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

ABOUT ACCESS CALIFORNIA

ACCESS California (or "ACCESS" for short) is a statewide consumer-led advocacy program of Cal Voices (formerly known as NorCal MHA) funded by the Council on Criminal Justice and Behavioral Health ("CCJBH").

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

PURPOSE

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

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

ACCESS California is a program of Cal Voices funded by the California Mental Health Services Act (Prop 63) and by the Council on Criminal Justice and Behavioral Health (CCJBH)

APPLICATION

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

ABBREVIATIONS

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

DEFINITIONS

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

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

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

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

MHSA PROGRAM PLANNING GUIDELINES

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

Describe the CPP undertaken to develop the MHSA Plan.

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

- Did you provide any training to stakeholders pursuant to 9 CCR § 3300(c)(3)(B) to ensure those participating in the CPP had adequate information and understanding to meaningfully participate?
 - How did the MHSa Plan change, if at all, based on the stakeholder feedback you received?

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

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

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

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

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

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

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

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

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

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

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

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

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

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