for Americans with disabilities. The final report is available at www.mentalhealthcommission.gov/reports/reports.htm.

New Heights: An MHSA-funded program serving transition-age youth county-wide.

NIMH: National Institute of Mental Health.

NOA: Notice of Action to inform Medi-Cal beneficiaries that services have been denied or modified.

Non-Traditional Mental Health Setting: Systems and organizations that are not traditionally defined as mental health providers, such as school and early childhood settings, primary health care systems, and community settings serving ethnically diverse and underserved or unserved communities.

NP: Network Provider

OAC: Mental Health Services Oversight and Accountability Commission (See MHSOAC)

ODS: See Drug Medi-Cal Organized Delivery System Waiver

OLPN: Online Progress Note

Online Progress Notes: documentation about client visits entered into a computer database.

Onset: The beginning of a serious psychiatric illness that may be diagnosed by using the DSM manual.

OSHPD: California Office of Statewide Health Planning and Development

Outcomes: Conditions of well-being for children, youth, adults, families and/or communities. County MHSA CSS plans will be evaluated for their contribution to meeting specific outcomes for the individuals served including: meaningful use of time and capabilities, including things such as employment, vocational training, education, and social and community activities; safe and adequate housing, including safe living environments with family for children and youth; reduction in homelessness; a network of supportive relationships; timely access to needed

help, including times of crisis; reduction in incarceration in jails and juvenile halls, and reduction in involuntary services, reduction in institutionalization, and reduction in out-of-home placements.

Outcomes research: Studies that measure the effects of care or services.

Outreach: The act of extending services or assistance to those in the community who may benefit from care but who have not, or have not been able to, come forth to seek it.

Outreach and Engagement: One of three categories of MHSA Community Service and Supports (CSS) denoting funds used for outreach and engagement of populations previously receiving little or no service.

PACE: Personal Assistance in Community Existence, an alternative model to PACT/ACT developed by Dr. Daniel Fisher and Laurie Ahern.

PACT: Program of Assertive Community Treatment is a team-based approach to the provision of treatment, rehabilitation, and support services. ACT/PACT models of treatment are built around a self-contained multidisciplinary team that serves as the fixed point of responsibility for all patient care for a fixed group of patients. In this approach, normally used with clients with severe and persistent mental illness, the treatment team typically provides all patient services using a highly integrated approach to care.

PAL: Public Assistance Liaison; training program developed at UCLA to teach mental health clients a series of basic living skills. Maintains a consistent training protocol for a variety of skills modules.

PART: Professional Assault Response Training

PART A Medicare: Medical Hospital Insurance (HI) under Part A of Title XVIII of the Social Security Act, which covers beneficiaries for inpatient hospital, home health, hospice and limited skilled nursing facility services. Beneficiaries are responsible for deductibles and copayments.

Part B Medicare: Medicare Supplementary Insurance (SMI) under Part B of Title XVII of the Social Security Act, which covers Medicare beneficiaries for physician services, medical supplies and other outpatient treatment. Beneficiaries are responsible for monthly premiums, copayments, deductibles and balance billing. .

Peer: an individual with lived experiences pertaining to mental health challenges or a member of a family that includes a person with lived mental health experiences.

Pastoral Counseling: Pastoral counselors are counselors working within traditional faith communities to incorporate psychotherapy, and/or medication, with prayer and spirituality to effectively help some people with mental disorders. Some people prefer to seek help for mental health problems from their pastor, rabbi, or priest, rather than from therapists who are not affiliated with a religious community.

Patient Protection and Affordable Care Act: See Affordable Care Act.

Patients' Rights Advocate: California law requires each county to assign a Patients' Rights Advocate to promote and represent clients' rights and interests. These aims are accomplished through direct assistance to practices of mental health programs and facilities and through training of mental health staff about the rights of mental health consumers.The California

Welfare & Institutions Code Chapter 6.2 Mental Health Advocacy, Article 1 General Provisions, Section 5500.

PCP: Primary care provider; health care providers capable of rendering a wide variety of basic health services.

PD: Public Defender

Peer: A consumer of behavioral health services or an individual whose family includes a consumer of behavioral health services.

Peer Center: A Medicaid category of program providership, frequently providing peer support services. Staffed and run by consumers.

Peer Recovery Specialist: A consumer or family member who conducts peer support, advocacy and outreach.

Peer Services: 1 a category of approved Medicaid reimbursable services; 2 a generic reference to any service that is provided by a consumer.

Peer Support: see Peer Services

Peer Support Center: a category of program providing Peer Services.

Performance Measures: Measures of how well our strategies are working.

PHF: Psychiatric Health Facility. It is a 16- bed, acute adult inpatient unit that accepts patients hospitalized involuntarily.

Planning Estimate: A calculated maximum amount of funding available to each county for expanded mental health services under the MHSA.

Posttraumatic Stress Disorder: An anxiety disorder that develops as a result of witnessing or experiencing a traumatic occurrence, especially life-threatening events.

PPACA: See Affordable Care Act.

PPO: Preferred Provider Organization; a corporation that receives health insurance premiums from enrolled members and contracts with independent doctors or group practices to provide care. Doctors are not prepaid, but they offer a discount from normal fee-for- service charges.

Pre-Implementation Funding: Funds available to counties for continued planning efforts while their Community Services and Supports Program and Expenditure Plan is reviewed by the State.

President's New Freedom Mental Health Commission: See "New Freedom Mental Health Commission."

Prevention: Services using interventions that reduce the likelihood of an onset of a serious illness or disorder.

Prevention and Early Intervention (PEI): An MHSA funding component that supports a variety of County programs, such as integration of primary and mental health care, early childhood mental health services, community health educators, crisis services and mobile crisis.

Primary Care: Integrated, accessible health care services by clinicians accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.

Priority Population: A specific group defined by the OAC as a population who should receive priority consideration by counties when determining who will receive MHSA funds.

Prisoner Realignment: In May 2011 a U.S. Supreme Court decision uphold a lower court decision that required California to lower its prison population by 30,000. On October 1, California's corrections realignment plan, went into effect. The plan shifts responsibility from the state to counties for the custody, treatment, and supervision of individuals convicted of specified nonviolent, non-serious, non-sex crimes.

Probate Conservatorship: A probate conservatorship is a court proceeding in which a judge appoints a responsible person (called a conservator) to care for another adult who cannot care for him/herself or his/her finances (called a conservatee).

Prodrome/Prodromal Syndrome: The period in the course of a disorder when some signs and symptoms are present but the full- blown criteria have not been met. Typically, the prodrome may be defined only retrospectively, after the individual has met the full criteria for the disorder.

Program: One or more services used in an organized manner to provide strategies for services and supports to an individual to achieve positive outcomes.

Progress Notes: Provider comments about client presentation, interventions, etc.

Promising Practice: A practice that incorporates the philosophy, values, characteristics, and indicators of other positive/effective public health interventions. A promising practice is based on guidelines, protocols, standards, or preferred practice patterns that have been proven to lead to effective outcomes. It also incorporates a process of continual quality improvement that has an evaluation component/plan in place to move towards demonstration of effectiveness, However, a promising practice does not yet have evaluation data available to demonstrate positive outcomes.

Promotora: A community health educator who typically reflects the ethnic and cultural background of the people he or she serves.

Prop 47: Requires misdemeanor sentence instead of felony for certain drug and property offenses. Inapplicable to persons with prior conviction for serious or violent crime and registered sex offenders.

Proposed Budget per Member per Month: A calculation that shows the budgeted amount estimated to be spent on each participant per month based on the best information available at the time the budget was prepared. This does not represent a case rate, which is a pre-determined payment amount per client.

Proposition (Prop) 63: A California ballot initiative that called for an additional tax of one percent be imposed on taxpayers' personal income over $1 million to provide dedicated funding for the expansion of mental health services and programs. After passing with 53.4% of the vote, in November 2004 Proposition 63 became the Mental Health Services Act (MHSA).

Provider network: Mental health professionals who accept Medi-Cal and are recommended to clients determined not to require clinic services.

PSC: Personal Service Coordinator.

PSR: Psychosocial Rehabilitation

Psychiatric Health Facility (PHF): A 16-bed inpatient unit that accepts individuals on involuntary holds, among others.

Psychiatric Rehabilitation: a model of program that operates from guidelines established by IAPSRS; aka Psychosocial Rehab (PSR).

QCM: Quality Care Management

Quality Assurance (QA): Activities and programs intended to ensure or improve the quality of care in a health care setting or program. The concept includes the assessment or evaluation of the quality of care; identification of problems or shortcomings in the delivery of care; designing activities to overcome these deficiencies; and follow-up monitoring to ensure effectiveness of corrective steps.

Quality Improvement Committee (QIC): Each County in California that has a Mental Health Plan (MHP) is required to establish a committee to monitor the quality of specialty mental health services provided to beneficiaries of the MHP.

Quality Management (QM): an organized plan and approaches for the continuous measurement, evaluation and improvement of processes or functions of care for individuals, groups and/or the organization.

Realignment: In 1991, California enacted the Bronzan-McCorquodale Act, referred to as "Realignment", in response to the State's $14.3 budget deficit. In the areas of mental health, social services, and health, realignment transferred program responsibilities from the State to the counties' control, altered program cost-sharing ratios, and provided counties with dedicated tax to pay for these changes. The realignment plan was intended to provide expanded discretion and flexibility to counties to expend State funding. Local mental health programs were given much greater autonomy and flexibility in how they designed their mental health systems of care. With funds allocated directly to local governments to provide mental health services, both inpatient and outpatient services increased measurably for patients with severe diagnoses, but declined for those with mild diagnoses. Service design shifted significantly toward case management and rehabilitative services that permit seriously mentally ill persons to maintain their recovery. (See also Prisoner Realignment)

Recovery: A process of change through which individuals improve their health and wellness, live a self-directed life and strive to reach their full potential.

Recovery Model: an approach to behavioral health disorders that emphasizes and supports a person's potential for recovery. Recovery is seen as a personal journey rather than a set outcome, and one that may involve developing hope, a secure base and sense of self, supportive relationships, empowerment, social inclusion, coping skills, and meaning.

Recovery-Oriented System of Care: A coordinated network of community-based services and supports that is person-centered and builds on the strengths and resiliencies of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems

Referral: The process of sending an individual from one practitioner to another for health care, mental health, or other services and supports.

Rehabilitation: Services that provide a balance of supports and skills, including supported education, employment, skills training and community integration.

Reserve: An amount set aside and not spent to ensure sufficient funding in years where there is a decline in MHSA revenues.

Resilience: The enduring ability of someone to recover from assaults to their person, whether physical, mental or emotional and, in the midst of that, maintain a sense of spirit and hope.

Respite Services: Services that provide a break for parents who have a child with a serious emotional disturbance. Respite services may also include adults and older adults.

Riese Hearing: A legal proceeding in which a judge determines whether an involuntary patient is capable of giving informed consent.

RLC: see Recovery Learning Community

ROI: Release of Information (also Return on Investment)

SAMHSA: Substance Abuse and Mental Health Services Administration, the US Federal agency charged with improving the quality and availability of prevention, treatment, and rehabilitative services in order to reduce illness, death, disability, and cost to society resulting from substance abuse and mental illnesses. SAMHSA is a branch of the United States Department of Health and Human Services.

S.B. 82: California Senate Bill 82, the Investment in Mental Health Wellness Act of 2013, funds focused on crisis

SB 163: Legislation signed by California Governor Wilson In 1998 creating a five-year pilot for flexible use of RCL 12-14 foster care funding statewide. Wraparound, an approach to implementing individualized, comprehensive services for youth with complicated multi-dimensional problems, was authorized throughout California. In August 2000, Gov. Gray Davis signed AB 2706 to expand the group of children eligible (RCL 10-14) for wraparound services as an alternative to institutional care. In August 2001, Gov. Davis signed AB 429 that removed the sunset on SB 163 and made Wraparound a permanent program in California.

Screening: The process used to identify individuals with an increased risk of having mental health disorders that warrant immediate attention, intervention, or more comprehensive review.

SD/MC: Short Doyle/Medi-Cal

SED: Serious Emotional Disturbance

Seeking Safety: A present-focused treatment for clients with a history of trauma and substance abuse. The treatment was designed for flexible use: group or individual format, male and female clients, and a variety of settings (e.g., outpatient, inpatient, residential).

Self-directed Recovery: consumers lead their treatment and recovery.

Serious Emotional Disturbance (SED): Diagnosable disorders in children and adolescents that severely disrupt their daily functioning at home, school, or community.

Service Capacity: An organization's ability to identify and provide a given service or services to its target community or population.

Severe Mental Illness (SMI): Pursuant to section 1912(c) of the Public Health Service Act, adults with serious mental illness SMI are persons: (1) age 18 and over and (2) who currently have, or at any time during the past year had a diagnosable mental behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-IV or their ICD-9-CM equivalent (and subsequent revisions) with the exception of DSM-IV "V" codes, substance use disorders, and developmental disorders, which are excluded, unless they co-occur with another diagnosable serious mental illness. (3) That has resulted in functional impairment, which substantially interferes with or limits one or more major life activities. Federal Register Volume 58 No. 96 published Thursday May 20, 1993 pages 29422 through 29425.

ShareCare Billing System: Software that enables the department to register a client, collect demographic and
diagnostic information and bill for services.

SHIA: Supportive Housing Initiative Act. In response to the growing number of homeless people in California, SHIA (AB 2780, Chapter 310, Statutes of 1998) was passed into law. The SHIA initiative targeted very low income adults having one or more disabilities, including mental illness, HIV or AIDS, substance abuse, or other chronic health conditions, and individuals with developmental disabilities, and may include families with children, elderly persons, young adults aging out of the foster care system, individuals exiting institutional settings, homeless people and veterans.

Short/Doyle Medi-Cal or SD/MC: Federal Medicaid funding in California used for the "public" mental health treatment services. This source of funding has typically been "capped", with 51% of the costs reimbursed from the Feds (referred to as Federal Financial Participation or FFP) with a mandated 49% match from state allocations to county mental health.

SMI: Severe Mental Illness.

SNF: Skilled Nursing Facility

SOAR: SSI/SSDI Outreach, Access and Recovery: a national project funded by the Substance Abuse and Mental Health Services Administration designed to increase access to SSI/SSDI for eligible adults who are homeless or at risk of homelessness and who have a mental illness and/or a co-occurring substance use disorder.

SOC: Share of Cost or System of Care

SSDI: Social Security Disability Insurance.

SSI/SSP: Supplemental Security Income/State Supplementary Program.

Stabilization: to make firm, to keep from fluctuating; as in symptom stabilization.

Stakeholder: (a) A person or group of people who impacts or is impacted by mental health services; (b) A person who represents others' interests relative to mental health services.

State Audit: A detailed review by the State Department of Mental Health of each county's financial records. Audit primarily focuses on allowability of expenditures and allocation of costs between programs and accounting for revenue off-sets. Audit typically conducted four to five years after the end of the fiscal year.

State Fair Hearing: Clients may request a state fair hearing for any Mental Health Plan related reason at any time before, during, or after the complaint resolution process has started.

Steering Committee: MHSA Community Planning body

Strategies: Coherent collections of actions that have a reasoned chance of improving our outcomes.

Stigma: A mark or token of infamy, disgrace, or reproach. Stigmatization of people with mental disorders has persisted throughout history, manifested by bias, distrust, stereotyping, fear, embarrassment, anger and/or avoidance.

SUD: Substance use disorder.

Surgeon General's Report: Published in December 1999 by the US Department of Health & Human Services, the first Surgeon's Generals report on mental health focused on effective treatments for mental health disorders, the connection between mental health and physical health, barriers to receiving mental health treatment, and the specific mental health issues of children, adults and the elderly. Available online from: www.surgeongeneral.gov/library/mentalhealth/home.html.

Supplant: Literally means to take the place of and serve as a substitute for. MHSA funds are not to take the place of and serve as a substitute for (or replace) existing state or county funds used to provide mental health services.

Support, Treatment, Advocacy and Referral Team: See START.

Supported Employment: Supportive services that include assisting individuals in finding work; assessing individuals' skills, attitudes, behaviors, and interest relevant to work; providing vocational rehabilitation and/or other training; and providing work opportunities. Includes transitional and supported employment services.

Supported Housing: Permanent affordable housing with combined supports for independent living.

Symptom: any condition accompanying or resulting from an illness or disease and serving as an aid in diagnosis.

System Development Funds: One of three categories of MHSA funding used to improve services and infrastructure for the identified initial full service populations and for other clients.

TAY: Transition-Age Youth (16-25).

Team-Building: If a team is a group of people working towards a common goal, 'team building' is the process of enabling that group of people to reach their goal.

Threshold Language: A term used by the state of California to denote a language spoken by 3,000 beneficiaries or 5% of the Medi- Cal population, whichever is lower, whose primary language is not English.

TISC: Trauma-Informed System of Care

Title 9: Section of California Code of Regulations pertaining to standards for the State Department of Mental Health.

Transform: To wholly change the mental health services system in appearance, structure, nature or function.

Transition Age Youth (TAY): Transition age youth between the ages of 16 and 25, who have serious emotional disorders/severe mental illness. They may be are at risk for homelessness or involuntary hospitalization, and/or aging out of children's mental health, child welfare and/or juvenile justice systems. Transition-age youth who have experienced a first episode of major mental illness are also included.

Transition to Independence Process (TIP): An evidence-based approach that stresses the importance of providing access to community-based outreach and support, engages transition-age youth in shaping their own future planning process, and uses a focus on each individual's strengths., engages transition-age youth in shaping their own future planning process, and uses a focus on each individual's strengths.

Trauma: A psychological or emotional reaction to an event or to an enduring condition in which the individual's emotional experience is overwhelming, or the individual experiences a perceived threat to life, bodily integrity or sanity.

Trauma-Informed: an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma.

Treatment Authorization Request (TAR): A request submitted to Medi-Cal seeking authorization and payment for services that are medically necessary, but that are either more extensive or different than are usually covered by Medi-Cal. E.g. Additional visits, new medication not yet on their pharmaceutical formulary, etc.

Treatment Planning: a strategic course of action that directs appropriate services and ensures recovery.

Trauma-Sensitive Care: Treatment that appreciates the high prevalence of traumatic experiences in persons who receive mental health services. Trauma-sensitive care incorporates a thorough understanding of the neurological, biological, psychological and social effects of trauma and violence on the individual and addresses these effects, is Care that addresses these effects, is collaborative, supportive and skill-based.

Treatment Team: the composition of people who facilitate Recovery; the consumer, doctor, certified peer specialist, Case Manager and/or others who are specified in the Treatment Plan.

Uniform Method of Determining Ability to Pay (UMDAP): Sliding fee scale used by counties to calculate the amount charged to a client for services. Calculated as an annual amount based on a client's income and assets.

UB 92: Uniform Billing Code of 1992. Federal code and billing form requiring hospitals to follow specific procedures.

Un-served Populations: Individuals who have received no services or are receiving inadequate services to meet their needs.

Under-served/inappropriately served: Individuals who have been diagnosed with serious mental illness and children who have been diagnosed with serious emotional disorders, and their families, who are receiving some service, but whose services do not provide the necessary opportunities to move forward and pursue their wellness/recovery goals.

Utilization Review (UR): a process to ensure a consumer is served appropriately.

W&I Code: Welfare and Institutions Code

Workforce Education and Training (WET): a time-limited MHSA funding component that has supports workforce development, training, and retention

WRAP (Wellness Recovery Action Plan): Plans authored by consumers to draw on their strengths, advance wellness, prevent escalation of symptoms, and promote successful recovery from crises. Consumers work in collaboration with trusted peers to create and use their unique WRAPs.

Wraparound: A family centered, community-oriented, strengths-based, highly individualized planning process aimed at helping people achieve important outcomes by meeting their unmet needs both within and outside of formal human services systems while they remain in their neighborhoods and homes, whenever possible.

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a continuation of NorCal MHA Mental Health America

OSHPD Office of Statewide Health Planning and Development

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