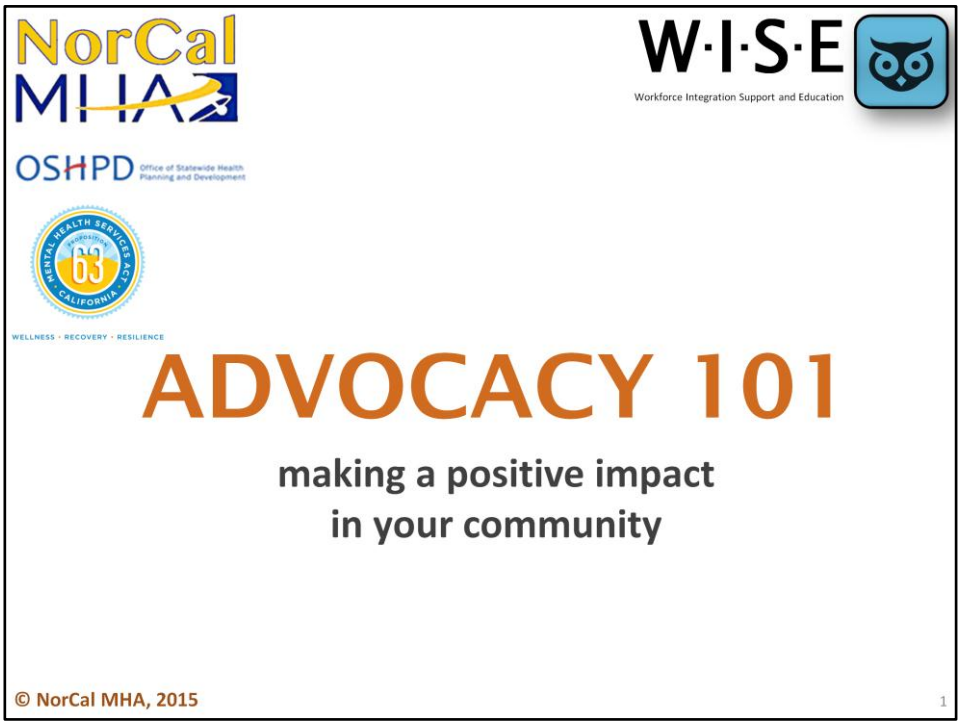
NorCal MHA
OSHPD Office of Statewide Health Planning and Development
WELLNESS · RECOVERY · RESILIENCE
W·I·S·E
Workforce Integration Support and Education
ADVOCACY 101
making a positive impact
in your community
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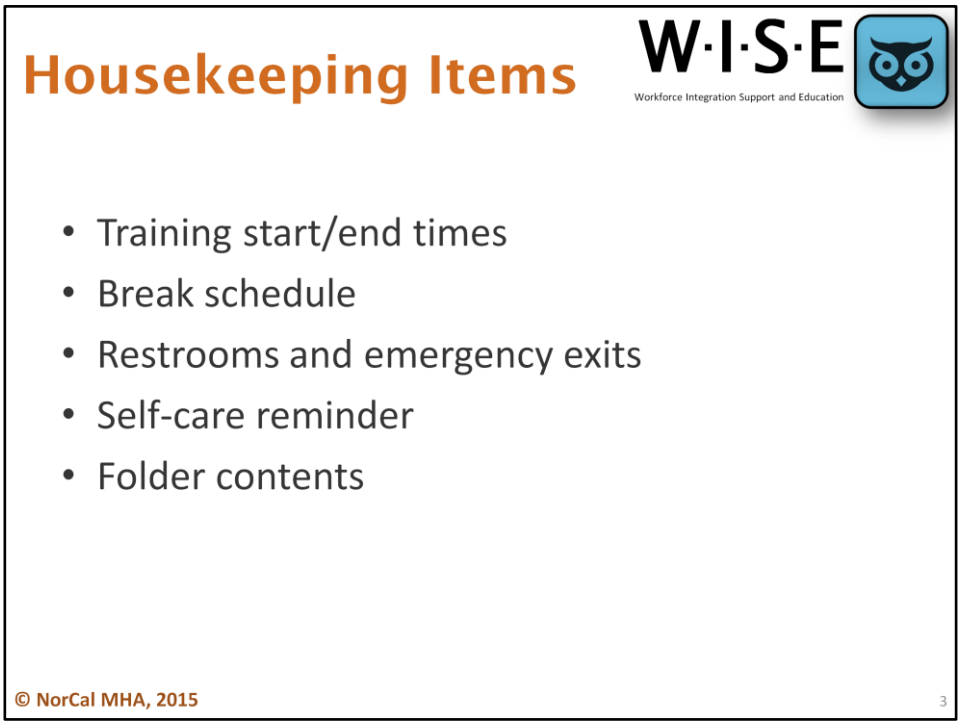
1

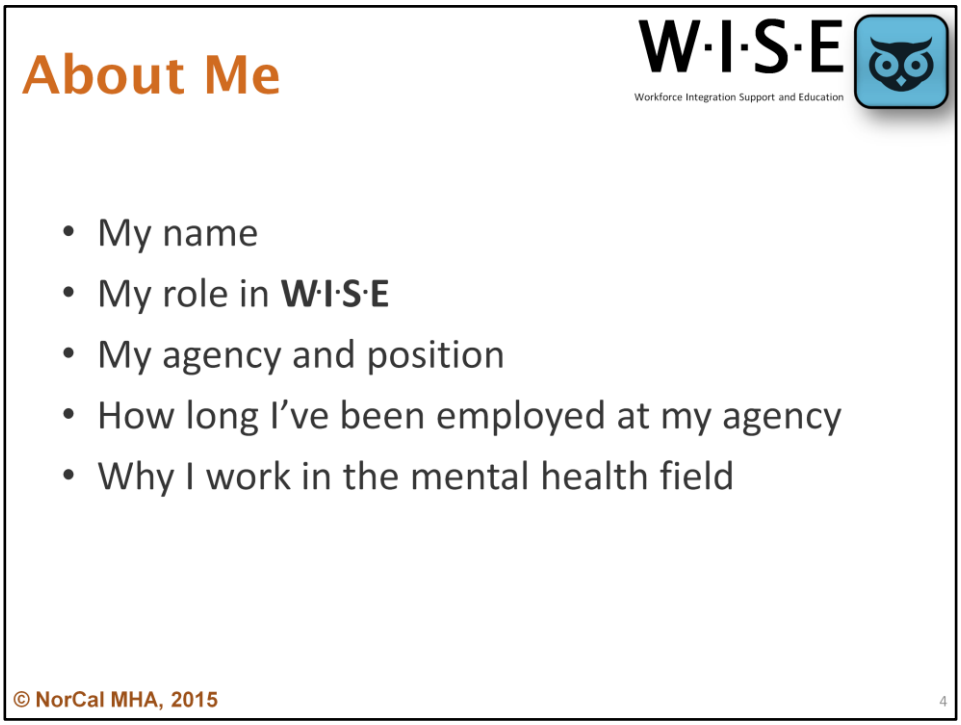
W·I·S·E
Workforce Integration Support and Education

Please complete your pre-training survey and demographic form

2



CUSTOMIZE, HIDE, OR OMIT, AS APPROPRIATE



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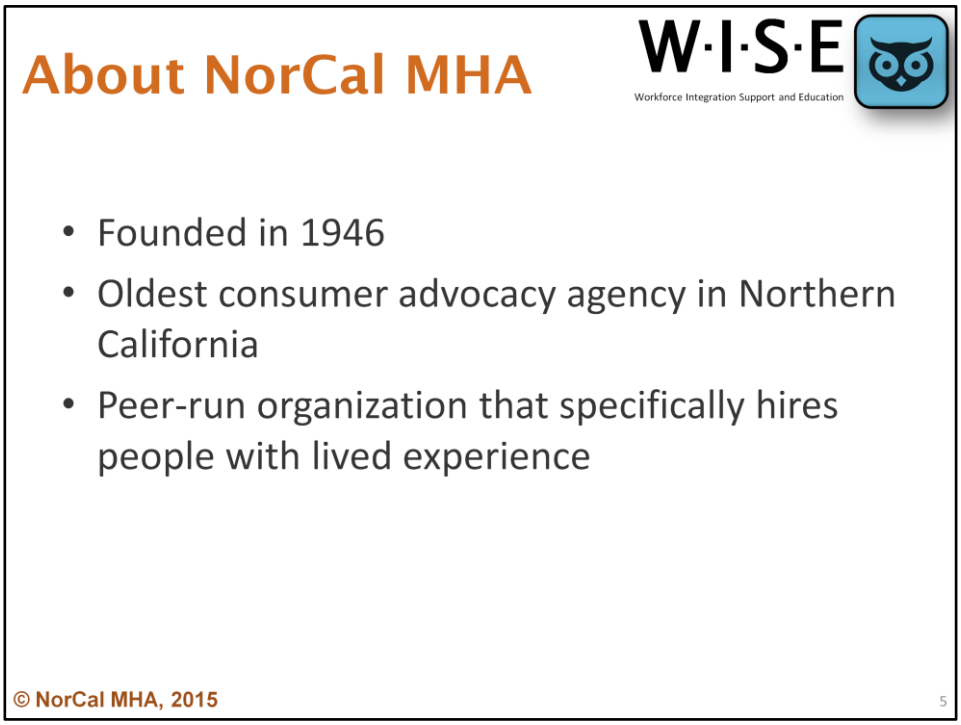


HIDE OR OMIT THIS SLIDE IF GROUP IS ALREADY FAMILIAR WITH NORCAL MHA <u>OR</u> SUBSTITUE THIS SLIDE WITH AN OVERVIEW OF YOUR OWN AGENCY

Peer-Run Org:

Over 50% of our Board

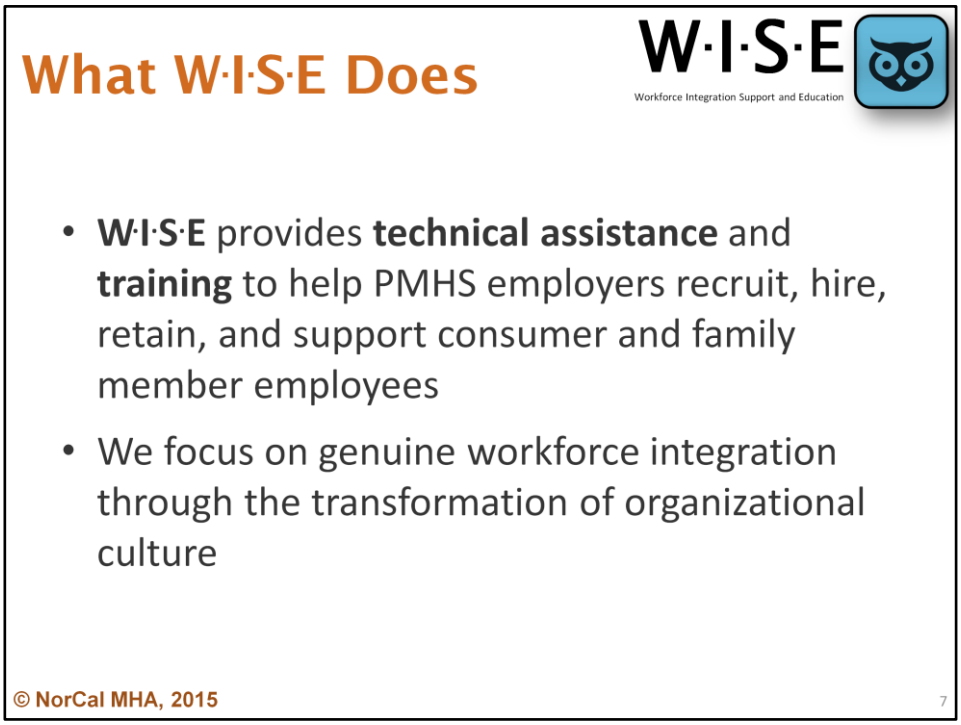
Over 90% of our staff, including all of our managers and Executive Leadership team

Member of CAMHPRO
Work throughout Northern California Have peer employees embedded in Amador County, Placer County, and Sacramento County
Work with many other Counties and CBOs across the state

About W·I·S·E

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

- **W·I·S·E** stands for Workforce Integration Support and Education
- **W·I·S·E** is a program of NorCal MHA, administered by the Office of Statewide Health Planning and Development (OSHPD), and funded by the California Mental Health Services Act (MHSA/Prop 63), as a component of OSHPD's statewide WET plan



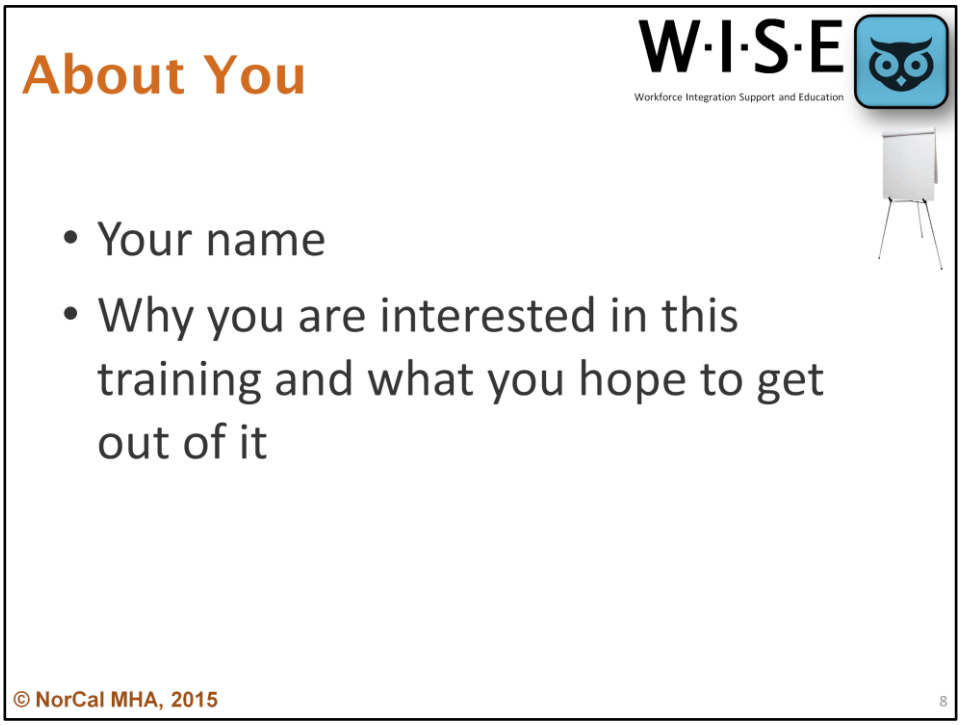
IF ASKED: Technical Assistance
Organizational assessments - **Assessments look at:**

Key informant interviews
Peer staff focus groups
Self-reported needs
Workplace culture
Policies and procedures
Job descriptions, hiring, onboarding, supervision, evaluation of peer staff
What's working? What could be improved? What do you need to do your job better?

Identification of strengths and opportunities
Implementation planning
Crafting peer roles and career paths
Supportive coaching and mentoring
Best practices and recommendations

Trainings
Organizational trainings for leaders and management (work culture and managerial competencies)
Professional development trainings for peers (technical and behavioral skills)

Creation of special trainings and educational materials, as needed



ASK: Why are you interested in this training and what do you hope to get out of it?

RECORD responses to last question – what attendees hope to get out of this training - on flipchart
Review these training goals at the end of the session to ensure the attendees' needs were met

Today We'll Learn About:

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

Part 1: The History of Mental Health Advocacy

Part 2: What is Advocacy?

Part 3: State and Local Advocacy Opportunities

Part 4: How Public Meetings Work

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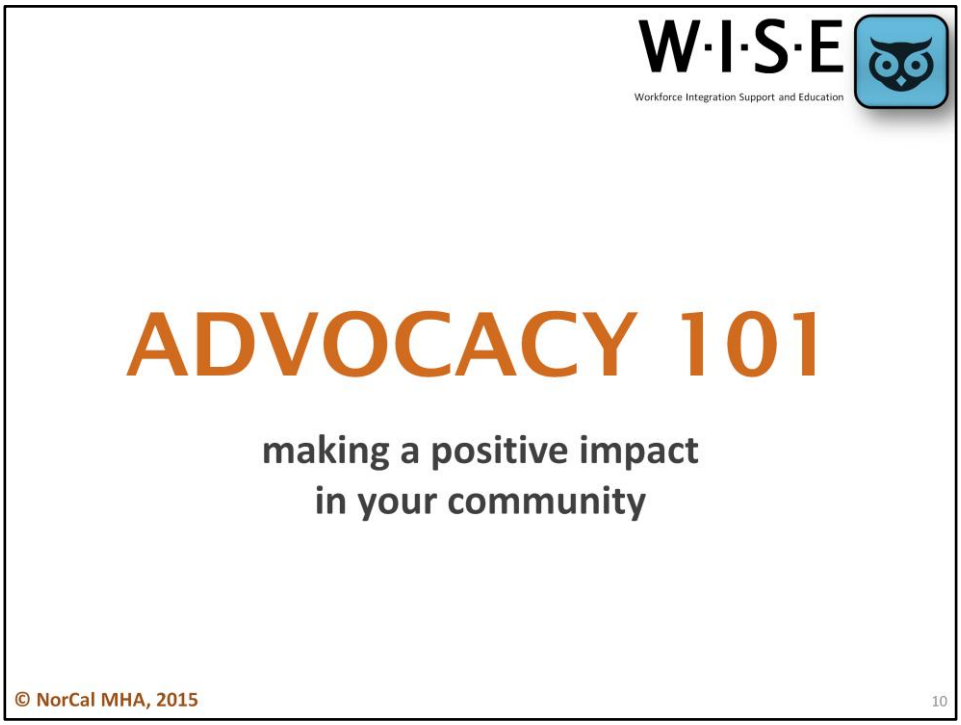
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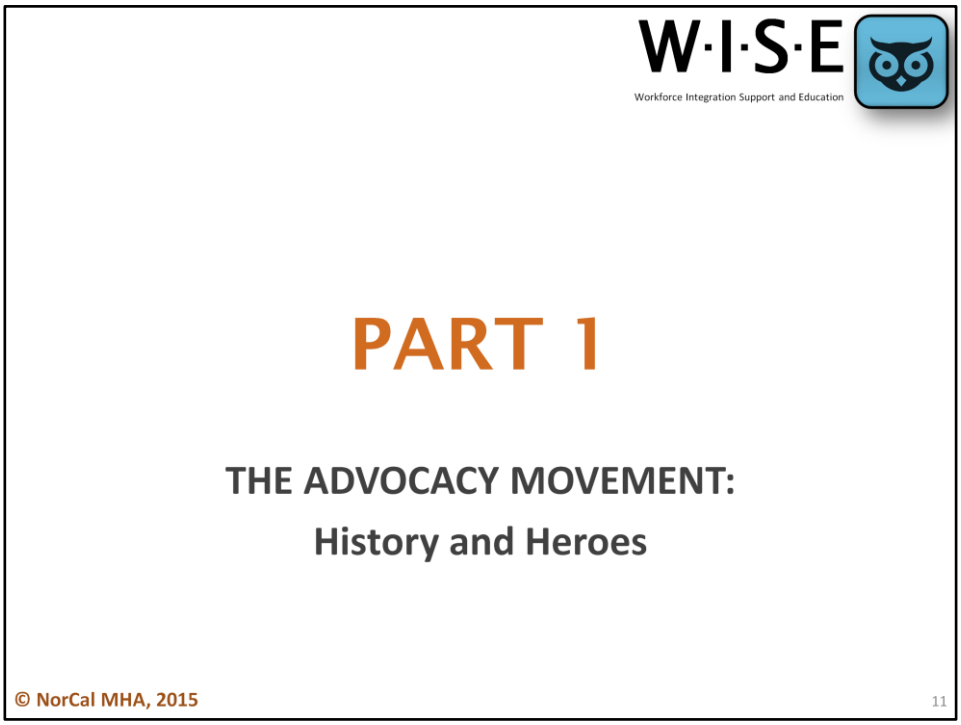
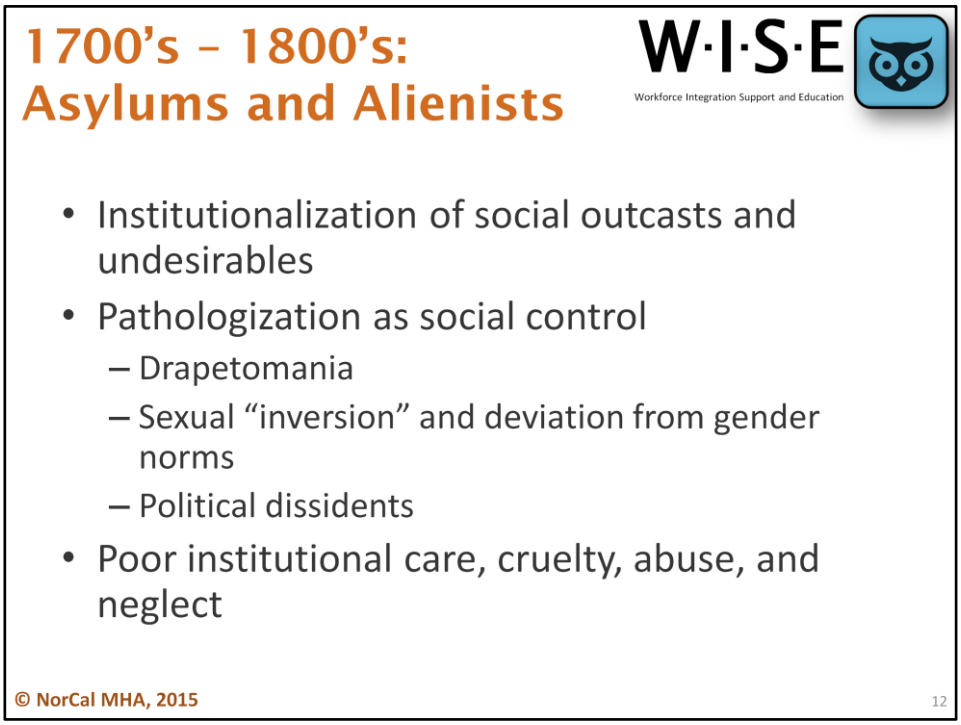


INITIATE BRIEF DISCUSSION:
How have mental health services changed over the past 100 years?
What are some key events that led to these changes?



18TH CENTURY

With the rise of madhouses and the professionalization and specialization of medicine, there was considerable incentive for medical doctors to become involved in the treatment of mental disorders. In the 18th century, they began to stake a claim to a monopoly over madhouses and treatments. Madhouses could be a lucrative business, and many made a fortune from them. There were some bourgeois ex-patient reformers who opposed the often brutal regimes, blaming both the madhouse owners and the medics, who in turn resisted the reforms.

By the end of the 17th century and into the Enlightenment, madness was increasingly seen as an organic physical phenomenon, no longer involving the soul or moral responsibility. The mentally ill were typically viewed as insensitive wild animals. Harsh treatment and restraint in chains was seen as therapeutic, helping suppress the animal passions. Treatment in the few public asylums was also barbaric, often secondary to prisons. The most notorious was Bedlam where at one time spectators could pay a penny to watch the inmates as a form of entertainment.

Towards the end of the 18th century, a moral treatment movement developed, that implemented more humane, psychosocial and personalized approaches. During the Enlightenment attitudes towards the mentally ill began to change. It came to be viewed as a disorder that required compassionate treatment that would aid in the rehabilitation

of the victim. When the ruling monarch of the United Kingdom George III, who suffered from a mental disorder, experienced a remission in 1789, **mental illness came to be seen as something which could be treated and cured.**

https://en.wikipedia.org/wiki/History_of_mental_disorders
https://en.wikipedia.org/wiki/History_of_psychiatric_institutions

19TH CENTURY
The 19th century, in the context of industrialization and population growth, saw a massive expansion of the number and size of insane asylums in every Western country, a process called "the great confinement" or the "asylum era".

Laws were introduced to compel authorities to deal with those judged insane by family members and hospital superintendents. Although originally based on the concepts and structures of moral treatment, they became large impersonal institutions overburdened with large numbers of people with a complex mix of mental and social-economic problems. However, it is well documented that very little therapeutic activity occurred in the new asylum system, that medics were little more than administrators who seldom attended to patients, and then mainly for other physical problems.

Asylum superintendents, later to be psychiatrists, were generally called "alienists" because they were thought to deal with people alienated from society.

In the United States it was proposed that black slaves who tried to escape were suffering from a mental disorder termed drapetomania. It was then argued in scientific journals that mental disorders were rare under conditions of slavery but became more common following emancipation, and later that mental illness in African Americans was due to evolutionary factors or various negative characteristics, and that they were not suitable for therapeutic intervention

https://en.wikipedia.org/wiki/History_of_mental_disorders

Around 1850, the idea of sexual “inversion” was brought forward to explain both gender nonconformity and same-sex attraction. The “inversion” scholars believed that homosexuality was an inborn tendency. They believed it resulted from changes to an individual’s brain while still in the womb. They thought these changes made both the brain and the behavior of “inverts” resemble those of the opposite sex. This idea that homosexuality was an inborn deviation from normal gender development was widely embraced. For example, women who fought for the right to vote were sometimes described as “mannish inverts” whose desire for masculine rights went along with their presumed seduction of younger women.

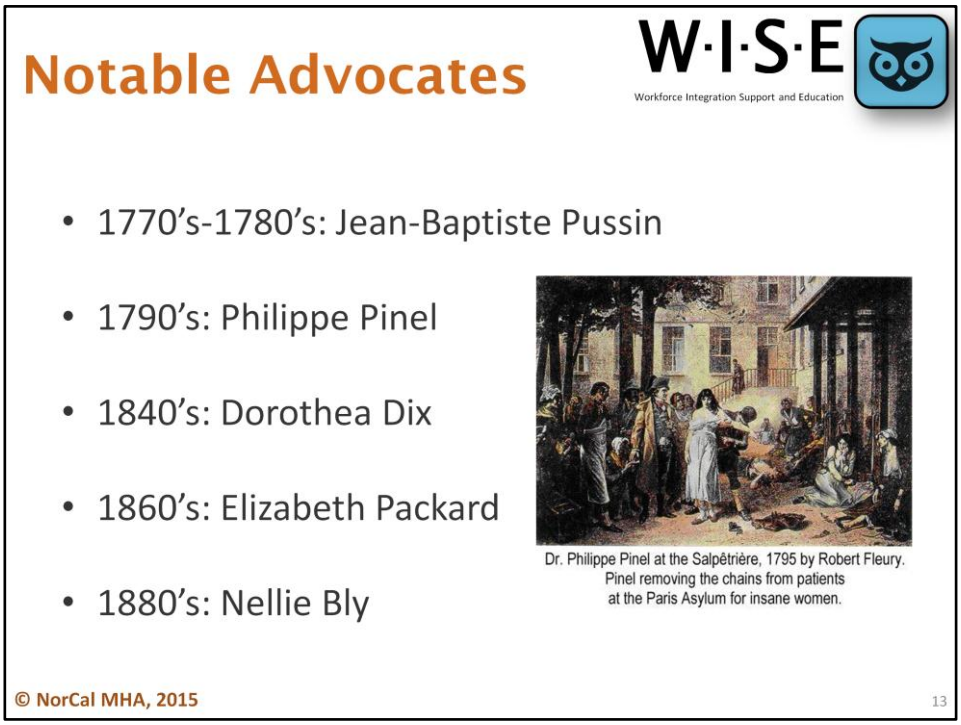
http://www.heretohelp.bc.ca/visions/lgbt-vol6/pathologizing-sexuality-and-gender#sthash.xEEEXVqR.dpuf

Anything that deviated from the "normal" ways of the 19th and early 20th century woman could be perceived as a sign of mental illness. It did not matter whether or not the women were actually suffering from a form of mental illness, sending them to mental institutions was a quick fix.

https://en.wikipedia.org/wiki/History_of_psychiatric_institutions

Psychiatrists around the world have been involved in the suppression of individual rights by states wherein the definitions of mental disease had been expanded to include political disobedience. Nowadays, in many countries, political prisoners are sometimes confined to mental institutions and abused therein. Psychiatry possesses a built-in capacity for abuse which is greater than in other areas of medicine. The diagnosis of mental disease can serve as proxy for the designation of social dissidents, allowing the state to hold persons against their will and to insist upon therapies that work in favor of ideological conformity and in the broader interests of society.

https://en.wikipedia.org/wiki/History_of_psychiatric_institutions



JEAN-BAPTISTE PUSSIN
French hospital superintendent who advocated a relatively humane treatment, engaged in psychologically-based work with patients with mental illness. In 1797, Pussin instituted a reform that permanently banned the use of all chains to restrain patients. https://en.wikipedia.org/wiki/Jean-Baptiste_Pussin

PHILIPPE PINEL
A French physician who studied under Pussin and was instrumental in the development of a more humane psychological approach to the custody and care of psychiatric patients. Pinel did away with bleeding, purging, and blistering in favor of a therapy that involved close contact with and careful observation of patients. Pinel visited each patient, often several times a day, and took careful notes over two years. He engaged them in lengthy conversations. His objective was to assemble a detailed case history and a natural history of the patient's illness. Pinel believed in developing specific practical techniques, rather than general concepts and assumptions. He engaged in therapeutic conversations to dissuade patients from delusions. He offered benevolent support and encouragement to patients**. Pinel argued that psychological intervention must be tailored to each individual rather than be based solely on the diagnostic category, and that it must be grounded in an understanding of the person's own perspective and history. He noted that "the treatment of [mental illness] without considering the**

[differentiating characteristics of the patients] has been at times superfluous, rarely useful, and often harmful", describing the partial or complete failures of some psychological approaches, as well as the harm that the usual cruel and harsh treatments caused to patients before they came to his hospital**. He saw improvement as often resulting from natural forces within the patient**, an improvement that treatment could at best facilitate and at worst interfere with.
https://en.wikipedia.org/wiki/Philippe_Pinel

DORTHEA DIX
An American activist who advocated on behalf of indigent individuals with mental illness. Through a vigorous program of lobbying state legislatures and the United States Congress, she created the first generation of government run institutions to ensure adequate care for those struggling with psychiatric disorders. She successfully persuaded the U.S. government and various states to fund the building of 32 state psychiatric hospitals.
https://en.wikipedia.org/wiki/Dorothea_Dix

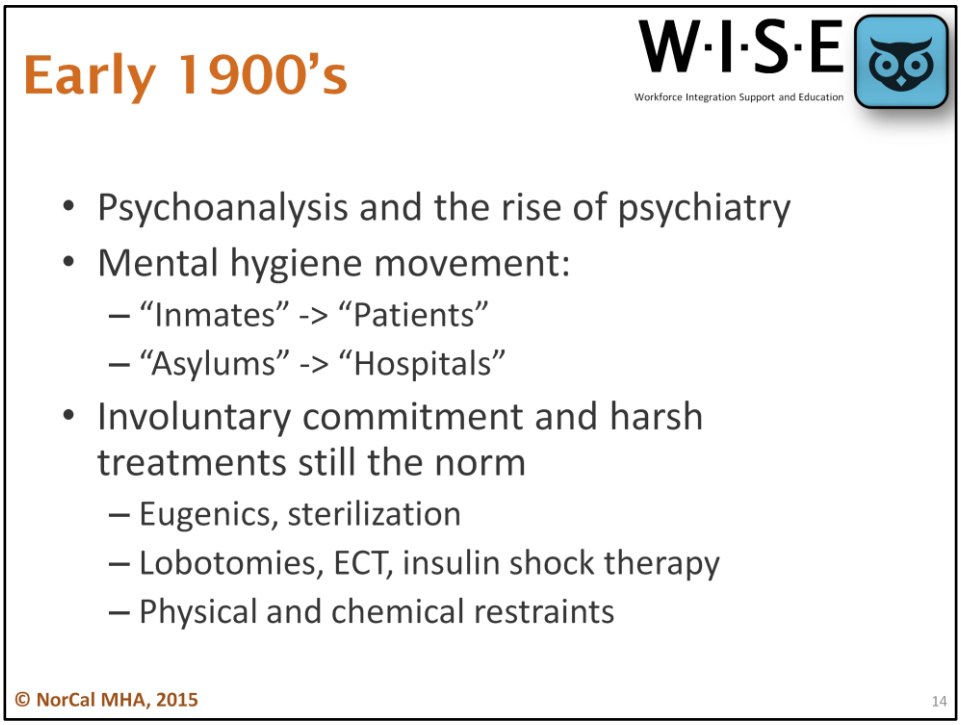
ELIZABETH PACKARD
Advocated for the rights of women and individuals with mental illness. She was forced into a psychiatric institution from 1860-1863 on the sole word of her husband, based on her vocal opposition to his religious beliefs and oppressive treatment. She sued her husband over her false imprisonment and to gain release from the institution. After testimony at her trial from several witnesses, the jury took only seven minutes to find in Elizabeth Packard's favor. She was legally declared sane, and Judge Charles Starr issued an order that she should not be confined. After her release, she founded the Anti-Insane Asylum Society and published several books, including Marital Power Exemplified, or Three Years Imprisonment for Religious Belief (1864), Great Disclosure of Spiritual Wickedness in High Places (1865), The Mystic Key or the Asylum Secret Unlocked (1866), and The Prisoners' Hidden Life, Or Insane Asylums Unveiled (1868). **In 1867, the State of Illinois passed a "Bill for the Protection of Personal Liberty" which guaranteed all people accused of insanity, including wives, had the right to a public hearing. She also saw similar laws passed in three other states.**
https://en.wikipedia.org/wiki/Elizabeth_Packard

NELLIE BLY
An American journalist, writer, industrialist, inventor, and a charity worker who was widely known for an exposé in which she faked insanity to study a mental institution from within. In 1887, she took an undercover assignment for which she agreed to feign insanity to investigate reports of brutality and neglect at the Women's Lunatic Asylum on Blackwell's Island. Committed to the asylum, Bly experienced its conditions firsthand. She wrote:

“What, excepting torture, would produce insanity quicker than this treatment? Here is a class of women sent to be cured. I would like the expert physicians who are condemning me for my action, which has proven their ability, to take a perfectly sane and healthy woman, shut her up and make her sit from 6 a.m. until 8 p.m. on straight-back benches, do not allow her to talk or move during these hours, give her no reading and let her know nothing of the world or its doings, give her bad food and harsh treatment, and see how long it will take to make her insane. Two months would make her a mental and physical wreck. … My teeth chattered and my limbs were ...numb with cold. Suddenly, I got three buckets of ice-cold water...one in my eyes, nose and mouth.”

After ten days the asylum released Bly at The World 's behest. Her report, later published in book form as Ten Days in a Mad-House, caused a sensation and brought her lasting fame. A grand jury launched its own investigation into conditions at the asylum, inviting Bly to assist. The jury's report recommended the changes she had proposed. **The grand jury also made sure that future examinations were more thorough so that only the seriously ill went to the asylum.**

https://en.wikipedia.org/wiki/Nellie_Bly



20TH CENTURY

The turn of the 20th century saw the development of psychoanalysis. Asylum superintendents sought to improve the image and medical status of their profession. Asylum "inmates" were increasingly referred to as "patients" and asylums renamed as hospitals. Referring to people as having a "mental illness" dates from this period in the early 20th century.

In the United States, a "mental hygiene" movement, originally defined in the 19th century, gained momentum and aimed to "prevent the disease of insanity" through public health methods and clinics. The term mental health became more popular, however. Clinical psychology and social work developed as professions alongside psychiatry. Theories of eugenics led to compulsory sterilization movements in many countries around the world for several decades, often encompassing patients in public mental institutions. World War I saw a massive increase of conditions that came to be termed "shell shock".

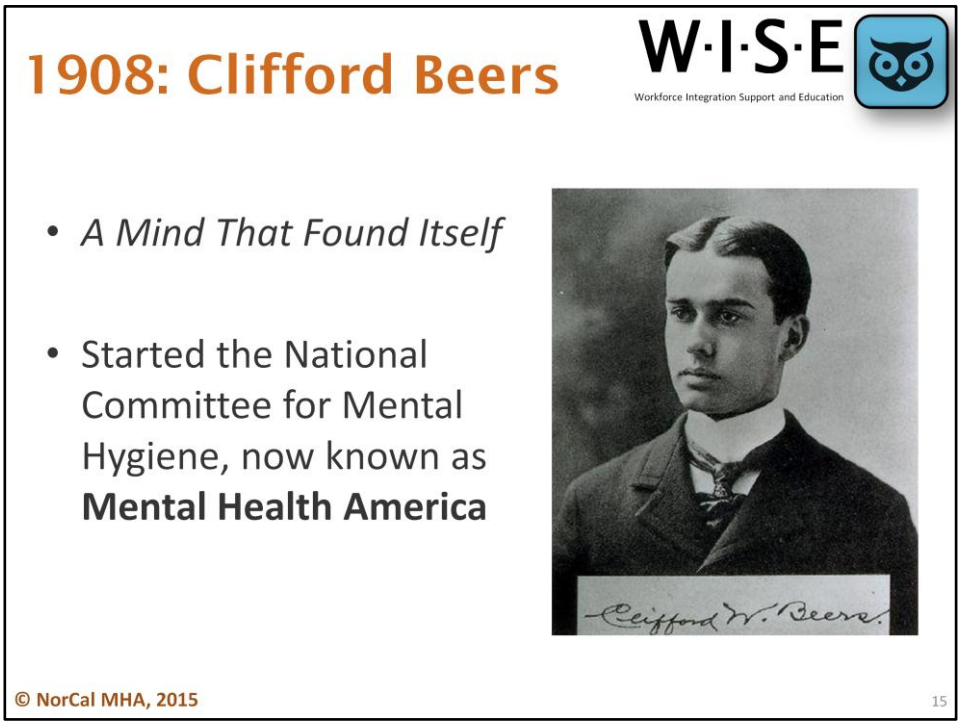
In Nazi Germany, the institutionalized mentally ill were among the earliest targets of sterilization campaigns and covert "euthanasia" programs. It has been estimated that over 200,000 individuals with mental disorders of all kinds were put to death, although their mass murder has received relatively little historical attention. Despite not being formally ordered to take part, psychiatrists and psychiatric institutions were at the

center of justifying, planning and carrying out the atrocities at every stage, , and "constituted the connection" to the later annihilation of Jews and other "undesirables" such as homosexuals in the Holocaust.

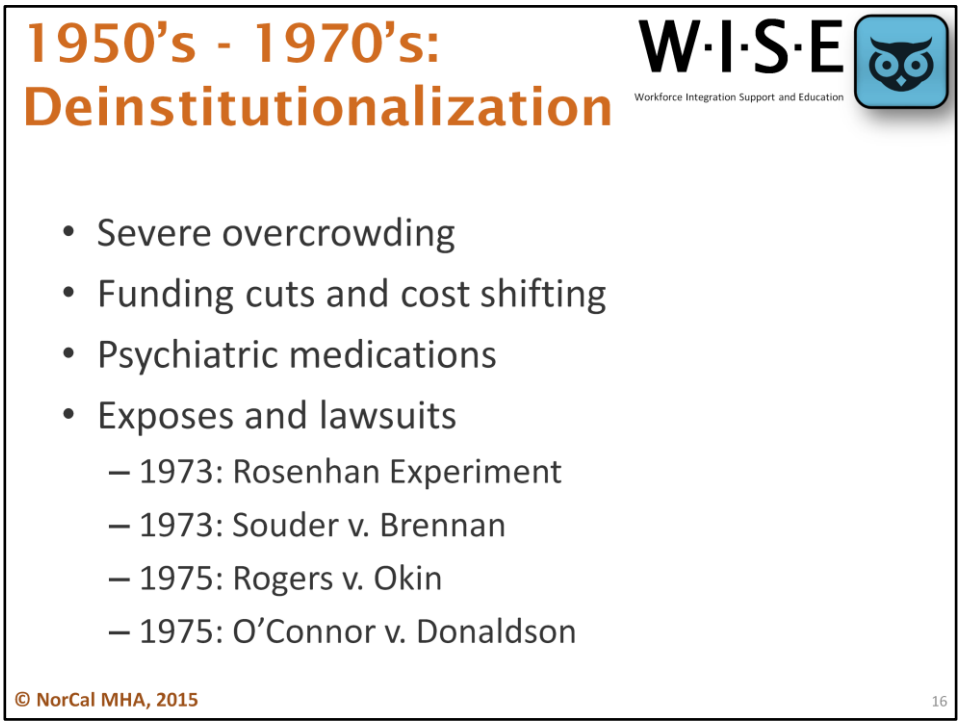
Soldiers received increased psychiatric attention, and World War II saw the development in the US of a new psychiatric manual for categorizing mental disorders, which along with existing systems for collecting census and hospital statistics led to the first Diagnostic and Statistical Manual of Mental Disorders (DSM).

Previously restricted to the treatment of severely disturbed people in asylums, psychiatrists cultivated clients with a broader range of problems, and between 1917 and 1970 the number practicing outside institutions swelled from 8 percent to 66 percent. "Outpatient commitment" laws were gradually expanded or introduced in some countries.

Lobotomies, Insulin shock therapy, Electro convulsive therapy, came in to use mid-century.



(1876-1943)
A graduate from Yale in 1897, he was confined to a private mental institution, and would later be confined to a state institution, where he experienced and witnessed serious abuse by the staff. In 1908, he published A Mind That Found Itself, a groundbreaking account of his experiences. It is still in print.
Beers gained the support of the medical profession and others in the work to reform the treatment of the mentally ill. In 1909 Beers founded the "National Committee for Mental Hygiene", now named "Mental Health America", in order to continue the reform for the treatment of the mentally ill.
Beers then worked to reform mental health systems in America. He also started the Clifford Beers Clinic in New Haven, in 1913, the first outpatient mental health clinic in the United States.
https://en.wikipedia.org/wiki/Clifford_Whittingham_Beers



By the beginning of the 20th century, increasing admissions had resulted in serious overcrowding, causing many problems for psychiatric institutions. Funding was often cut, especially during periods of economic decline and wartime. Asylums became notorious for poor living conditions, lack of hygiene, overcrowding, ill-treatment, and abuse of patients; many patients starved to death.

As hospitalization costs increased, both the federal and state governments were motivated to find less expensive alternatives to hospitalization. The 1965 amendments to Social Security shifted about 50% of the mental health care costs from states to the federal government, motivating the government to promote deinstitutionalization.

The first community-based alternatives were suggested and tentatively implemented in the 1920s and 1930s, although asylum numbers continued to increase up to the 1950s. The movement for deinstitutionalisation moved to the forefront in various countries during the 1950s and 1960s with the advent of chlorpromazine and other antipsychotic drugs.

The prevailing public arguments, time of onset, and pace of reforms varied by country. In the United States, class action lawsuits and the scrutiny of institutions through disability activism and antipsychiatry helped expose poor conditions and treatment. Sociologists and others argued that such institutions maintained or created dependency, passivity,

exclusion, and disability, which caused people to remain institutionalised. Rosenhan's experiment in 1973 "accelerated the movement to reform mental institutions and to deinstitutionalize as many mental patients as possible."

A prevailing argument claimed that community services would be cheaper and that new psychiatric medications made it more feasible to release people into the community. Mental health professionals, public officials, families, advocacy groups, public citizens, and unions held differing views on deinstitutionalisation.

https://en.wikipedia.org/wiki/Deinstitutionalisation

Rosenhan Experiment

David Rosenhan, a Stanford University professor, wrote "On being sane in insane places" published by the journal Science in 1973. His study is considered an important and influential criticism of psychiatric diagnosis.

Rosenhan's study was done in two parts. The first part involved the use of healthy associates or "pseudopatients" (three women and five men, including Rosenhan himself) who briefly feigned auditory hallucinations in an attempt to gain admission to 12 different psychiatric hospitals in five different states in various locations in the United States. All were admitted and diagnosed with psychiatric disorders. After admission, the pseudopatients acted normally and told staff that they felt fine and had no longer experienced any additional hallucinations. All were forced to admit to having a mental illness and agree to take antipsychotic drugs as a condition of their release. The average time that the patients spent in the hospital was 19 days. All but one were diagnosed with schizophrenia "in remission" before their release. The second part of his study involved an offended hospital administration challenging Rosenhan to send pseudopatients to its facility, whom its staff would then detect. Rosenhan agreed and in the following weeks out of 193 new patients the staff identified 41 as potential pseudopatients, with 19 of these receiving suspicion from at least 1 psychiatrist and 1 other staff member. In fact, Rosenhan had sent no one to the hospital.

The study concluded "it is clear that we cannot distinguish the sane from the insane in psychiatric hospitals" and also illustrated the dangers of dehumanization and labeling in psychiatric institutions. It suggested that the use of community mental health facilities which concentrated on specific problems and behaviors rather than psychiatric labels might be a solution and recommended education to make psychiatric workers more aware of the social psychology of their facilities.

https://en.wikipedia.org/wiki/Rosenhan_experiment

Souder v. Brennan

In 1973, a federal district court ruled in (Souder v. Brennan) that patients in mental

health institutions must be considered employees and paid the minimum wage required by the Fair Labor Standards Act of 1938 whenever they performed any activity that conferred an economic benefit on an institution. Following this ruling, institutional peonage was outlawed as evidenced in the Pennsylvania's Institutional Peonage Abolishment Act of 1973.

Many assume that the advent of modern psychotropic medications was the catalyst for deinstitutionalization in the U.S. However, large numbers of patients began leaving state institutions only after new laws made unpaid patient labor illegal. In other words, when patients no longer worked for free, the economic viability of many state institutions ceased and this led to the closing of many state hospitals.

Rogers v. Okin
In 1975, the United States Court of Appeals for the First Circuit ruled in favour of the Mental Patient's Liberation Front of Rogers v. Okin, establishing the right of a patient to refuse treatment.

https://en.wikipedia.org/wiki/Deinstitutionalisation

O'Connor v. Donaldson
The United States Supreme Court ruled that a state cannot constitutionally confine a non-dangerous individual who is capable of surviving safely in freedom by themselves or with the help of willing and responsible family members or friends.

https://en.wikipedia.org/wiki/O%27Connor_v._Donaldson

1956: The Bell of Hope

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Mental Health America issued a call to asylums across the country for their discarded chains and shackles, which it melted down and recast into a sign of hope: the Mental Health Bell

17

In general, professionals, civil rights leaders, and humanitarians saw the shift from institutional confinement to local care as the appropriate approach. The deinstitutionalization movement started off slowly but gained momentum as it adopted philosophies from the Civil Rights Movement. During the 1960s, deinstitutionalization increased dramatically, and the average length of stay within mental institutions decreased by more than half. Many patients began to be placed in community care facilities instead of long-term care institutions.

https://en.wikipedia.org/wiki/Deinstitutionalisation

In 1955, following a major period of deinstitutionalization, the Mental Health Study Act was passed. For the next four years, the Joint Commission on Mental Illness made recommendations to establish community mental health centers across the country. In 1963 the Community Mental Health Centers Act was passed, essentially kick-starting the community mental health revolution. This Act contributed further to deinstitutionalization by moving mental patients into their "least restrictive" environments.

In 1965, with the passing of Medicare and Medicaid, there was an intense growth of skilled nursing homes and intermediate-care facilities that alleviated the burden felt by the large-scale public psychiatric hospitals.

In 1975 Congress passed an Act requiring community mental health centers to provide aftercare services to all patients in the hopes of improving recovery rates.

In 1980, just five years later, Congress passed the Mental Health Systems Act of 1980, which provided federal funding for ongoing support and development of community mental health programs. This Act strengthened the connection between federal, state, and local governments with regards to funding for community mental health services.

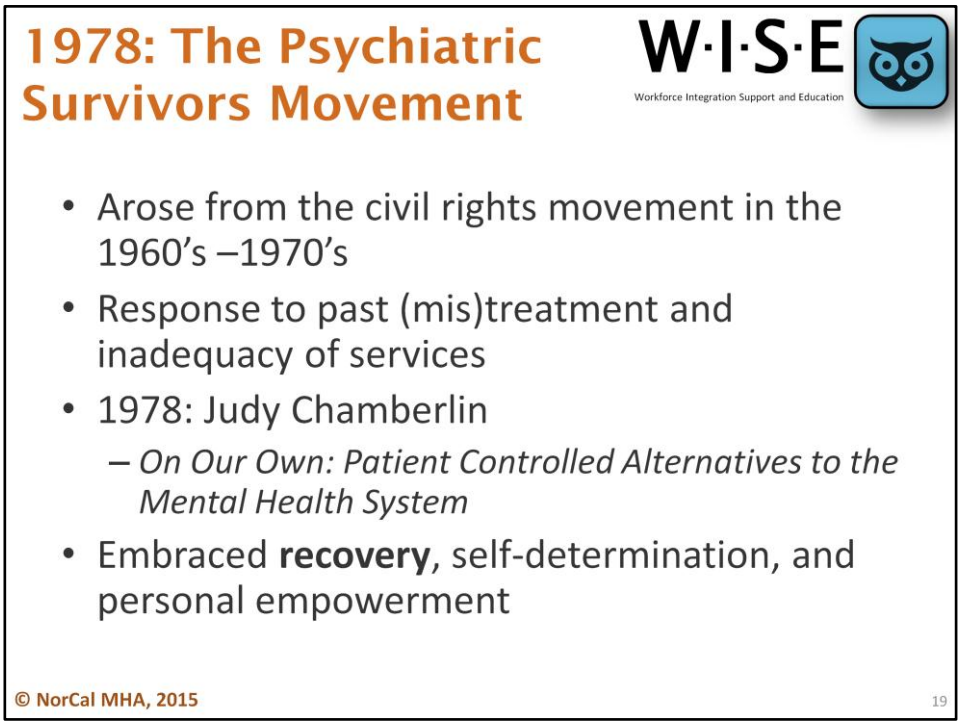
The Omnibus Budget Reconciliation Act of 1981 was passed by the efforts of the Reagan administration as an effort to reduce domestic spending. **The Act rescinded a large amount of the legislation just passed, and the legislation that was not rescinded was almost entirely revamped. It effectively ended federal funding of community treatment for the mentally ill, shifting the burden entirely to individual state governments**. Federal funding was now replaced by granting smaller amounts of money to the individual states.

In 1986 Congress passed the Mental Health Planning Act of 1986, which was a Federal law requiring that at the state government level, all states must have plans for establishing case management under Medicaid, improving mental health coverage of community mental health services, adding rehabilitative services, and expanding clinical services to the homeless population.

As the 1990s began, many positive changes occurred for people with mental illnesses through the development of larger networks of community-based providers and added innovations with regards to payment options from Medicare and Medicaid. Despite the drive for community mental health, many physicians, mental health specialists, and even patients have come to question its effectiveness as a treatment. **The underlying assumptions of community mental health require that patients who are treated within a community have a place to live, a caring family, or supportive social circle that does not inhibit their rehabilitation. These assumptions are in fact often wrong. Many people with mental illnesses, upon discharge, have no family to return to and end up homeless.**

In 1999 the Supreme Court ruled on the case Olmstead v. L.C. The Court ruled that it was a violation of the Americans with Disabilities Act of 1990 to keep an individual in a more restrictive inpatient setting, such as a hospital, when a more appropriate and less restrictive community service was available to the individual.

https://en.wikipedia.org/wiki/Community_mental_health_service



By the 1970s, the women's movement, gay rights movement, and disability rights movements had emerged. It was in this context that former mental patients began to organize groups with the common goals of fighting for patients' rights and against forced treatment, stigma and discrimination, and often to promote peer-run services as an alternative to the traditional mental health system. Unlike professional mental health services, which were usually based on the medical model, peer-run services were based on the principle that individuals who have shared similar experiences can help themselves and each other through self-help and mutual support. Many of the individuals who organized these early groups identified themselves as psychiatric survivors.

During the early 1970s, groups spread to California, New York, and Boston, which were primarily antipsychiatry, opposed to forced treatment including forced drugging, shock treatment and involuntary committal.

The ex-patients emphasized individual support from other patients; they espoused assertiveness, liberation, and equality; and they advocated user-controlled services as part of a totally voluntary continuum. Very much the product of the rebellious, populist, anti-elitist mood of the 1960s, they strived above all for self-determination and self-reliance. In generally, the work of some psychiatrists, as well as the lack of criticism by the psychiatric establishment, was interpreted as an abandonment of a moral

commitment to do no harm. There was anger and resentment toward a profession that had the authority to label them as mentally disabled and was perceived as infantilizing them and disregarding their wishes.

https://en.wikipedia.org/wiki/Psychiatric_survivors_movement

6 minute running time

All three had experienced “forced treatment” by the mental health systems of the day and went on to become pivotal members of the Consumer/Survivor/Ex-Patient Mental Health Movement.

As a young woman, **Sally Zinman** was locked up and tortured in a so-called mental health institution. After discovering others with similar histories, Ms Zinman became a passionate and ground-breaking activist in the militant madness movement.

Currently, Ms. Zinman works with the California Association of Mental Health Peer-Run Organizations and is a consultant with Alameda County’s Behavior Health Services, Consumer Empowerment Department.

Howard Geld, known as Howie the Harp to the mentally ill and homeless to whom he committed his life after spending time in institutions for the emotionally disturbed while a teen-ager, was widely credited with being a pioneer in advocacy for mental patients, founding or co-founding many organizations that are now part of national and international movements.

When **Judi Chamberlin** was 21 years old, followed her doctor’s advice and voluntarily

committed herself to a mental hospital. She found out quickly that she could not leave when she wanted to.

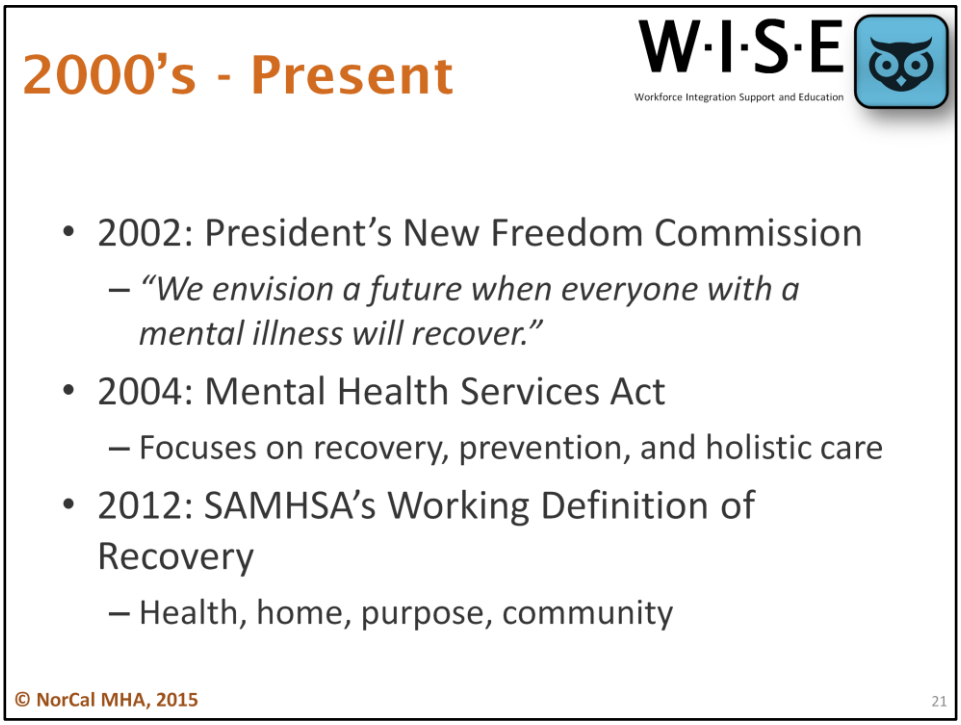
After her release, she moved to Vancouver, British Columbia, where she lived with other people who'd been diagnosed with mental illness but who'd then gotten government money to develop their own treatments.

She began to others “basic 101” on mental health advocacy: That we're equal; that we have rights." She argued that just the ability to have some say in your own treatment was a key part of making that treatment work.

Robert Whitaker, the author of Mad in America, says Chamberlin was "a seminal figure in the rise of the consumer movement." She was able to get across the patient's point of view in a way that was strong, but also clear.

Chamberlin told people with mental illness that they were, like everyone else, people with quirks and differences, but with strengths and abilities, too.

She worked at Boston University on mental health issues and started a center with federal funding to support other psychiatric survivors.



The New Freedom Commission on Mental Health was established by U.S. President George W. Bush in April 2002 to conduct a comprehensive study of the U.S. mental health service delivery system and make recommendations based on its findings. The commission has been touted as part of his commitment to eliminate inequality for Americans with disabilities.

The commission recommended to the president a set of goals intended to move the American mental health system towards a recovery oriented system, with the overall goal of helping all individuals with mental illness and disability recover, with early detection and access to the necessary support and treatment. The report's recommendations include increased public education regarding mental health, greater involvement of patients and families in care decisions, creating individualized care plans, increasing support for employment and affordable housing, early screening and treatment, and greater use of evidence-based practices. The commission also recommended that services for people with mental illness and disabilities were "fragmented" and needed to be better coordinated at the state level.

https://en.wikipedia.org/wiki/New_Freedom_Commission_on_Mental_Health

California Milestones

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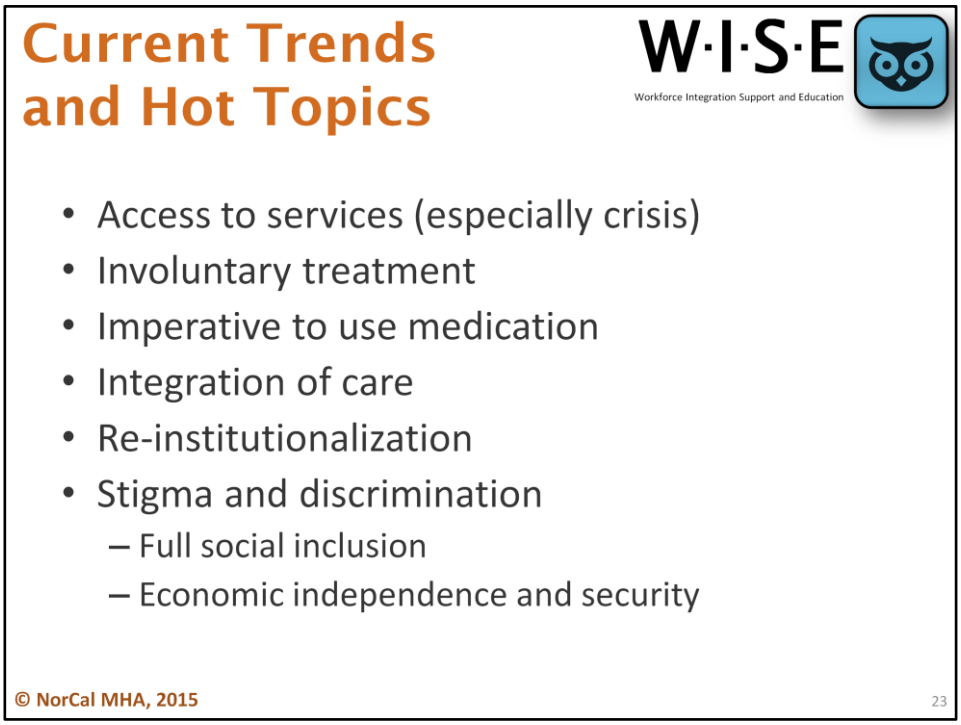
Workforce Integration Support and Education

WHEN	WHAT
1957: Short-Doyle Act	• Established current community-based treatment structure of public mental health services • Established local Mental Health Advisory Boards
1968: Lanterman-Petris-Short Act	• Established due process rights of individuals facing involuntary commitment
1991: The Bronzan-McCorquodale Act	• Authorized the 1991 realignment that shifted mental health program and funding responsibilities from the state to counties
1992: The Children's Mental Health Services Act	• Outlines a coordinated, goal-directed system of mental health care for children and their families that emphasizes an interagency approach
1996: The Adult and Older Adult Mental Health Systems of Care Act	• Outlines a recovery-oriented, outcome-based mental health treatment approach for adults with serious mental disorders
2004: The Mental Health Services Act	• Creates funding to fill gaps in the adult and older adult and children's systems of care • Establishes local MHSA Steering Committees



Re-institutionalization (criminalization of behaviors and circumstances associated with mental illness)
A process of indirect cost-shifting may have led to a form of "re-institutionalization" through the increased use of jail detention for those with mental disorders deemed unmanageable and noncompliant. In summer 2009, author and columnist Heather Mac Donald stated in City Journal, "jails have become society's primary mental institutions, though few have the funding or expertise to carry out that role properly... at Rikers, 28 percent of the inmates require mental health services, a number that rises each year.

What Do You Think?

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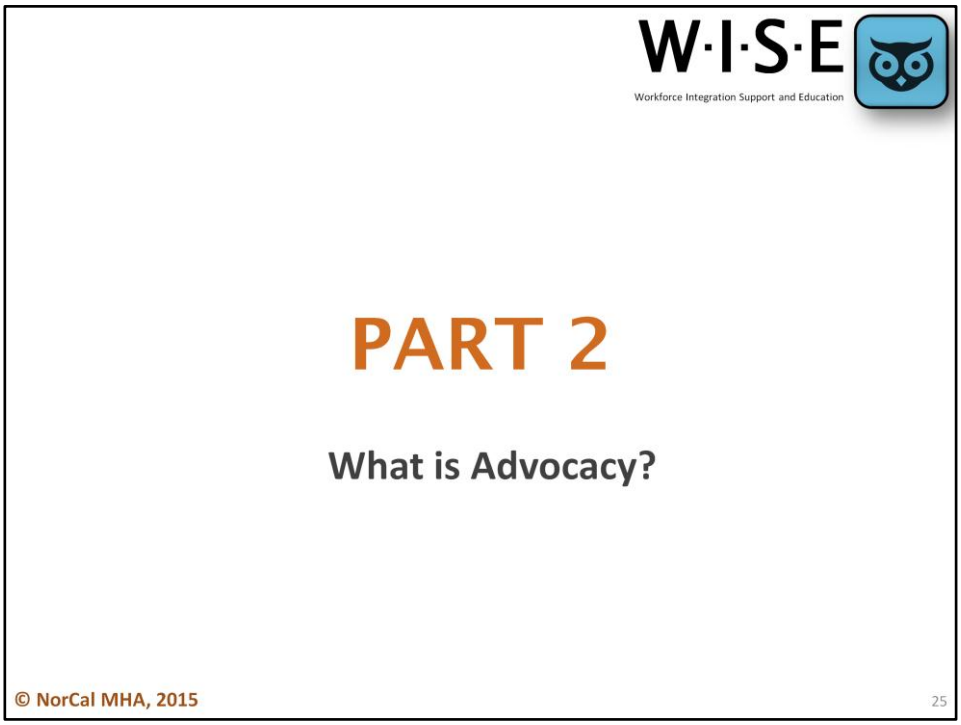
- Given the extensive advocacy efforts of numerous individuals over hundreds of years, why do we still have difficulty engaging community members around mental health policy issues?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Workforce Integration Support and Education
PART 2
What is Advocacy?
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What is Advocacy?

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"Public support for or recommendation of a particular cause or policy"

Oxford Dictionary

Advocacy is….

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"To have your story move audiences from apathy to empathy to action."

— John Capecci and Timothy Cage, Living Proof: Telling Your Story to Make a Difference

Advocacy Does…

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"Advocates are not content just to give a fish or teach how to fish. They will not rest until they have revolutionized the fishing industry."

— Bill Drayton, Leading Social Entrepreneurs Changing the World

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"Advocacy is an important means of raising awareness on mental health issues and ensuring that mental health is on the national agenda of governments. Advocacy can lead to improvements in policy, legislation and service development."
Promote the human rights of persons with mental disorders and to reduce stigma and discrimination.

Advocacy is considered to be one of the eleven areas for action in any mental health policy because of the benefits that it produces for people with mental disorders and their families. (See Mental Health Policy, Plans and Programs.) The advocacy movement has substantially influenced mental health policy and legislation in some countries and is believed to be a major force behind the improvement of services in others (World Health Organization, 2001a). In several places it is also responsible for an increased awareness of the role of mental health in the quality of life of populations.
Citation: Mental Health Policy and Service Guidance Package – ADVOCACY FOR MENTAL HEALTH
World Health Organization, 2003

Advocacy Actions

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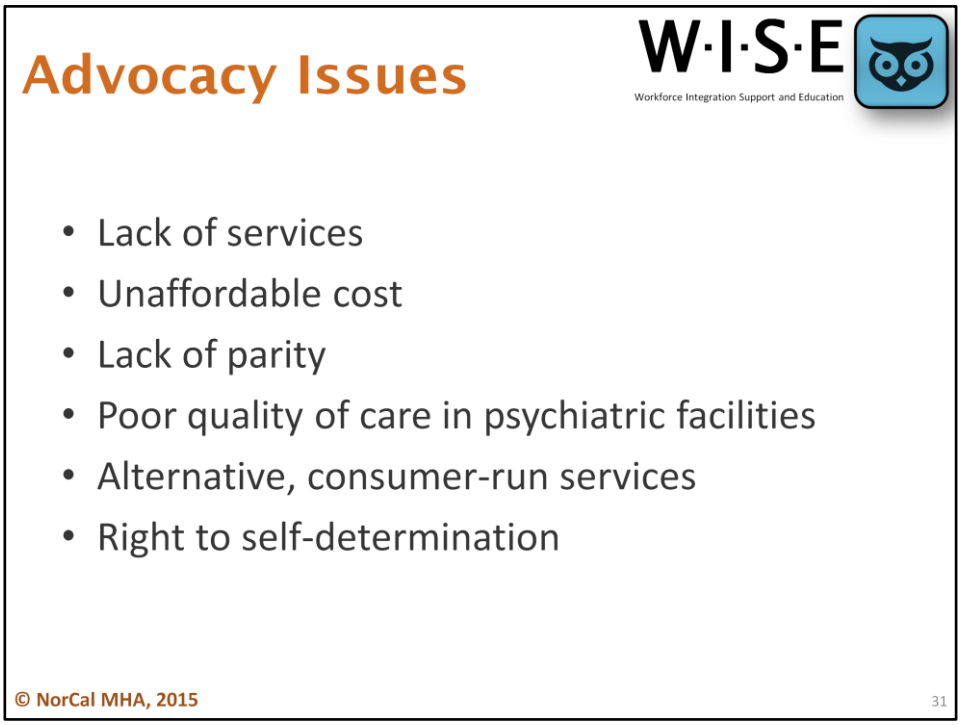
- Awareness-raising
- Information
- Education
- Training
- Mutual help
- Counselling
- Mediating
- Defending
- Denouncing



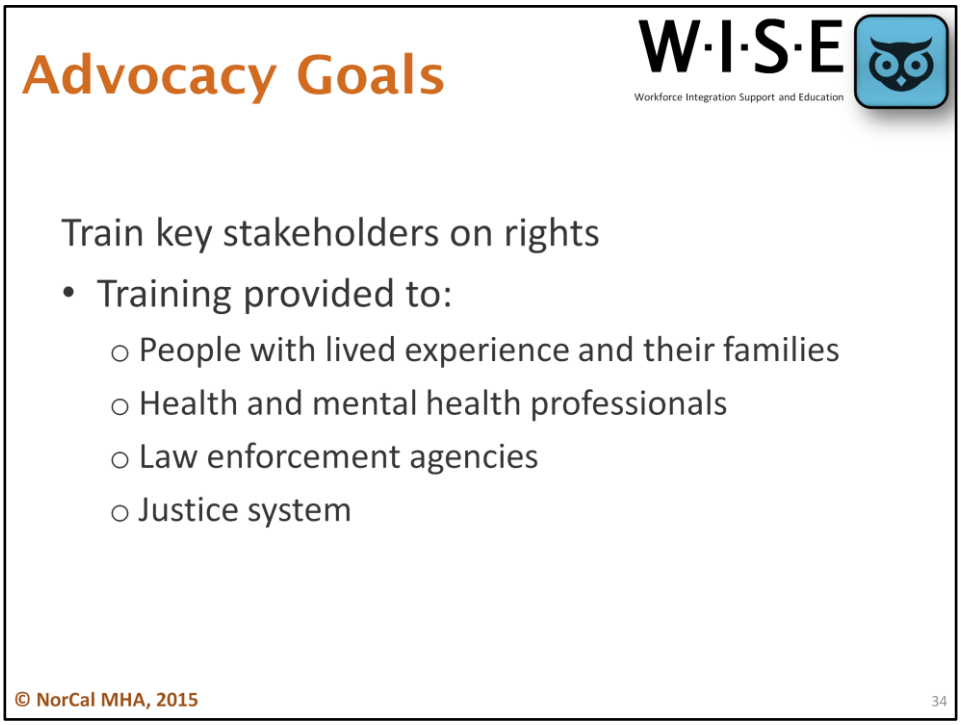
•Lack of mental health services
•Unaffordable cost of mental health care through out-of-pocket payments
•Lack of parity between mental health and physical health
•Poor quality of care in mental hospitals and other psychiatric facilities
•Need for alternative, consumer-run services;
•Paternalistic services
•Right to self-determination and need for information about treatments

•Need for services to facilitate active community participation
•Violations of human rights of persons with mental disorders
•Lack of housing and employment for persons with mental disorders
•Stigma associated with mental disorders, resulting in exclusion
•Absence of promotion and prevention in schools, workplaces, and neighborhoods
•Insufficient implementation of mental health policy, plans, programs and legislation

Mental health and mental disorders are not regarded with anything like the same importance as physical health. Indeed, they have been largely ignored or neglected (World Health Organization, 2001a).

There is still no scientific evidence that advocacy can improve the level of people's mental health. However, there are many encouraging projects and experiences in various countries

- Placing of mental health on government agendas
- Improvements in the policies and practices of governments and institutions
- Changes in laws and government regulations
- Improvements in the promotion of mental health and the prevention of mental disorders
- Protection and promotion of the rights and interests of persons with mental disorders and their families
- Improvements in mental health services, treatment and care



Goal: Train key stakeholders on the rights of people with mental disabilities
Training needs to be provided to:
people with mental disabilities themselves as well as their families - so that they can claim their rights;
health and mental health professionals - so that they understand the rights of their patients and apply these in practice;
the police force who are in daily contact with people with mental disabilities;
lawyers, magistrates and judges who make important decisions concerning the lives of people with mental disabilities.
All people and professionals who have an impact on the lives of people with mental disabilities should receive training on human rights issues.

- Facilitating discussions and consultations between the different stakeholders within the country interested in mental health reform.
- Working closely with systems to analyze and draft mental health policies and strategic plans and advise on their implementation
- Providing the opportunity to policy makers, health planners and service providers to gain more knowledge and skills through training workshops in a number of areas critical to policy making and service planning (developing policies and plans; developing law; improving access to psychotropic drugs, developing mental health information systems, implementing quality improvement strategies, budgeting and financing for mental health, mental health monitoring and evaluation).
- Many people with mental disabilities are assumed to have no capacity to make decisions for themselves and are therefore being detained and treated in psychiatric institutions unjustifiably and against their will, where they are being treated appallingly and inhumanely. Advocacy works to unite and empower people to improve the quality of care and promote human rights in mental health facilities and social care homes.
- Mental health policies and laws are absent or inadequate and yet they are critical to improving conditions for people with mental disabilities.

Policy Advocacy vs. Personal Advocacy

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- Personal Advocacy – for yourself or someone under your care
- Policy Advocacy – for better outcomes for all

Policy Advocacy Creates Change

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- Lobbying
- Education
- Capacity building
- Relationship building
- Forming networks
- Leadership development

BREAK TIME!

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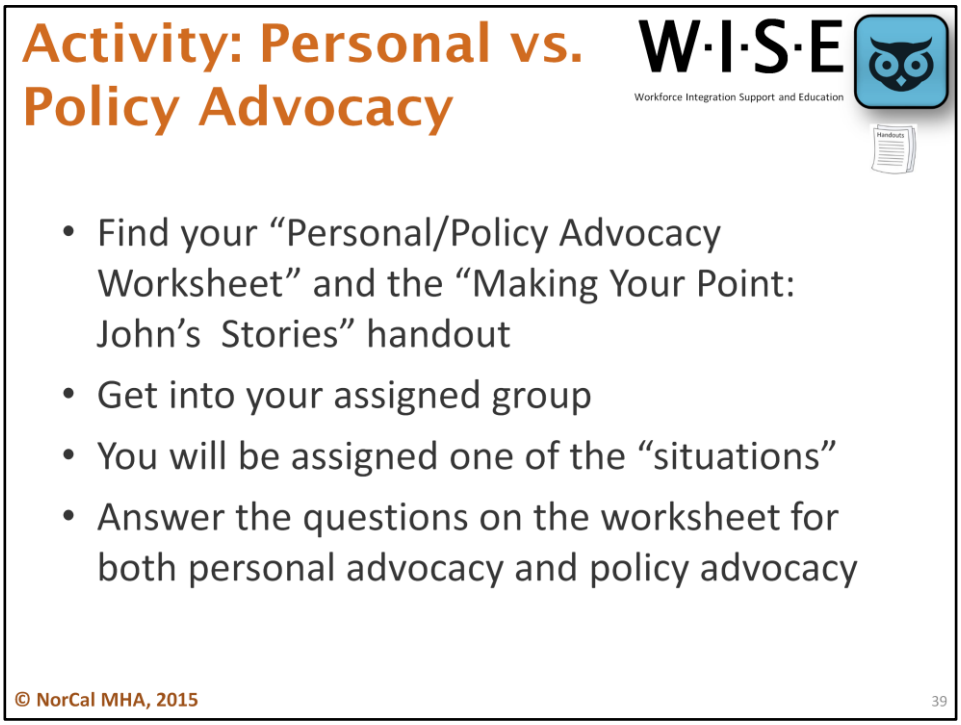
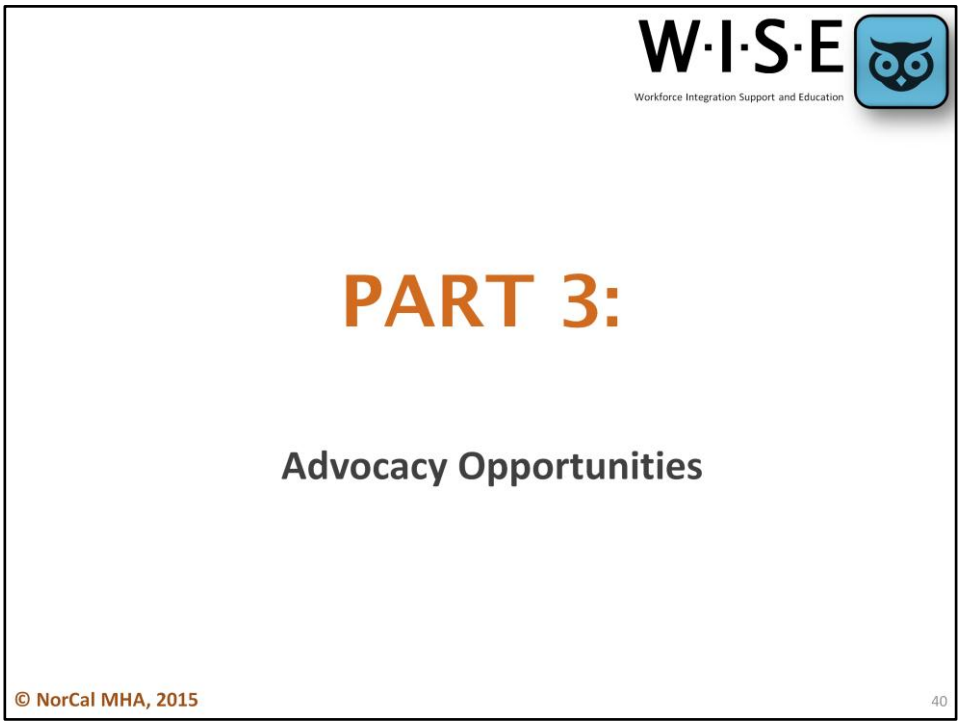


Handouts: Personal/Policy Advocacy Worksheet, Making Your Point: John's Stories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PART 3:
Advocacy Opportunities
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Where Can My Voice be Heard?

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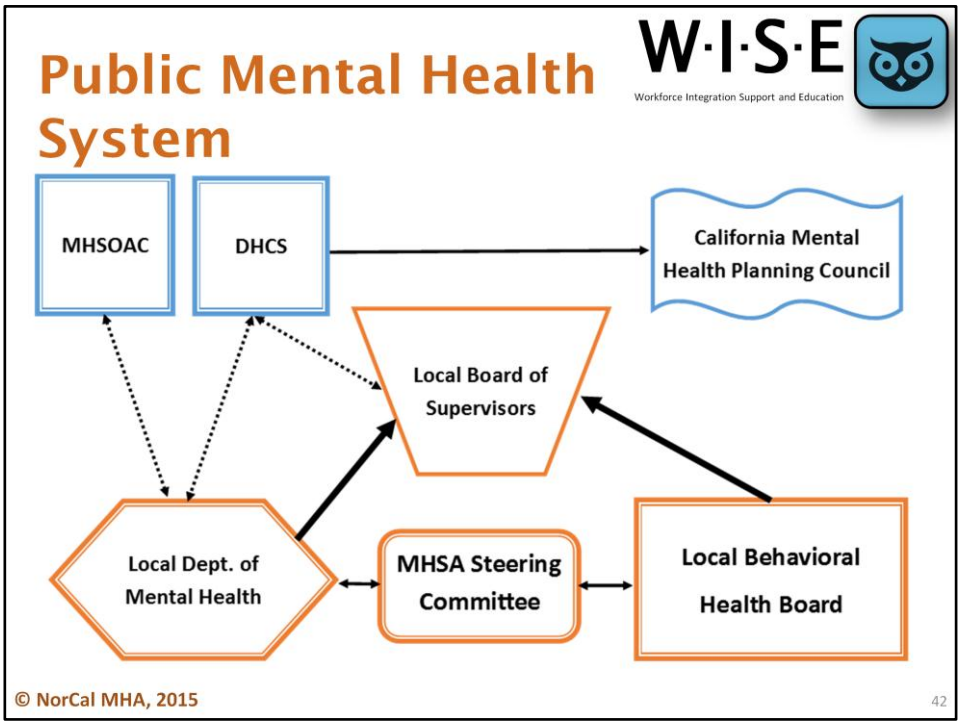
- Local
  - Mental Health Board
  - MHSA Steering Committee
  - Cultural Competence Committee
  - Schools and Higher Education
  - Local Board of Supervisors
- State
  - Mental Health Services Oversight and Accountability Commission - MHSOAC
  - Department of Health Care Services - DHCS
  - OSHPD
  - CalMHSA
  - State Legislature


Public Mental Health System
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Workforce Integration Support and Education
MHSOAC
DHCS
California Mental Health Planning Council
Local Board of Supervisors
Local Dept. of Mental Health
MHSA Steering Committee
Local Behavioral Health Board
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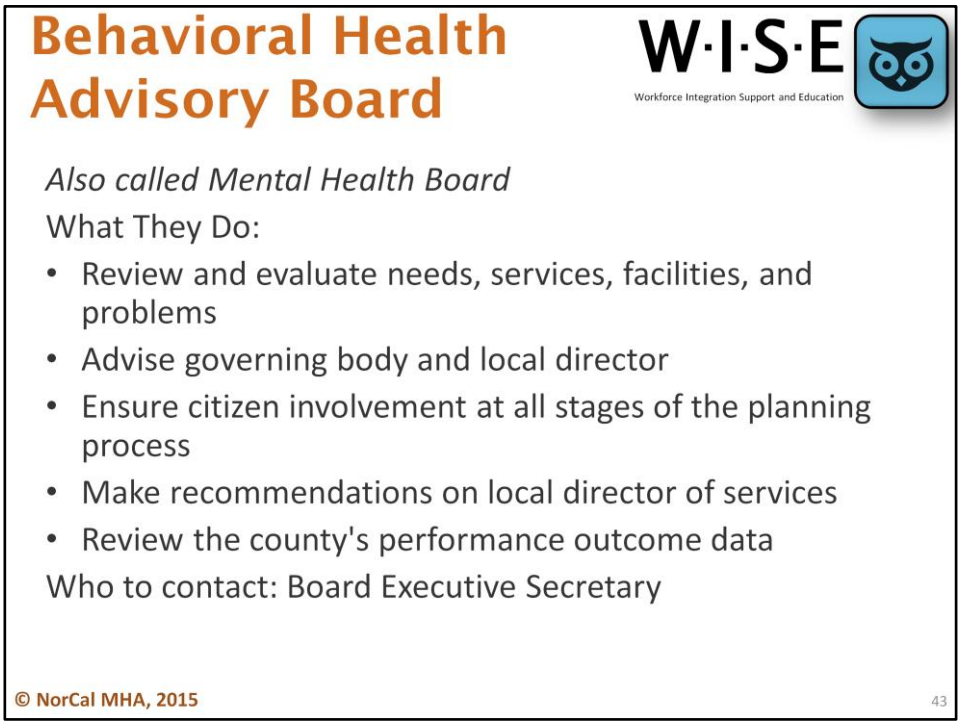
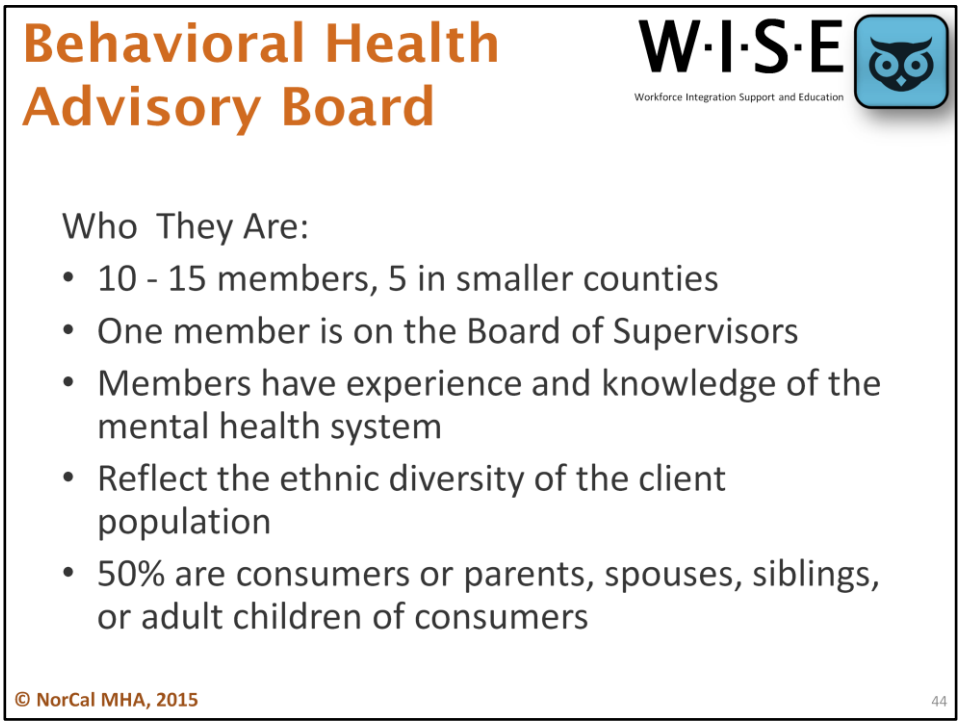


Also called Behavioral Health Advisory Board
What They Do
Review and evaluate mental health needs, services, facilities, and special problems.
Advise the governing body and the local mental health director
Review and approve the procedures used to ensure citizen and professional involvement at all stages of the planning process.
Submit an annual report on the needs and performance of the mental health system.
Review and make recommendations on applicants for a local director of mental health services.
Review and comment on the county's performance outcome data



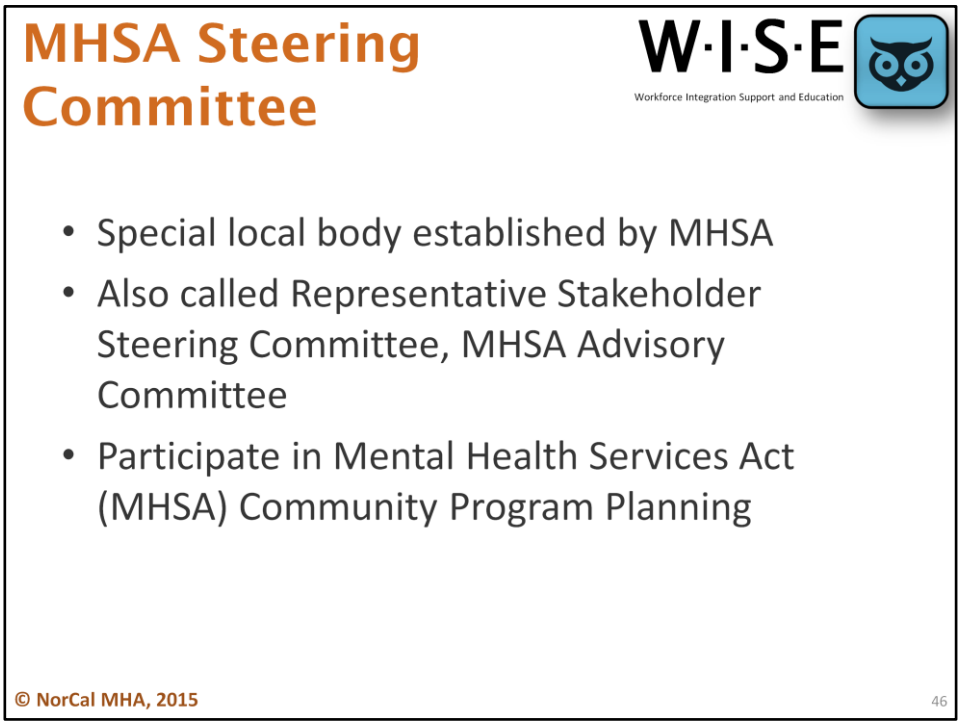
Who They Are
10 to 15 members, 5 in smaller counties
One member is on the Board of Supervisors.
Members have experience and knowledge of the mental health system.
Should reflect the ethnic diversity of the client population in the county.
Fifty percent of the board membership shall be consumers or the parents, spouses, siblings, or adult children of consumers, who are receiving or have received mental health services.

Behavioral Health Advisory Board

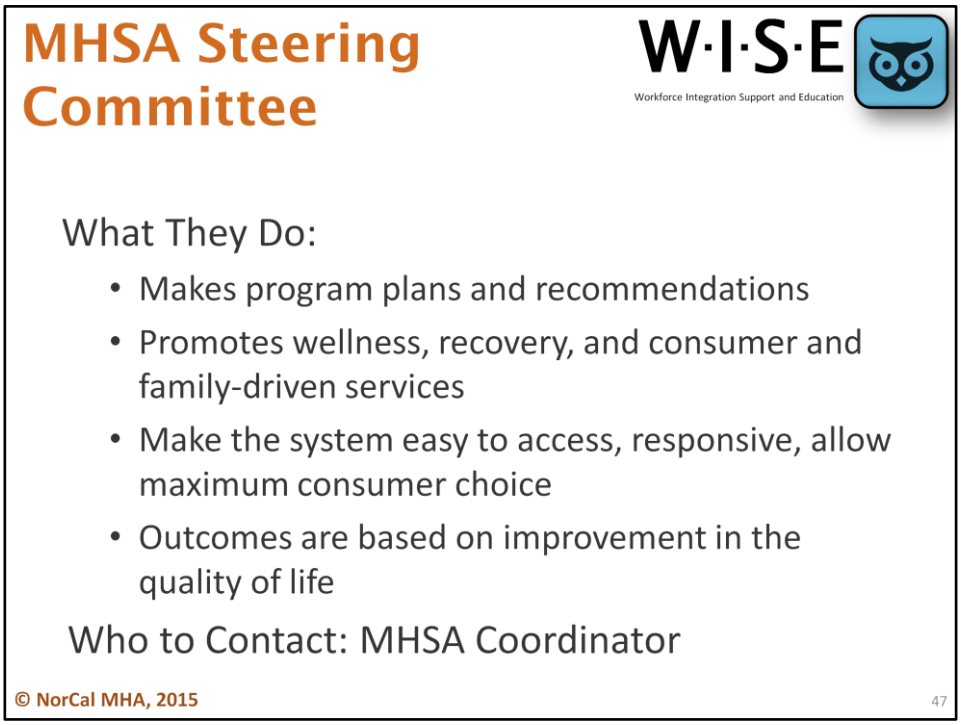
W·I·S·E
Workforce Integration Support and Education

Subcommittees

- What they do:
  - May form Sub Committees to represent specific interests or projects
  - Examples: Stakeholder, Older Adult, Minority Advisory, Family of Adolescents and Children, Budget and Funding Oversight



Part of local Behavioral Health Department
Community Program Planning (CPP) provides a structured process that the County uses in partnership with stakeholders in determining how best to utilize funds that become available for the MHSA components.
By law, County MHSA CPP processes must adhere to the following general standards:
Community Collaboration
Cultural Competence
Client and Family Driven
Emphasize Wellness, Recovery and Resilience
Include Clients and family members



What They Do

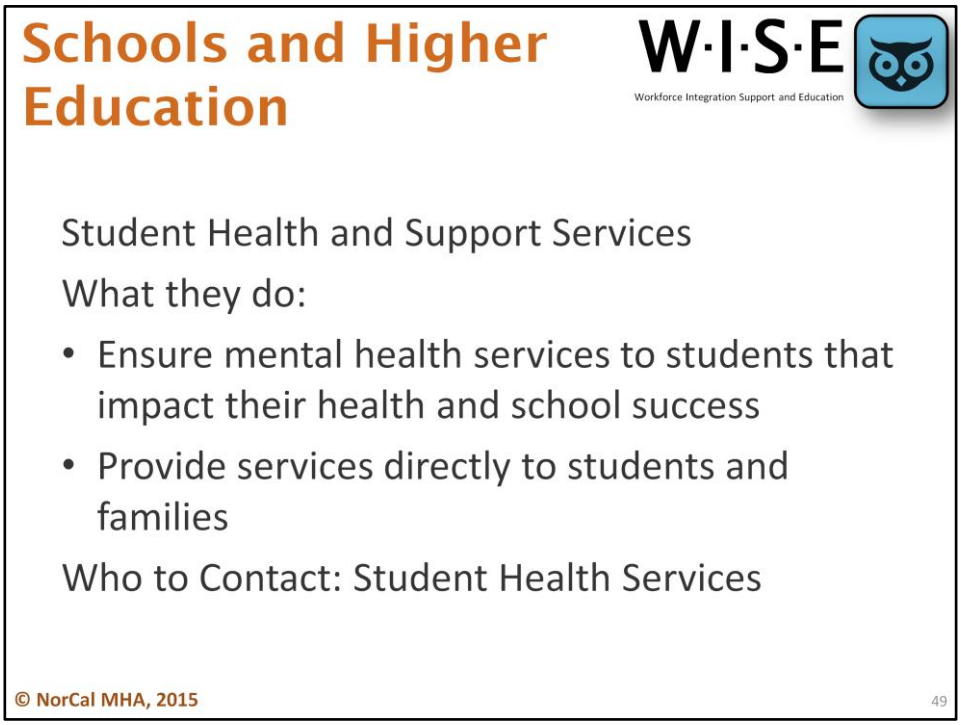
•Makes program recommendations to the County Behavioral Health Services for MHSA funding.
•Creating a comprehensive, integrated, culturally and linguistically responsive system of mental health services
•Promotes wellness, recovery, resilience, and consumer and family-driven services.
•Works to make the system easy to access, responsive to consumers and family members, allow maximum consumer choice, and support integration into the community.
•Outcomes will be evaluated based on improvement in the quality of life of individuals

Patients' Rights Advocate

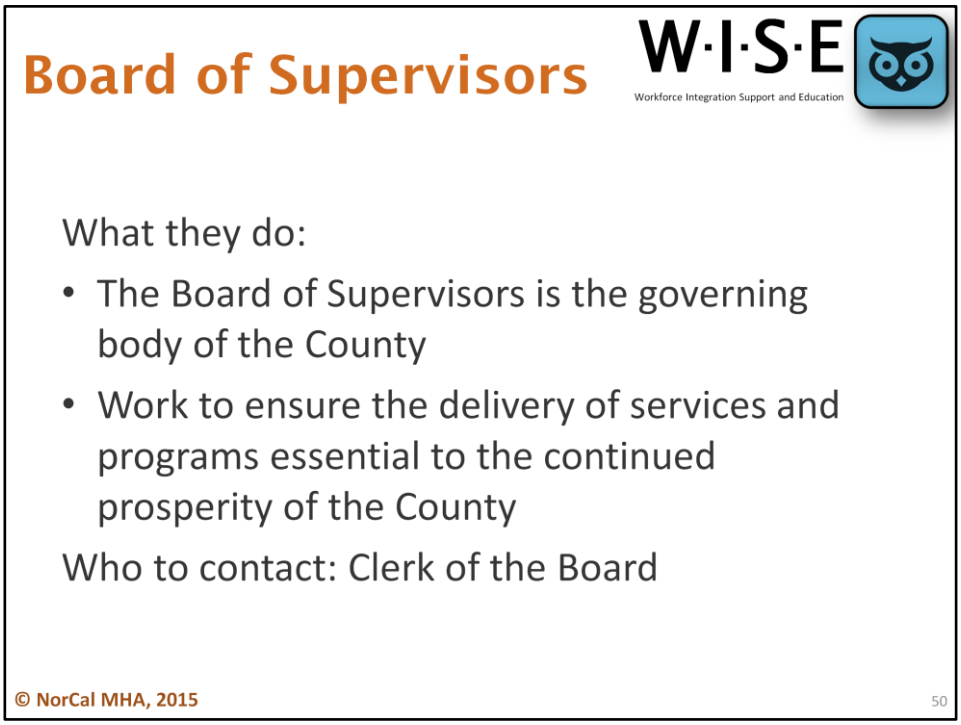
Patients, family members, and friends of patients have an Advocate available to answer questions and respond to patient grievances. For further information, please call (530) 632-3202.

Consumer Advocate-Liaison, Advocate for Adults & Families, Advocate for Children, Youth, & Families

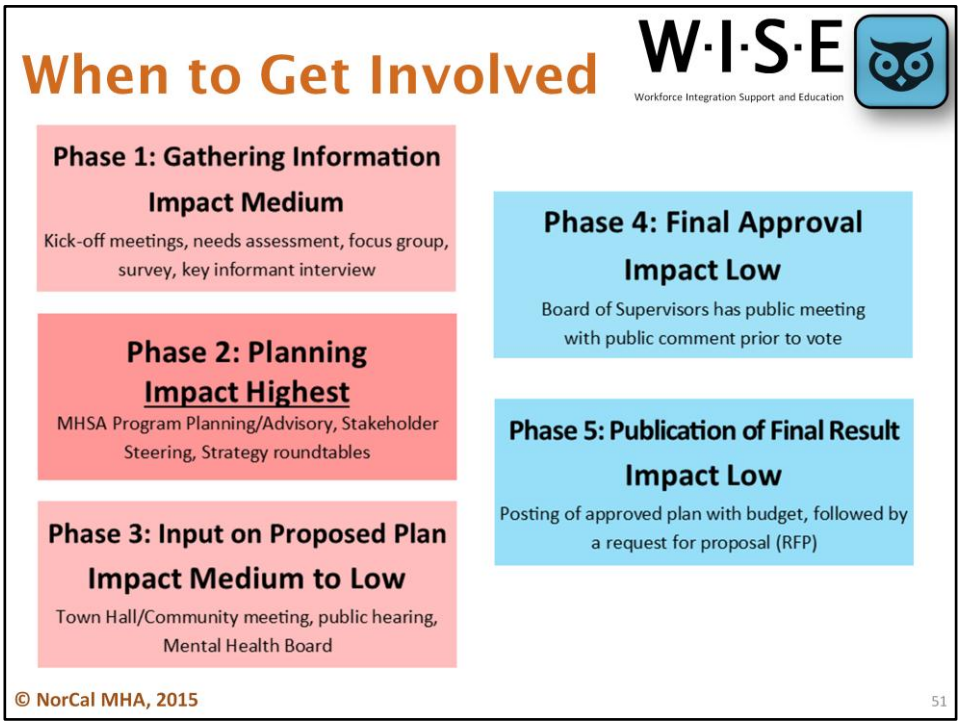
What they do
County Department of Behavioral Health strives to reduce/eliminate cultural disparity by improving access to culturally and linguistically sensitive/competent mental health services for individuals living with mental health, substance abuse, or co-occurring disorders.
Who to Contact – Ethnic Services Manager/Coordinator



Student Health and Support Services
What they do
Ensure mental health services to students that impact their health and school success
Provide services directly to students and families and work with a wide array of community mental health providers
Who to Contact – Student Health Services



What they do
The Board of Supervisors is the governing body of the County.
Work to ensure the delivery of services and programs essential to the continued prosperity of the County.
Who to contact: Clerk of the Board



Development Phases for County MH Programs

Phase 1: Gathering Information - Impact-Medium

Kick-off meetings, needs assessment, focus group, survey, key informant interview

Phase 2: Planning – **Impact Highest**

MHSA Program Planning/Advisory, Stakeholder Steering, Strategy roundtables

Phase 3: Input on Proposed Plan - Impact Medium to Low

Town Hall/Community meeting, public hearing, Mental Health Board

Phase 4: Final Approval - *Impact Low*

Board of Supervisors has public meeting with public comment prior to vote

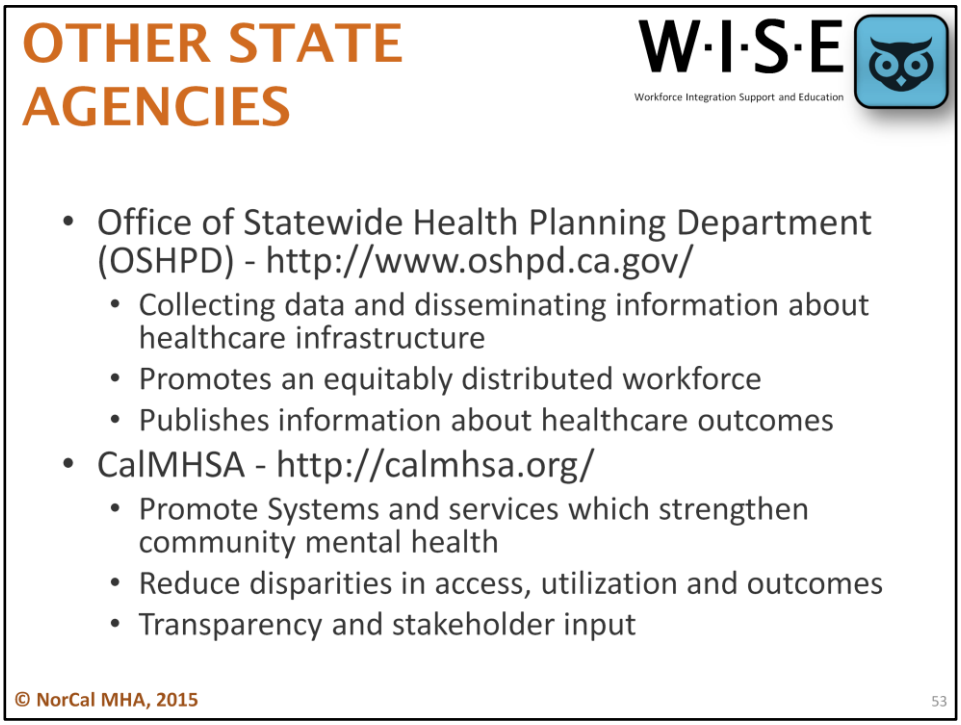
Phase 5: Phase 5: Publication of Final Result - *Impact Low*

Posting of approved plan with budget, followed by a request for proposal (RFP)

Department of Health Care Services coordinates all mental health service delivery with the County

- Acute Psychiatric Emergency Services: Inpatient Psychiatric Hospitalization
- Employment Services
- Homeless & Housing Services
- Outpatient Mental Health Services: Crisis Residential Services
- Subacute Services: Psychiatric State Hospitalization
- PLUS all MHSA Programs

Where to find out more:
http://www.dhcs.ca.gov/services/Pages/MentalHealthPrograms-Svcs.aspx



Office of Statewide Health Planning Department (OSHPD)

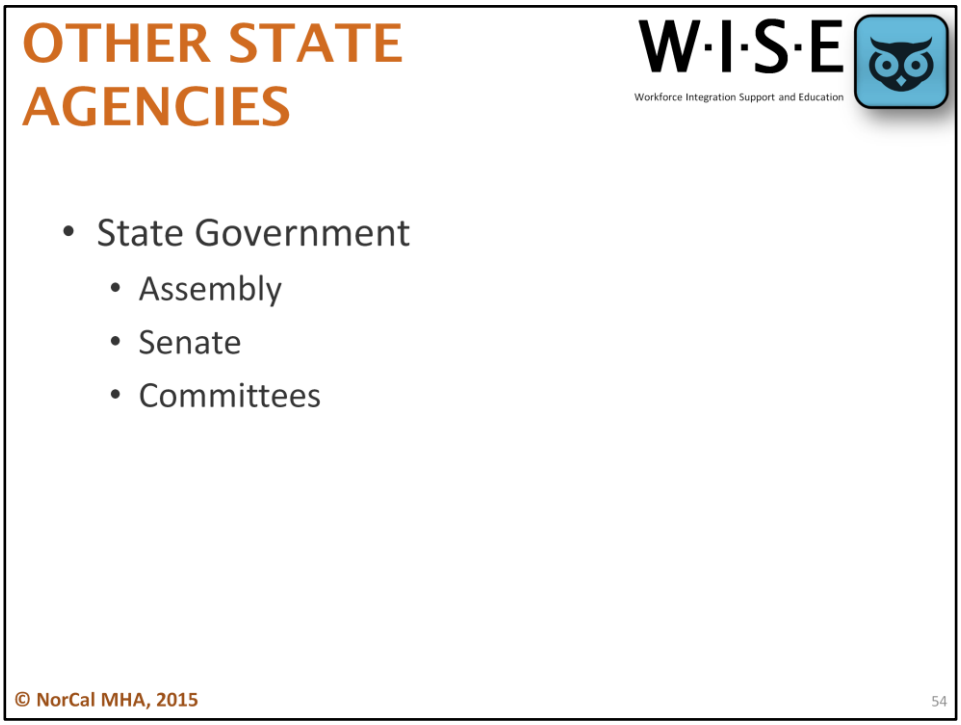
- •Collecting data and disseminating information about California's healthcare infrastructure
- •Promotes an equitably distributed healthcare workforce, publishes valuable information about healthcare outcomes

CalMHSA

Systems and services which strengthen and transform community mental health and reduce disparities in access, utilization and outcomes by age, race, ethnicity and gender, sexual orientation, nationality and disability;

Efficiency, expertise, innovation, accountability and quality;

Transparency and stakeholder input;



State Government

- •ASSEMBLY
- •SENATE
- •COMMITTEES

Lunch Break

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Workforce Integration Support and Education

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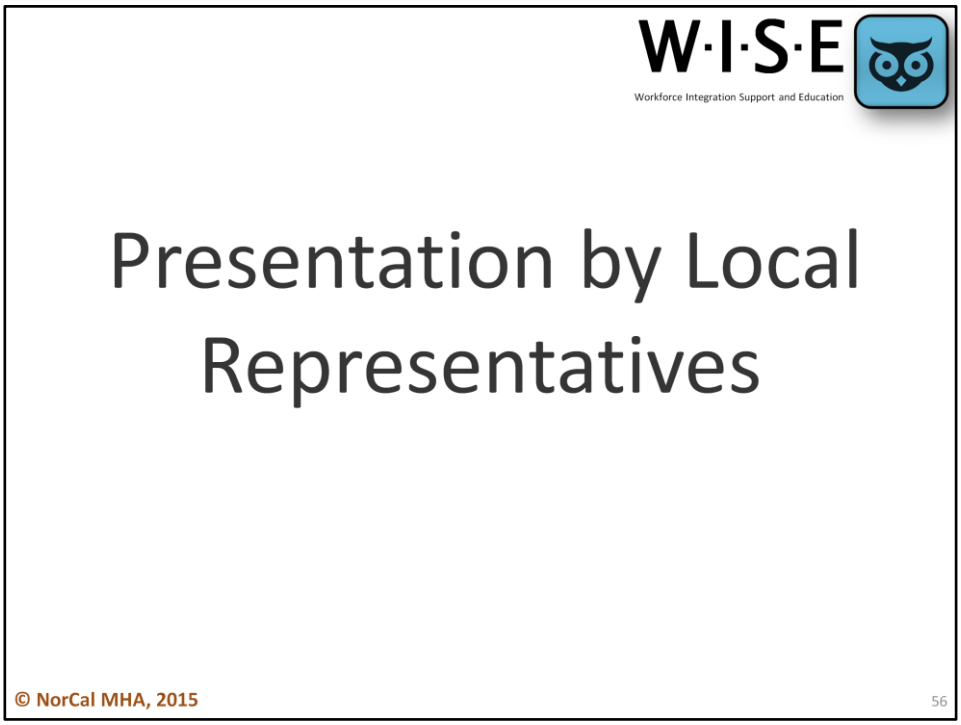
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Workforce Integration Support and Education
Presentation by Local Representatives
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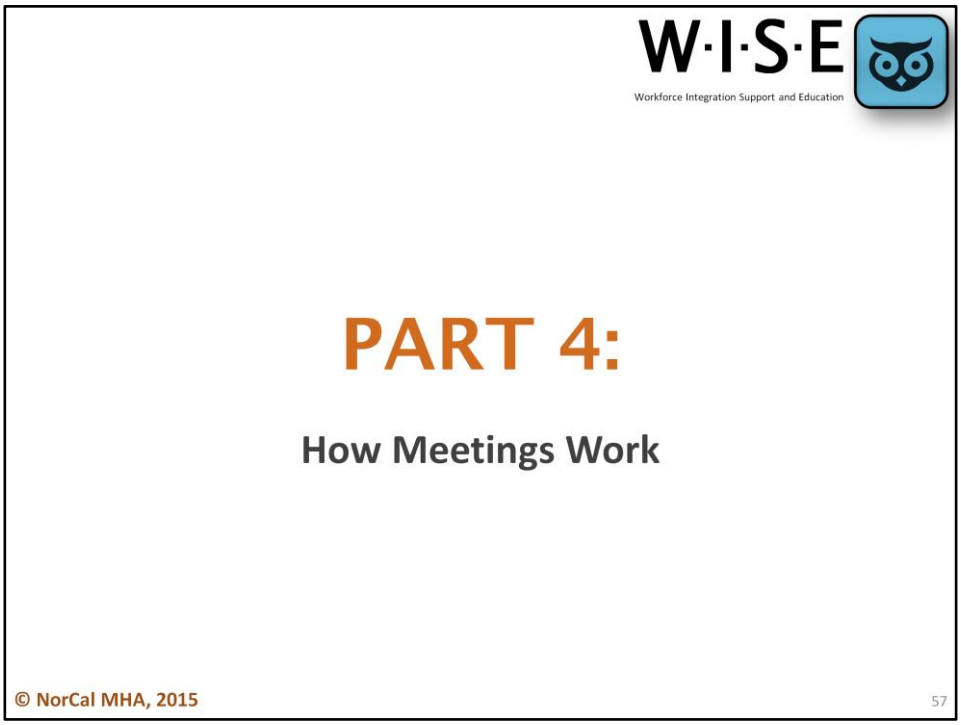
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Workforce Integration Support and Education
PART 4:
How Meetings Work
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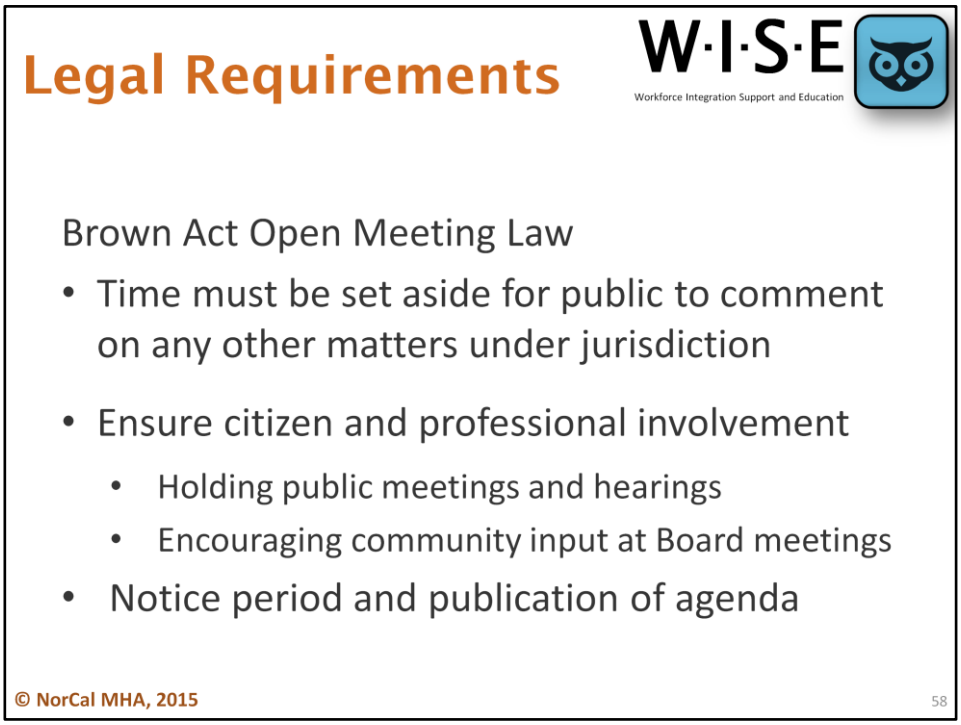


Brown Act Open Meeting Law

•"The people insist on remaining informed to retain control over the legislative bodies they have created."

•"Time must be set aside for public to comment on any other matters under the body's jurisdiction."

Ensure citizen and professional involvement by:

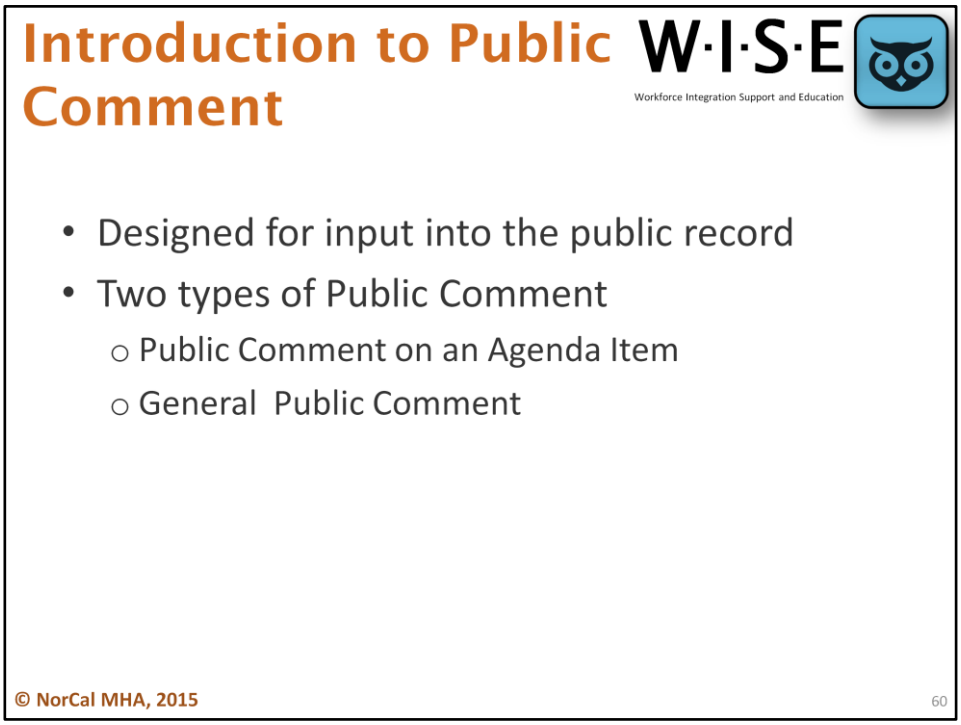
Holding public meetings and hearings
Encouraging community input at Board meetings

Notice period (Xdays in advance of meeting) and publication of agenda

Attending a Meeting

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

- Introduction to Public Comment
- Types of Public Comment
- Doing Your Homework
- At the Meeting
- Make Your Point
- After the Meeting

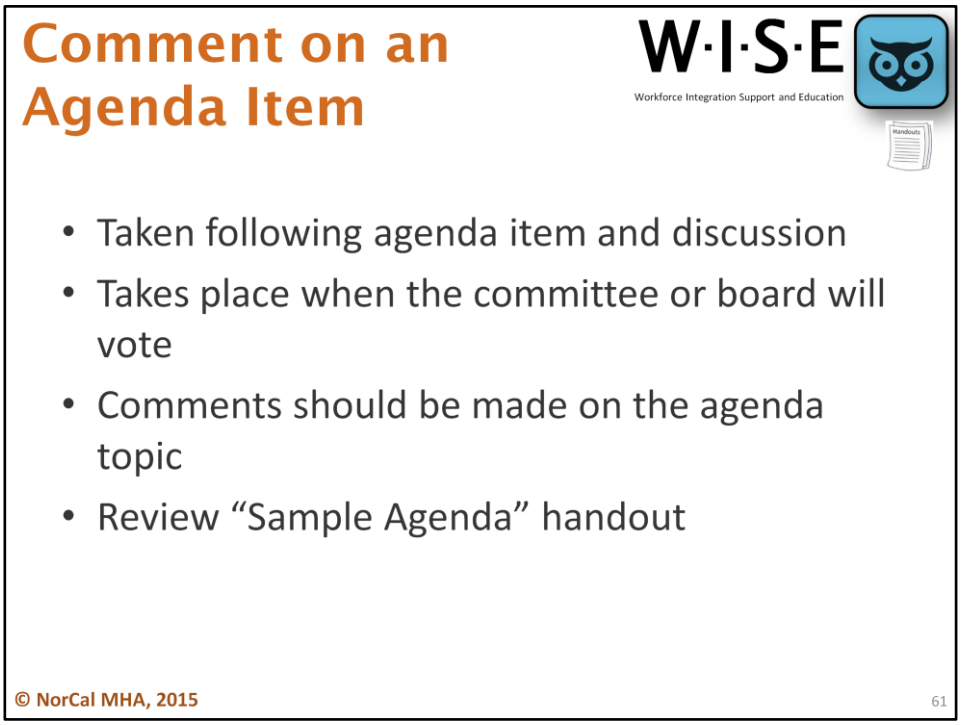


A Public Comment period is designed to allow you to get your input – briefly stated – into the public record.

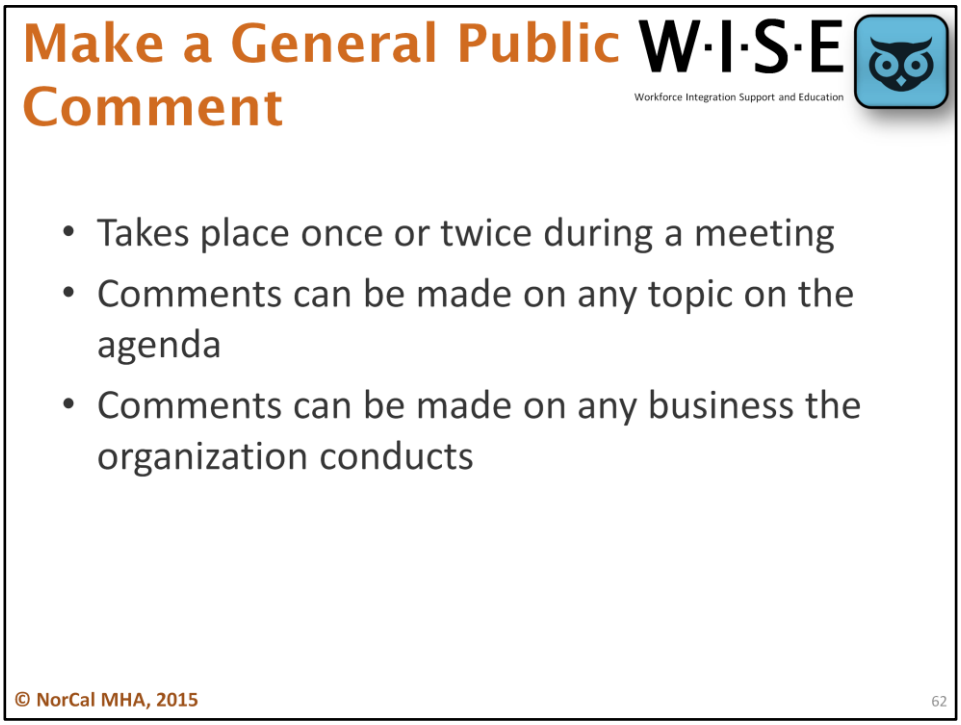
It is not the time for you to engage in conversation with the committee or board members holding the meeting (unless they ask you questions, which you can then answer)

There are typically <u>two</u> types of Public Comment taken during meetings:

1. <u>Public Comment on an *Agenda Item*,</u> and
2. <u>*General* Public Comment</u>



Review the Handout: Sample Board Meeting Agenda



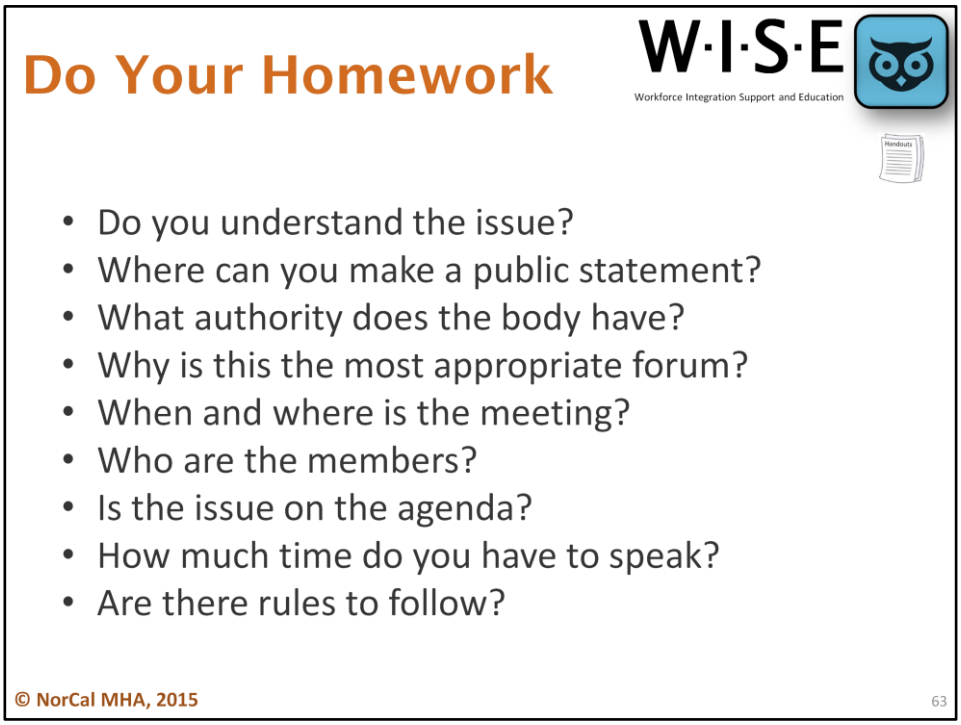
Usually takes place once or twice during a meeting, depending on the length of the meeting

At shorter meetings, Public Comments may be taken in the middle or at the end of the meeting, before the meeting is adjourned

At longer meetings, some taking a full, working day,
Public Comment may be taken twice during the course of the meeting:

1. At the end of the morning session, before the committee breaks for lunch, and
2. At the end of the meeting, before the meeting is adjourned

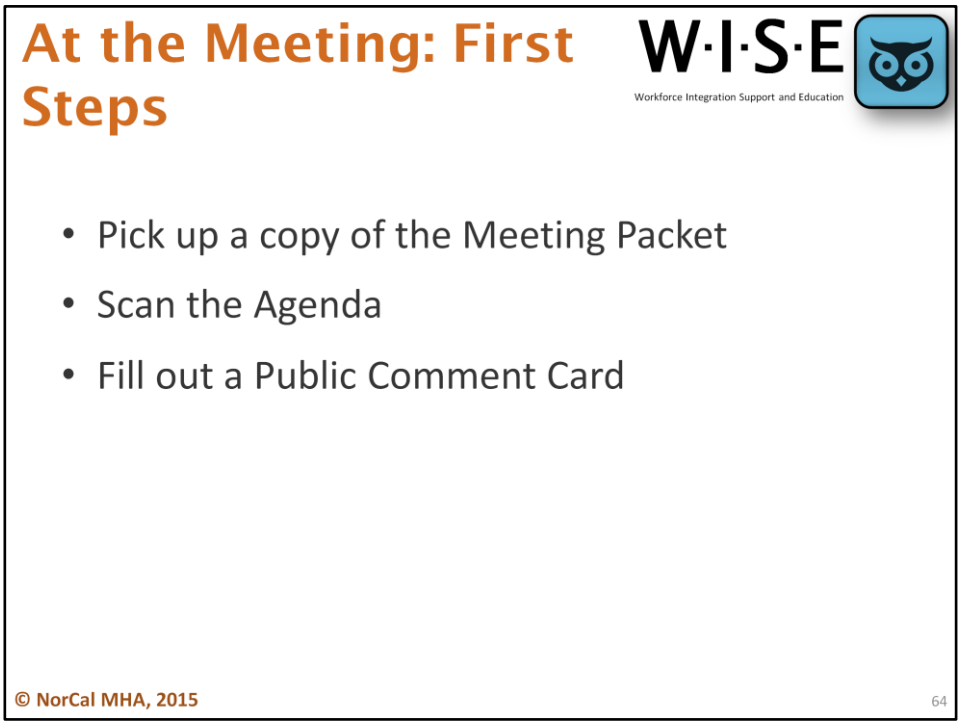
Comments can be made on any item of the agenda – You can make comment here on another item on the agenda that has already taken place
Comments can be made on any business the organization conducts – You can make comment on any business the agency conducts for future consideration



Review handout: Doing Your Homework

Go over steps.

ASK: Why is it important to answer some or all of these questions?



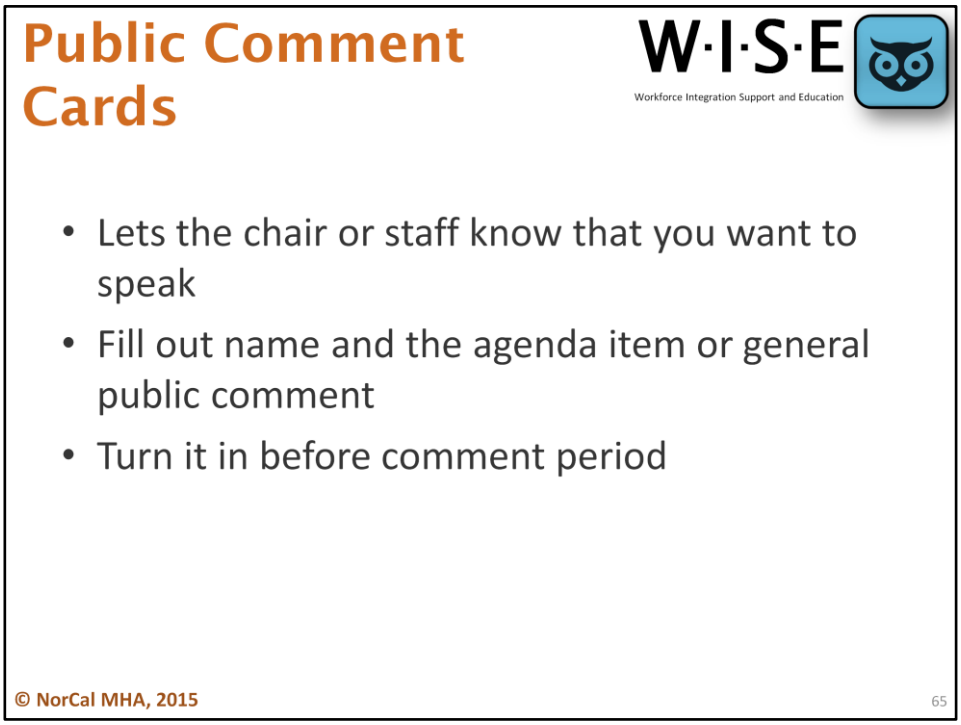
If you are at a meeting in person, pick up a copy of the **Meeting Packet** (including that day's meeting Agenda and often other materials related to presentations or items to be discussed that day)

If you are calling in to participate in a meeting on the phone or using your computer, the materials (including Agenda) are often made available on line, typically 10 days before the meeting takes place

Scan the Agenda to get an idea of what will be discussed that day

If you see an Agenda item that you want to give input on,

Fill out a ***Public Comment Card***



Public Comment Cards let the chair or staff of the meeting know that you want to speak on an issue

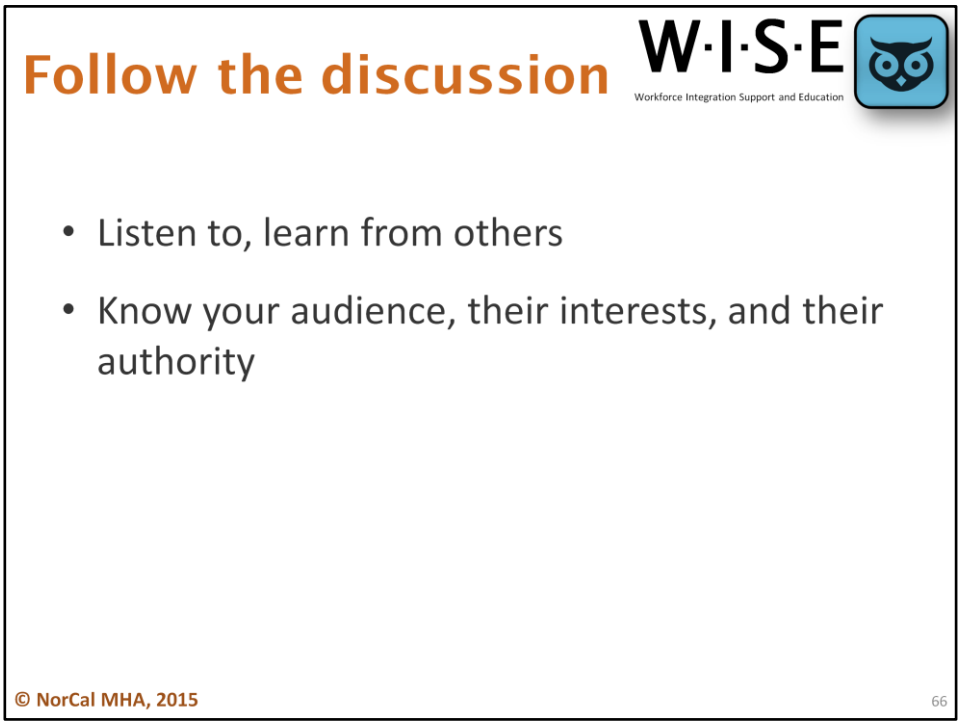
Cards generally have spaces for information about you (name, organizational affiliation, contact info & topic you want to address)

Much of this information is considered OPTIONAL, however. Usually, providing your **name** and the **agenda item or general public comment** which you want to speak is enough

If you want to speak during a General Public Comment segment, indicate this by writing *"General" or "General Public Comment"* on the card

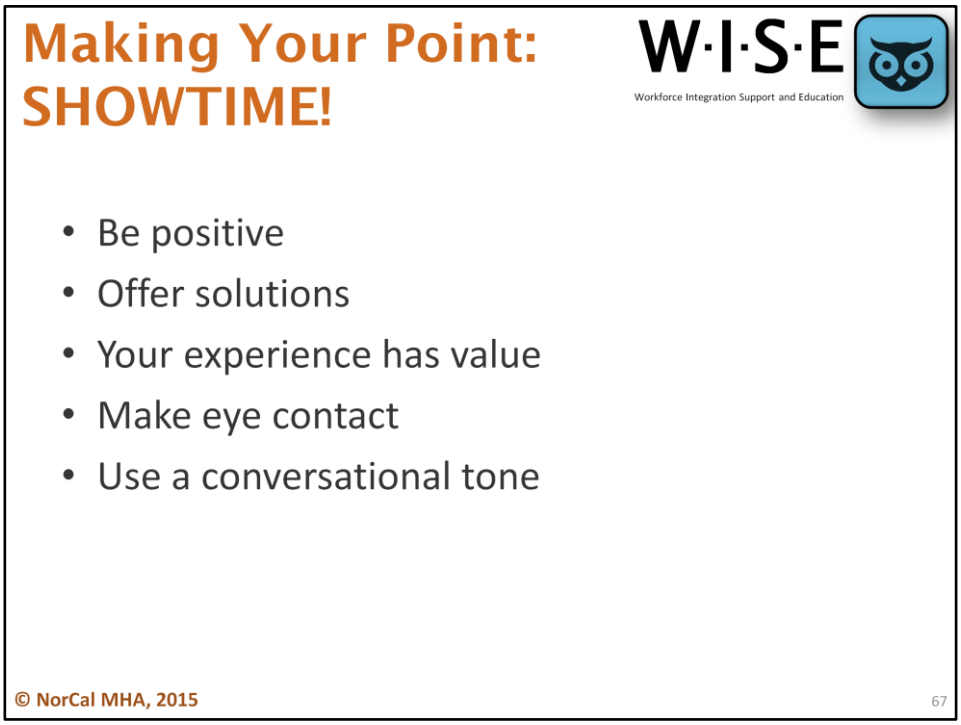
Turn in your Public Comment Card to the designated staff or committee member *before* the start of the public comment section on the agenda item you wish to speak about, or before the start of the General Public Comment segment

If you are calling in to a meeting by phone or computer, the chair will often ask if anyone wants to comment before the comment segment, list the names, and then call your name when it is time to speak



Listen to, learn from others
The issues you care about may be the focus of a presentation or a discussion involving committee members, staff, representatives of interested organizations , advocates and other members of the public

Know the interests and authority of the body you'll be addressing, who are its members, what organizations they may represent, etc.
Useful information can be found on the agencies' website, such as its bylaws or charter, past agendas, meeting minutes, and member biographies



Committee members are people, too. Meetings can be long, and they have a lot to listen to. Simple things can help to make your remarks more memorable:

Make eye contact as you speak
Use a conversational tone; don't "preach"
Be to-the-point (Public Comment is typically limited to ***three minutes***!)

Making Your Point

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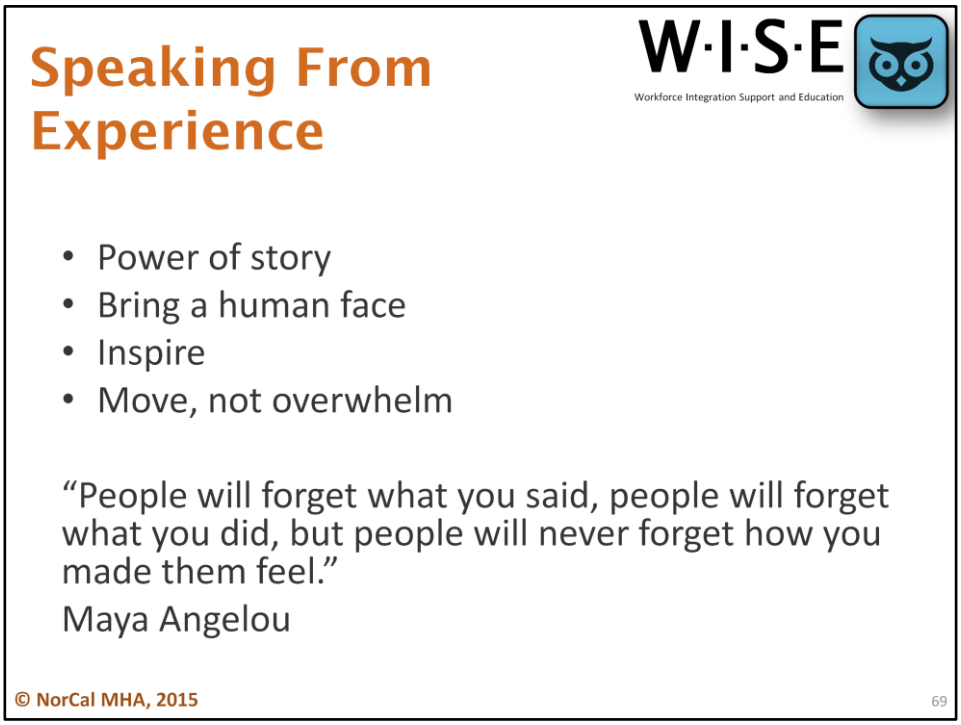
- Using your experience to change hearts and minds

"Experience is what you get when you didn't get what you wanted. And experience is often the most valuable thing you have to offer."
—Randy Pausch, The Last Lecture



Maya Angelou once said, "People will forget what you said, people will forget what you did, but people will never forget how you made them feel." And what's the best way to make people feel? By telling a compelling story.

Stories are all around us. They are what move us, make us feel alive, and inspire us. Our appetite for stories is a reflection of the basic human need to understand patterns of life — not merely as an intellectual exercise but as a personal, emotional experience.

Stories are the way to reach out to people and emotionally connect by showing our human side.

The goal of our story is inspire someone to take action, having learned from our experience.

This is done with just the right emotion, to move but not overwhelm the listener.

If your story triggers deep emotion, rewrite it so that you may be more composed during your speech.

BREAK TIME!

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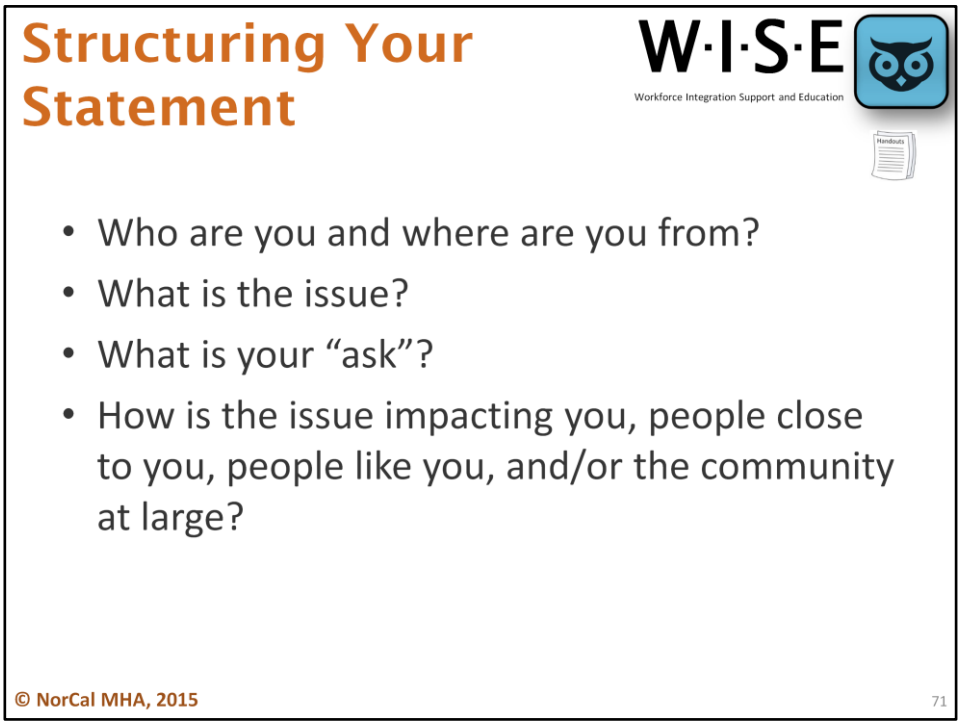
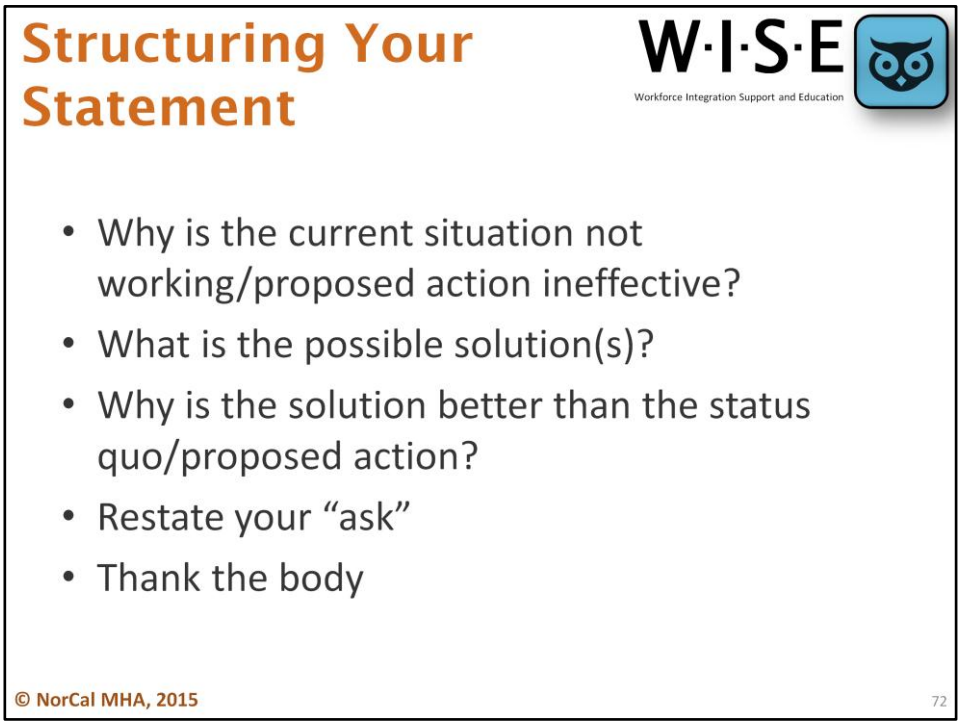


<u>Review the "Making Your Point" handout questions. Make sure they have "John's Stories "and "Personal/Policy Advocacy Worksheet" as well.</u>

Who are you and where are you from? (1 sentence)
What is the issue? (1-2 sentences)
What is your "ask"? What **<u>exactly</u>** 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. (1-2 sentences)
Thank the body. (1 sentence)

Writing Your Statement

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Group Activity:

- Get into your groups
- Review "Making Your Point: John's Stories"
- Review the "Personal Policy Advocacy" worksheet
- Use the sample situation to answer all the questions on the worksheet

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Writing Your Statement

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GROUP PRESENTATION

- Volunteers to share their statement

What Do You Think?

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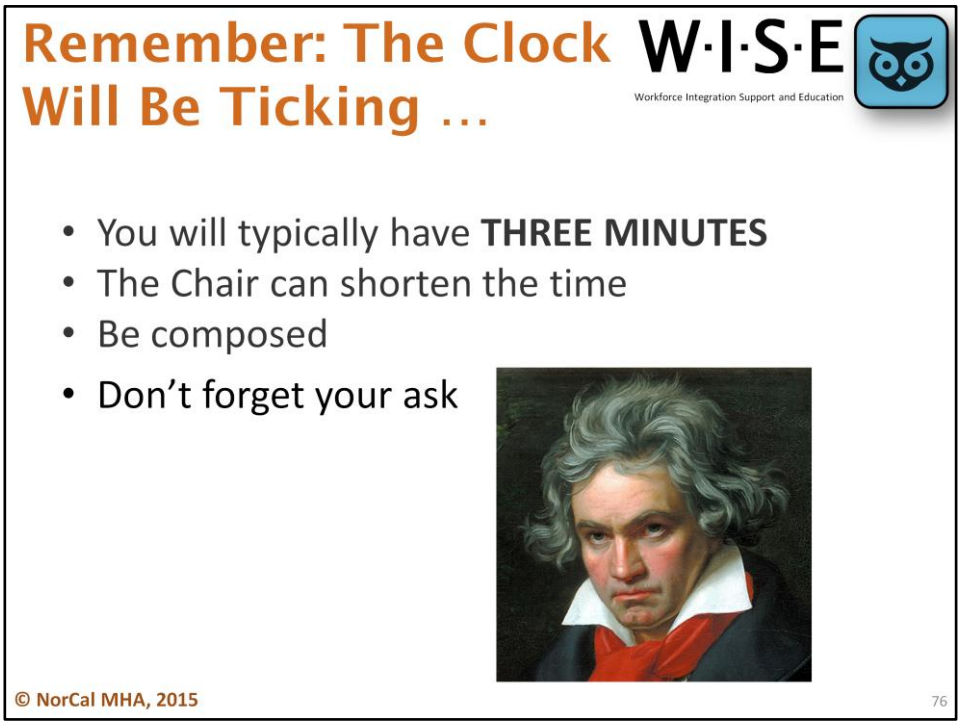
- What was the experience like?
- What were the challenges?
- Are you happy with the final result?

Reflections on preparing your own statement



You will typically have **THREE MINUTES** to make your comments

The Commission Chair has the power to shorten that time, especially if there are many people who want to speak on an issue

Don't forget your ask. Depending on how much you want to say, and ***how prepared you are***, three minutes can seem like three seconds or an eternity! Don't spend all your time getting to your point.

PICTURE: Beethoven composing himself

What's the Point?

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- Know your ask
- Share your story
- Keep it brief
- Emphasize recovery and hope
- Have solutions
- Use your "secret" weapon

The "Secret" Weapon

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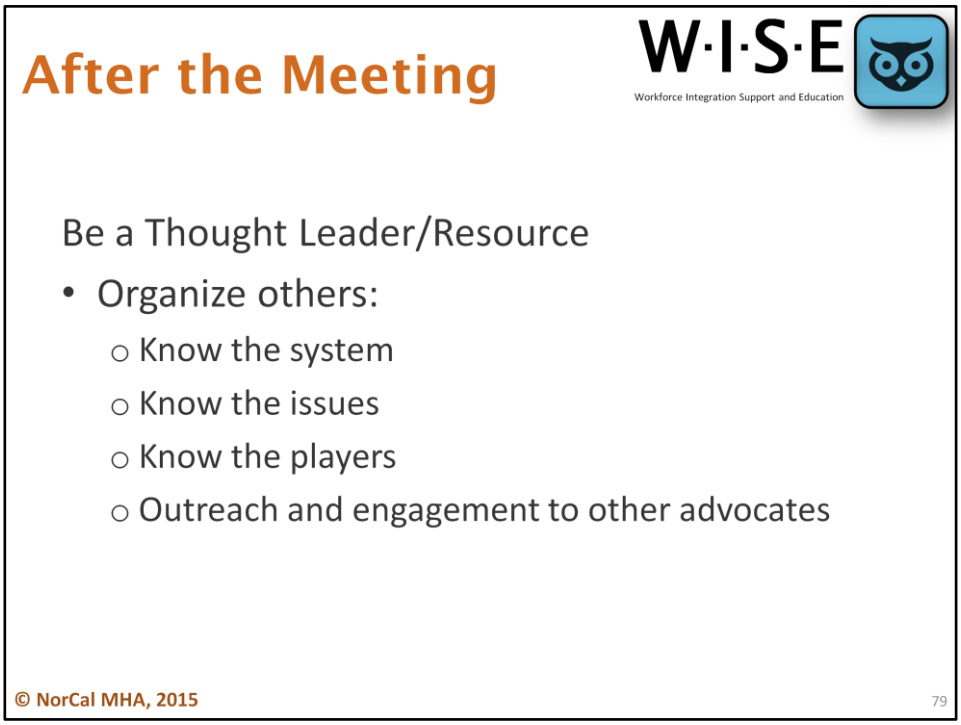
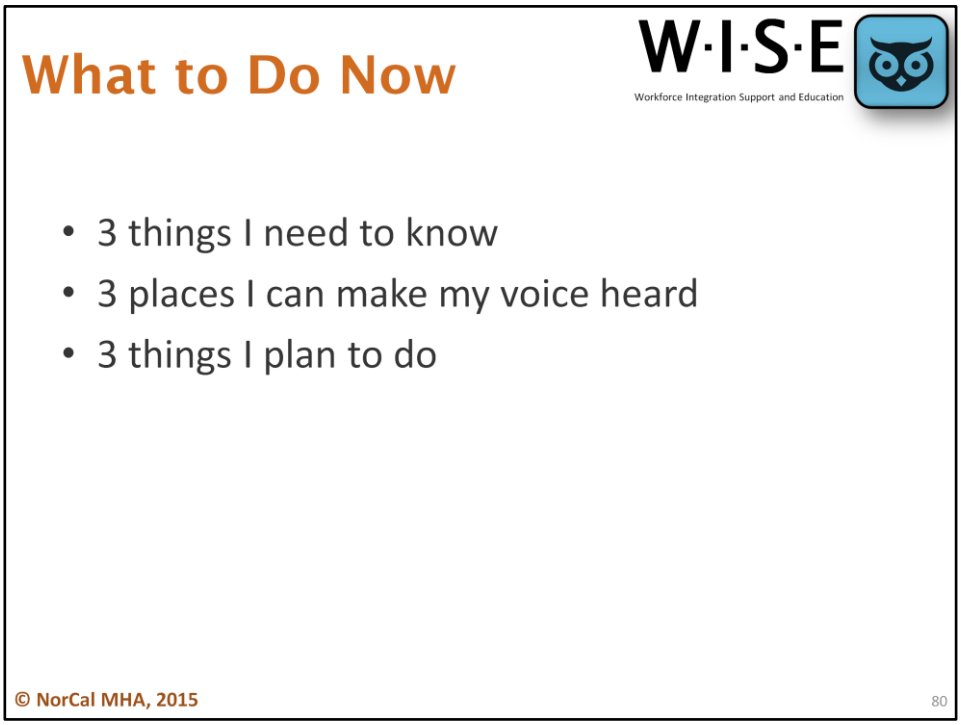
- "Advocating well with a personal story is not a call to simply "Insert Story Here." The power of your story may not lie in its drama, but in its absolutely perfect relationship to your cause."

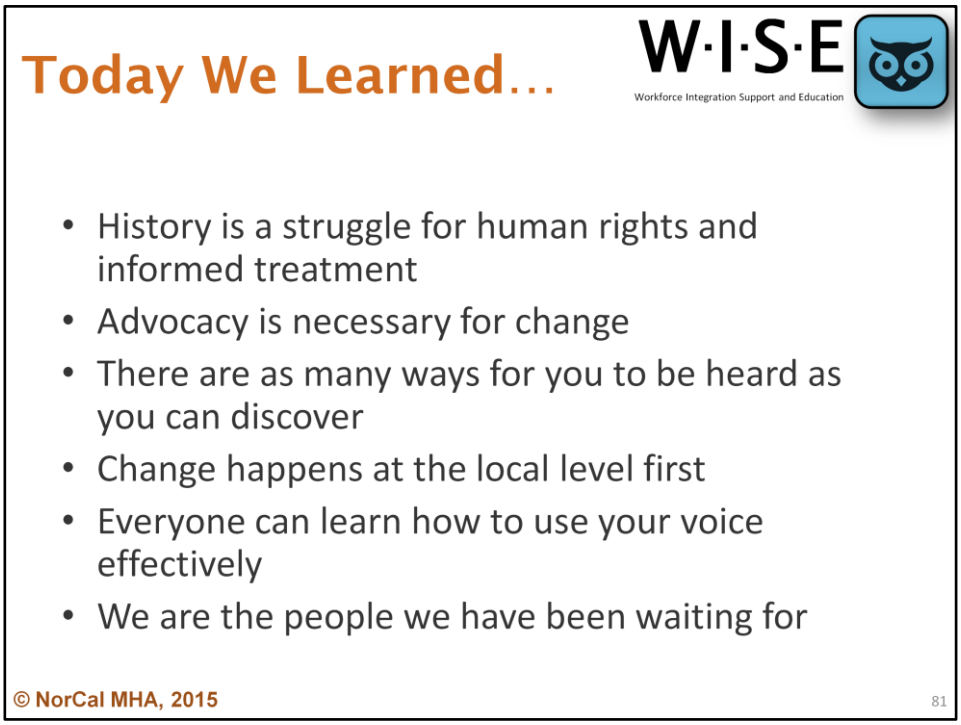
— John Capecci and Timothy Cage, Living Proof: Telling Your Story to Make a Difference



Just by showing up you will be considered a thought leader.
Find a way to communicate with your audience after the event.
Let them know through email or personal phone call that you value their time and opinion. Tell them you are glad to discuss the issues at a later time.
If they are less than positive, tell them you value their opinion, and let them know that you are available as a resource should they want more information.
In either case, leave them with the impression that you want to build a relationship with them, and hope to work with them in the future.



Patients' Rights Advocate
Patients, family members, and friends of patients have an Advocate available to answer questions and respond to patient grievances. For further information, please call (530) 632-3202.
Consumer Advocate-Liaison, Advocate for Adults & Families, Advocate for Children, Youth, & Families



REVIEW training goals from Slide 8

ASK audience if this training met the needs they identified when the training began

Today We Learned…

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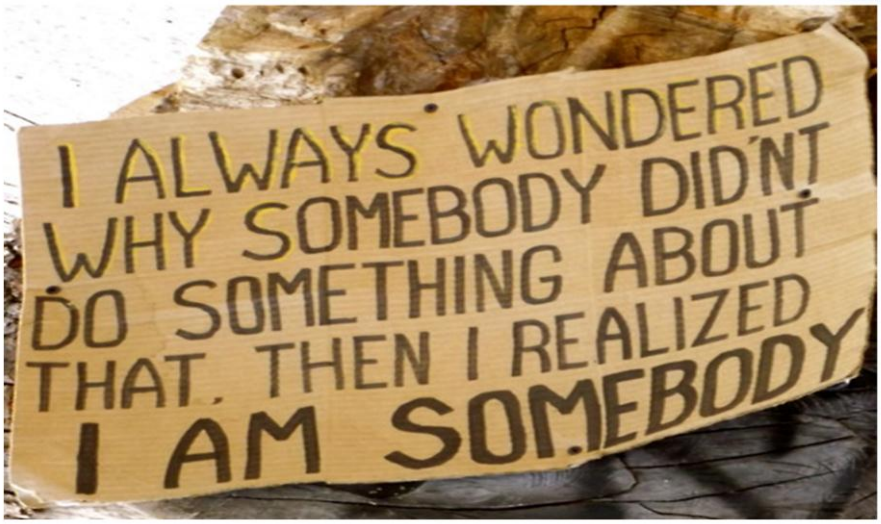

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Please complete your post-training survey and trainer evaluation form

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W·I·S·E Contact Info

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