California Department of Mental Health (DMH)
Vision Statement and Guiding Principles for DMH Implementation of the Mental Health Services Act
February 16, 2005

Introduction

The Mental Health Services Act (MHSA) includes a clear set of challenging goals for all stakeholders to hold in common as the MHSA becomes reality.[1] Within the context of those common goals, the California Department of Mental Health (DMH) developed, in partnership with stakeholders, a ***Vision Statement*** and ***Guiding Principles*** to use as it implements the Community Services and Supports component of the MHSA.[2]

Most of the language and concepts included in the Vision Statement and Guiding Principles document were originally presented to MHSA stakeholders on the DMH website and at a public meeting in Sacramento in December 2004. At that time it was entitled "DMH Vision Statement". Since then, in response to stakeholder comments and DMH policy clarification, this document has become a Vision Statement and Guiding Principles for DMH to hold for itself and stakeholders as it implements the Community Services and Supports component of the MHSA.

VISION STATEMENT

TO GUIDE DMH IN THE IMPLEMENTATION OF COMMUNITY SERVICES AND SUPPORTS

As a designated partner in this critical and historic undertaking, the California Department of Mental Health (DMH) will dedicate its resources and energies to work with stakeholders to create a state-of-the-art, culturally competent system that promotes recovery/wellness for adults and older adults with severe mental illness and resiliency for children with serious emotional disorders and their families. In its implementation responsibilities under the MHSA DMH pledges to look beyond "business as usual" to help build a system where access will be easier, services are more effective, out-of-home and institutional care are reduced and stigma toward those with severe mental illness or serious emotional disturbance no longer exists.

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[1] Mental Health Services Act, "Section 3. Purpose and Intent."

[2] "Community Services and Supports " means the same as "System of Care" in the MHSA, Welfare and Institutions Code Sections 5878.1-.3 and 5813.5

GUIDING PRINCIPLES

TO GUIDE DMH IN THE IMPLEMENTATION OF COMMUNITY SERVICES AND SUPPORTS

Beyond the goals in statute for the MHSA as a whole, DMH has developed, with stakeholder input, a set of Guiding Principles. These Guiding Principles will be the benchmark for DMH in its implementation of the MHSA Community Services and Supports component. DMH will work toward significant changes in the existing public mental health system in the following areas:

Consumer and Family Participation and Involvement

1. Significant increases in the level of participation and involvement of clients and families in all aspects of the public mental health system including but not limited to: planning, policy development, service delivery, and evaluation.

2. Increases in consumer-operated services such as drop-in centers, peer support programs, warm lines, crisis services, case management programs, self-help groups, family partnerships, parent/family education, and consumer provided training and advocacy services.

3. Full implementation of an approach to services through which each client and her/his family, as appropriate, participates in the development of an individualized plan of services determined by the individual's goals, strengths, needs, race, culture, concerns and motivations.

Programs and Services

4. Changes in access and increased geographic proximity of services so that clients will be able to receive individualized, personalized responses to their needs within a reasonable period of time and to the extent needed to enable them to live successfully in the community.

5. Elimination of service policies and practices that are not effective in helping clients achieve their goals. Ineffective treatment methods will be replaced by the development and expansion of new values-driven, evidence-based and promising practices, policies, approaches, processes and treatments which are sensitive and responsive to clients' cultures and produce more favorable outcomes.

6. Increases in the array and types of available services so children, transition age youth, adult and older adults clients and their families will be able to choose, in consultation with mental health professionals, the kinds of services and the intensity of services that will assist them in attaining the goals in their individualized plans.

7. Integrated treatment for persons with dual diagnoses, particularly serious mental illness and serious substance use disorders, through a single individualized plan, and integrated screening and assessment at all points of entry into the service system.

Age–Specific Needs

8. For children, youth and their families, implementation of specific strategies to achieve more meaningful collaboration with child welfare, juvenile justice, education and primary healthcare, in order to provide comprehensive services designed to enable youth to be safe, to live at home, to attend and succeed in school, abide by the law, be healthy and have meaningful relationships with their peers.

9. For transition-age youth[3], programming to address the unique issues of this population who must manage their mental health issues while moving toward independence. This should include a person as a point of contact who would follow youth as they transition from the youth systems into the adult system or move out of the mental health system. To meet the needs of these youth, programming needs to include specific strategies for collaboration between the youth and adult systems of care, education, employment and training agencies, alternative living situations and housing and redevelopment departments.

10. For adults, implementation of specific strategies to achieve more meaningful collaboration with local resources such as physical health, housing, employment, education, law enforcement and criminal justice systems in order to promote creative and innovative ways to provide integrated services with the goals of adequate health care, independent living and self-sufficiency.

11. For older adults, implementation of specific strategies to increase access to services such as transportation, mobile and home-based services, comprehensive psychiatric assessments which include a physical and psychosocial evaluation, service coordination with medical and social service providers and integration of mental health with primary care. The ability to reside in their community of choice is a fundamental objective.

[3] The MHSA defines transition age as youth ages 16 to 25 in Welfare and Institutions Code (WIC) 5847.

12. For all ages, reductions in the negative effects of untreated mental illness including reductions in institutionalization, homelessness, incarceration, suicide, and unemployment.

Community Partnerships

13. Significant increases in the numbers of agencies, employers, community based organizations and schools that recognize and participate in the creation of opportunities for education, jobs, housing, social relationships and meaningful contributions to community life for all, including persons with mental illness. Care must be collaborative and integrated, not fragmented.

Cultural Competence

14. Outreach to and expansion of services to client populations to more adequately reflect the prevalence estimates and the race and ethnic diversity within counties and to eliminate disparities in accessibility and availability of mental health services.

15. Implementation of more culturally and linguistically competent assessments and services that are responsive to a client's and family's culture, race, ethnicity, age, gender, sexual orientation and religious/spiritual beliefs.

Outcomes and Accountability

16. Expanded commitment to outcome monitoring including developing/refining strategies for evaluation of consumer outcomes, and system and community indicators, using standardized measurement approaches whenever possible. Data needs to be readily accessible and viewed as an essential part of program planning.

17. Development and implementation of policy and procedures to ensure that changes in service array in the future are based on intended outcomes. This may necessitate increased training and support for the mental health workforce.

18. Achievement of the MHSA accountability goals necessitates statewide adoption of consistent, effective service delivery approaches as well as standard performance indicators, data measurement and reporting strategies.

Taking a Comprehensive Viewpoint

19. Beyond the MHSA goals, and the DMH Vision Statement and Guiding Principles for implementation of Community Services and Supports, DMH will rely on the principles, goals, strategies, data and other information from the following nationally recognized documents and sources:

    - Principles articulated in the *President's New Freedom Commission Report* on Mental Health report.

    - Accountability based on the spirit of the Institute of Medicine's *Crossing the Quality Chasm* report.

    - Accountability based on the findings of Mental Health: Culture, Race and Ethnicity, A Supplement to Mental Health: A Report of the Surgeon General, U.S. Department of Health and Human Services, 2001.

    - The vision, mission and values of the public mental health system as articulated in the California Mental Health Planning Council's *Master Plan.*

    - DMH will also consider previous reviews of the public mental health system such as the Little Hoover Commission reports and the reports of the Select Committee of the California Legislature.

Summary of Stakeholder Input

DMH and all stakeholders owe a debt of gratitude to those individuals who attended the December 17, 2004 initial MHSA stakeholders meeting in Sacramento. The comments and input provided on that occasion have proven to be invaluable guidance for DMH in the implementation of Community Services and Supports.

Pacific Health Consulting Groups noted the following as key stakeholder concerns about the original Vision Statement in the summary of the December 17, 2004 meeting:

"Participants provided both written and verbal comments about the vision statement. About 260 people provided about 380 written comments, many making more than one comment. The major themes were, in order of the numbers of comments per theme:

- Populations/Consumers and Family
- Children
- Alternative Treatments/Support Services
- Integration with Primary Care
- Workforce and Training
- Cultural Competence
- Outcomes/Quality of Life
- Prevention and Early Intervention
- Best Practices/Seamlessness/Transformation
- Stakeholders/Collaboration/Criminal Justice
- Substance Abuse/Co-occurring Disorders"

DMH concurred with stakeholder comment that the Vision Statement as initially written was too long and yet didn't address all the various components of the MHSA. It was also clear that the goals written in the MHSA itself provide the best over-all picture of what the MHSA should achieve.

DMH adapted the language of the Vision Statement so that it became both a Vision Statement and Guiding Principles. These are intended to refer *only* to DMH's implementation of the MHSA Community Services and Support Component within the context of the goals of the MHSA. DMH realizes it may be necessary to develop similar implementation visions and principles as it proceeds with implementation of other components. In addition, many stakeholder concerns expressed about the initial draft have been clarified and moved to DMH Letter 05-01 which was issued in January, 2005. Remaining concerns are included in the "Draft Community Services and Supports Plan Requirements" that is presently under review by stakeholders.