



# United Advocates for Children of California

1401 El Camino Ave., Suite 340 ~ Sacramento, CA 95815

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## California Family Partnership Association

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## The Mental Health Services Act: Recommendations for Implementation

The Mental Health Services Act has the potential to transform the service delivery system for children with emotional, behavioral, and mental health problems. The Mental Health Services Act could be a catalyst for implementation of a Children's System of Care Planning Model as a framework for the entire public children's mental health system, as well as implementation of the goals of The President's New Freedom Commission on Mental Health. Parents/Caregivers and their children have established recommendations for the utilization of new funding and services through The Mental Health Services Act.

Improving the quality of life and optimizing the outcomes of children and their families requires that mental health services are tailored; built on the child and family's cultural values, beliefs and strengths; include informal social supports; and are based on goals shared by the family and the providers of care. The implementation of family-driven care is a qualitative change in the full array of services offered to children and their families. This full array of services includes both in-home and out-of-home care.

Optimal mental health treatment is effective in alleviating distress, preventing serious and persistent disturbance, and promoting resiliency and recovery for children and their families. The following child and family outcomes are desired by families:

- Loving and cohesive families that can care for their children in a safe environment
- Happy, hopeful and self-assured children
- Children who have pro-social and supportive friendships
- Children who are law abiding
- Children who have success in school
- Children who are prepared to work and live independently as they transition into adulthood

Families also believe that an optimal service system has the following characteristics:

- Proactively identifies children at-risk and children showing symptoms of emotional, behavioral, and mental health conditions, and assures easy and immediate access to care
- Provides comprehensive and coordinated services to meet the immediate and anticipated needs of each child and family



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- Provides services that are strength-based and culturally appropriate
- Provides services that are tailored to the needs and culture of each child
- Provides services that have demonstrated effectiveness based on application of evidence-based practice/best practice approaches
- Is equally effective at proactive identification, engagement into care, provision of care, and achievement of outcomes with children and their families from all ethnic and cultural groups

The MHSAs declare a purpose and intent “to expand the kinds of successful, innovative services programs for children, adults and seniors begun in California, including culturally and linguistically competent approaches for underserved populations.”<sup>1</sup> Additionally, the MHSAs state that “in consultation with mental health stakeholders, the department shall revise the program elements in Section 5840 applicable to all county mental health programs in future years to reflect what is learned about the most effective prevention and interventions programs for children, adults, and seniors.”<sup>2</sup>

Implementation of the MHSAs is intended to promote a transformation of the system, but often the first priority is to use additional funds to fill gaps in available services. It is commonly believed that children and youth with emotional, behavioral, and mental health conditions do not achieve expected outcomes because there are not enough services. Adding new services then becomes the obvious solution. However, a growing body of literature on system of care suggests that increases in services alone do not result in significant improvement of child outcomes. Achieving expected outcomes also involves improving the quality of existing services.

California has the largest population in the nation, and between 1995 and 2025 is expected to lead the nation in population growth with multicultural and multilingual populations increasing. The diversity of languages and beliefs, coupled with the adverse effects of discrimination and stigma, results in significant challenges involving access to quality mental health services. When quality care is not accessible, emotional disorders worsen, and often children and youth are diverted into non-mental health service systems. The poverty rate for children in California is 27.3 percent, which is higher than the national average of 25.7 percent. Many of these children live in rural communities and are children from families of minority ethnic and cultural groups that experience significant institutional discrimination, both of which contribute to the development of emotional disorders and interfering with accessing quality mental health care.

<sup>1</sup> Mental Health Services Act, Section 3 (c).

<sup>2</sup> Mental Health Services Act, Section 4, Part 3.6, 5840 (e).



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No child should be refused entry into school, expelled from school, or denied high quality educational services because of an unaddressed or unidentified mental health or related need. No parent should have to relinquish custody of their child in order to access the mental health treatment needs of their child. No family should have to suffer inadequate or insufficient treatment due to language or cultural barriers to mental health treatment.

Yet, for 300,000 children and youth in California this is the case. The California Mental Health Planning Council estimates that “approximately 600,000 adults, older adults, and children and youth in need of mental health treatment are not receiving services. In round numbers, this figure breaks down to 300,000 children and youth, 200,000 adults, and 100,000 older adults.”<sup>3</sup>

The Mental Health Services Act establishes funds to offer “services to severely mentally ill children for whom services under any other public or private insurance or other mental health or entitlement program is inadequate or unavailable.”<sup>4</sup> This additional resource could potentially decrease the number of children and youth who are in need of mental health treatment and do not receive services.

## **Recommendations for Implementation:**

1. California Children’s System of Care
2. Evidence-based Practice and Best Practice Approaches to Care
3. Family Driven Services
4. Family Partnership Programs
5. Stigma and Discrimination Awareness

### **1. California Children’s System of Care**

The Mental Health Services Act calls for services provided to “severely mentally ill children as defined in Section 5878.2 and that they be part of the children’s system of care established pursuant to this Part.”<sup>5</sup> One of the core concept recommendations of parents/caretakers and their children is that all public services delivered to children and their families adhere to the core values and guiding principles of children’s system of care. Further, it recommends that the State Department of Mental Health take an active role in developing a children’s system of care planning model framework in which all counties implement public mental health services with fidelity to the children’s system of care planning model.

<sup>3</sup> California Mental Health Master Plan: A Vision for California (March 2003).

<sup>4</sup> Mental Health Services Act, Section 5, 5878.3 (a).

<sup>5</sup> Mental Health Services Act, Section 5, 5878.1 (a).



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“A Guide to Implementing Children’s System of Care,” published by the Cathie Wright Technical Assistance Center, explains, “Implementing a system of care involves changing the service delivery culture to one in which clearly identified values and principles provide a foundation for the achievement of specific goals through a flexible network of services and supports provided by a team for a targeted group of children and their families. Services are designed to fit the individual child and family, rather than to focus on programs into which a child must fit or fail. Negative outcomes are viewed as system failures, rather than child and family failures. Every family embodies strengths. The service delivery system needs to identify these and collaborate with the family to build upon them. The model is both results and cost focused. This emphasis on accountability, on providing the most effective services in the most efficient manner, has been the strategy that has perhaps contributed the most to the successful expansion of Children’s System of Care in California.”<sup>6</sup>

California is in the unique position to build a system of care that expands the public services system for children and youth. Stakeholders have an opportunity to build a system of care for children and youth that incorporates structures to support the capacity to function effectively in cross-cultural social justice situations; incorporates meaningful partnership with families and youth in structural decision making, design, and implementation; and that incorporates a cross-agency perspective that builds structures that operate in a non-categorical fashion.

Recognizing that children’s system of care changes and evolves over time, that policies, organizational arrangements, service delivery approaches, and treatments change and adapt to changing needs, opportunities and environmental circumstances, building system of care involves making changes at the state and county levels. Fundamentally, a system of care is a range of treatment services and supports supported by an infrastructure and guided by a philosophy.

## Recommendations:

1. The State Department of Mental Health takes the lead in the development of the structures and processes required to build a Children’s System of Care for California in the current climate of change.
2. California Children’s System of Care is a framework in which all eligible populations of children within the county who depend on public systems for mental health treatment services are a focus of care.
3. The Children’s System of Care framework is organized around all of the families’ needs in coordination with multiple systems and agencies:

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<sup>6</sup> A Guide to Implementing Children’s System of Care in California (1998) Cathie Wright Technical Assistance Center and California Institute for mental Health



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- a. Mental Health Services
  - b. Social Services
  - c. Educational Services
  - d. Juvenile Justice Services
  - e. Health Services
  - f. Substance Abuse Services
  - g. Vocational Services
  - h. Recreational Services
4. California Children's System of Care should be developed with the following operational characteristics:
- a. Partnership with families
  - b. Collaboration across agencies
  - c. Cultural and linguistic competence
  - d. Blended/coordinated funding
  - e. Shared governance across systems and with families
  - f. Shared outcomes across systems
  - g. Easy access to services and supports
  - h. Interagency services planning teams which include the family
  - i. Interagency services monitoring teams which include family members
  - j. Single plan of care across agencies/systems
  - k. Cross-agency care coordination
  - l. Individualized care/services/supports
  - m. Home and community based care/services/supports
  - n. Broad, flexible array of services and supports
  - o. Integration of clinical care services and natural community supports
  - p. Integration of evidence-based and best practices treatment approaches
  - q. Cross-agency management information systems
5. California Children's System of Care should be developed with the following core values and principles:
- a. Family Driven: Adapts services to the family rather than expecting the family to adapt to the services.
  - b. Community Based: Provides local, integrated, and coordinated services for all levels of care
  - c. Collaborative: Draws on the resources of the community, works in coordination with other programs to provide a range of treatment options directly or through interagency agreements.
  - d. Egalitarian: Provides services in an environment and a manner that enhances the self-worth and dignity of the family and child: respects their wishes and individual goals.
  - e. Empowering: Maximizes opportunities for family involvement and self-determination in the planning and delivery of services, and fosters a sense of personal efficacy that encourages families and their children to want to effect changes in their lives.



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- f. Inclusive: Services all families and their children in the public system, or tracks referrals for those families and children whom the public system is unable to serve.
  - g. Visible, Accessible, and Engaging: Provides services that attract families and their children.
  - h. Flexible: Incorporates flexibility in service provision and funding to support individualized services.
  - i. Culturally Competent: Provides services and supports that are culturally and linguistically competent.
  - j. Family-driven: Recognizes the pivotal role that families play in the lives of their children and works to ensure open and honest communication among family members.
  - k. Affirming: Targets strengths, not deficits, of children and their families.
6. Building a Children's System of Care requires multiple stakeholders at the national, state, and local levels:
- a. Families including children and youth
  - b. Providers
  - c. Line Staff
  - d. Administrators
  - e. Policy Makers
  - f. Evaluators

## 2. Evidence-based Practice and Best Practice Approaches to Care

The Mental Health Services Act provides for innovative programs in Section 9, Part 3.2, Innovative Programs. All too frequently children receive care that is based on outdated practices and narrowly defined outcomes as opposed to care that is based on increasing evidence of effectiveness. The system seems to rely on practices that have little supporting evidence or, at worst, have poor outcomes. The care that is often provided is based on "what we've always done" rather than on evidence-based practice/best practice approaches for "what works."

The compatibility of evidence-based practice/best practice approaches and children's system of care are not competing efforts but complementary. Children's system of care focuses on improving access, developing a broad array of services and ensuring coordination; it provides the context for evidence-based practice/best practice approaches. It is these two concepts working together that provide the hope for improved access and quality of care. The movement toward evidence-based practice/best practice approaches converges well within a system of care approach.

Dedicated mental health professionals are ready to help children and their families who are suffering from mental health and related needs. They work for the right



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causes, but are frustrated in their efforts by a system that is inflexible, discourages innovation and may punish risk-takers. An improved and expanded workforce which provides evidence-based/best practice approaches to mental health services will place mental health professionals within a system that rewards innovation, efficiency and responsiveness.

There are limitations to the traditional scientific research model when it is applied to complex circumstances involving children and their families. These circumstances include multiple diagnoses, multiple cultural contexts, and the need to conduct research in actual settings. Research that is done in relation to a simple diagnosis, in a generalized cultural context, and within a “laboratory-like” setting may not be relevant to children and their families who cannot be studied in these circumstances and who may constitute a considerable segment of the California children’s mental health service delivery system. Recognizing the limitations of the traditional scientific research model, families want to promote evidence-based practice/best practice approaches to care with greater cultural competence and greater child and family outcomes.

## **Recommendations:**

1. The definitions of evidence-based and best practices differ across and within areas of the children’s mental health service delivery system. The State Department of Mental Health and local county mental health system leaders must support the widespread adoption of clearly articulated definitions of evidence-based practice and best practices: When is a practice considered evidence-based and when is a practice considered a best practice?
2. Families desire the availability of the most effective mental health care possible for their children. Evidence-based practice/best practice approaches must be available within the range of choices for all family care plans.
3. Research in children’s mental health has shown some practices to be ineffective or even harmful. There must be strong advocacy from all levels of the children’s public service delivery system against the use of these practices.
4. California should place a high priority on research related to the effectiveness of evidence-based practice/best practice approaches to treatment for children and their families belonging to diverse groups. Research should:
  - a. Investigate differences in outcomes, if any, for persons belonging to different racial, ethnic, and cultural groups, as well as any modifications or adaptations that may be needed to enhance the effectiveness of specific evidence-based programs within these groups.



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- b. Investigate factors that contribute to consumer and practitioner access to evidence-based programs and the extent to which these factors differ across racial, ethnic, and cultural groups, and design strategies to increase access accordingly.
  - c. Investigate the critical system, infrastructure, and knowledge transfer components related to the successful, sustained implementation of evidence-based programs and any adjustments or variations needed to address the needs of different cultural groups.
  - d. Explore the extent to which positive outcomes for children and their families who are receiving evidence-based programs are related to the inclusion of common programmatic elements, such as being individually-orientated, home-based and family-focused, and placing a strong emphasis on supports for practitioners.
  - e. Seek to understand the relationship of racial, cultural, and community infrastructure and “protective” factors that reduce risk and increase resilience of specific groups with respect to mental health, and incorporate knowledge about such protective factors into the development and testing of mental health treatments and services.
  - f. Develop curricula of training and professional programs that explicitly cover evidence-based programs and best practice models and racial and cultural aspects and differences that may affect access to, and effectiveness of, such programs.
  - g. Provide resources to develop and increase the workforce capacity to effectively implement racially and culturally appropriate intervention strategies.<sup>7</sup>
5. California has significant and unacceptable disparities in access to and provision of quality mental health services for racially, ethnically, and linguistically diverse children and their families. Much of the research on practices and services in children’s mental health has not included racially and ethnically diverse individuals.
- a. Research of culturally-specific evidence-based practices needs to be enhanced and adequately funded.
  - b. Evidence-based practices that have been proven to be effective with non-ethnic minority populations, if implemented with ethnic minority groups must track effectiveness with these groups.
  - c. Evidence-based practices which have been proven to be effective with non-ethnic minority populations must track any

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<sup>7</sup> Consensus Statement on Evidence-Based Programs and Cultural Competence, July 2003, National Implementation Research Network, funded by the Annie E. Casey Foundation and the Louis de la Parte Florida Mental Health Institute.



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- modifications and/or adaptations made, to collect and generate new information to enhance the effectiveness of these evidence-based practices to ethnic minority populations.
- d. The selection of a treatment practice needs to be based on mutual decision-making between informed clients, and for children, their family/guardians, and their providers.<sup>8</sup>
  6. Discourage policy mandates that require the practices used by government-funded agencies to be evidence-based. These policy mandates may ignore the factors of lack of availability of practices for all areas of need and effectiveness of existing practices for all children and their families.
  7. Support the development and use of new and potentially successful practices. The continuous “discovery” of new practices should be promoted, since new practices may well be more effective for some children and their families than existing practices.
  8. The movement toward evidence-based practice/best practice approaches should not be allowed to undercut the ability of individual children and their families to make choices from among existing practices that have not been researched or have been inconclusively studied.
  9. Evidence-based practice/best practice approaches must not be allowed to undermine the children’s system of care structure, core values and guiding principles.

### 3. Family Driven Services

California defined the term *family driven* by implementing a participatory process that has been inclusive of a broad-based stakeholder group including youth, family members, mental health advocates, the provider community, and mental health administrators. The process was initiated prior to the release of the President’s Freedom Commission Report on Mental Health, 2003. In 2002, the California Mental Health Advocates for Children and Youth (CMHACY) as well as United Advocates for Children of California (UACC) attempted to create a single set of concrete operational definitions for the core values of Children’s System of Care, including family driven services, cultural competency, accountability, and individualized care. The purpose of creating these operational definitions was to decrease the significant variance in actual practice that exists across California counties that are implementing Children’s System of Care.

Although the process was initiated in 2002, the definition for *family-driven services* was finalized at a stakeholder meeting sponsored by the California Institute for

<sup>8</sup> National Hispanic-Latino American Agenda Summit; Mental Health Issues Platform and Issues Committee, pp. 22-23, Final Committee Report, July 13, 2004



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Mental Health (CIMH) for the California Mental Health Director's Association. UACC worked collaboratively with CIMH to recruit family members to attend the meeting and participate in finalizing and approving the definition. The final definition follows below.

## **Definition of "Family Driven"**

Family driven services exist when the beliefs, opinions, and preferences of every child, youth and their family/caregiver are a deciding determinant in service planning on the individual level; are a significant determinant in program development and implementation at the agency level; and are integral to legislation and appropriation at the policy level.

Children, youth and their family/caregiver make the decisions about their own care and participate in developing and implementing strategies for mental health system improvement.

## **Defining Characteristics of the Definition of Family Driven Include:**

- Children, youth and their families/caregivers are responsible for making care plan decisions based on partnership with their provider(s).
- Care plans are clearly related to the child, youth and family/caregiver beliefs, opinions and preferences.
- Children, youth and their families/caregivers are respected and valued.
- The adverse effects of mental health stigma including shame, guilt and blame are understood and mitigated.
- Parents and other family/caregiver members receive easily understood information on emotional disorders, the process for obtaining prompt access to needed mental health screening, assessments and care, entitlements to care, and legal rights and protections.
- Services and supports build on child, youth and family/caregiver strengths.
- Children, youth and their families/caregivers are offered easily understood information necessary to be full and credible participants in service planning.
- Communication with children, youth and their families/caregivers is clear and honest.

## **Recommendations:**

1. All public children's mental health services should be delivered using the definition of *family-driven services* as defined by California stakeholders.

## **4. Family Partnership Programs**



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The Mental Health Services Act calls for the involvement of family members of children and youth who utilize mental health services within the child serving systems in a number of areas. The proposition calls for outreach to families to recognize the early signs of potentially severe and disabling mental illnesses.<sup>9</sup>

The Mental Health Services Act also calls for family involvement in a consultation and advisory capacity.<sup>10</sup> More often than not, family members will have the most impact on public agencies and policies through their participation on various policy-making advisory or planning committees. Parents/Caregivers and their children recommend that family members continue to serve in the capacity of improving services for children and youth through their on-going dialogue on vision and goals, attention to how power is shared, attention to how responsibilities in planning and decision-making are distributed, and open and honest two-way communication and sharing of information.

Family and youth involvement has developed in response to significant obstacles to accessing optimal care and include the following:

- Stigma around mental illness results in people not talking about their children experiencing emotional disorders, and not seeking needed care when it is available
- Shame and guilt result when youth and their families feel that their children's emotional conditions are sign of weakness, and the result of their failings. These beliefs and attitudes prevent care from being sought. Moreover, when care is received, these attitudes can adversely affect engagement in care, and the development of constructive relationships with providers
- Blame is expressed by providers who attribute the origins of a child's emotional condition to parental failings. These attributions can adversely affect engagement in care, and the development of constructive relationships with providers
- Ethnic and cultural discrimination persist in many aspects of American society, including the mental health service system. Discrimination can influence the identification of need, attributions about the origins of disorders, access to care, and the quality of care.
- Mental health care is not always accessible. Financial barriers (i.e. lack of mental health insurance coverage) prevent children and their families from accessing prevention and early intervention services. In some situations, care is only available under the most dire conditions and only in limited scope (inpatient or residential).
- Care is often fragmented across numerous child and family serving agencies including schools, public health, child welfare, and probation, in addition to mental health.

<sup>9</sup> Mental Health Services Act, Section 4, 5840 (1).

<sup>10</sup> Mental Health Services Act, Section 4, 5840 (e), Section 8, 5820 (g) (h), Section 10, 5845 (5).



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- When care is accessed, the interventions that are offered and provided may be redundant, imprecise or ineffective.

The defining feature of family partnership programs is that youth with emotional, behavioral, and mental health conditions and family members operate them. The lesson learned when one has experienced a mental health condition and accesses care distinguishes the activities of family partnership programs.

The development of family partnership programs originates within children's system of care. These programs share the common goal of transforming the service delivery system in order to promote optimal outcomes for children and their families. Family partnership programs may differ in terms of how they are intended to impact the system, but have many means for achieving a set of common ends.

## **Recommendations:**

1. Each California County should fund a local family-run partnership program to provide an array of services to youth and their families. The following array of activities of family partnership programs were identified by the SAMHSA Infrastructure Grants through the Government Performance and Results Act (GPRA) data collection:
  - a. Training: Conducting conferences and workshops, and supporting family members and youth to attend training events. Youth, families and providers may be participants.
  - b. Information and Referral: A process, either by phone or in person, to offer family members/youth information about mental health disorders or services and supports provided to family members.
  - c. Newsletter or Information Dissemination: The distribution of information about mental health disorders, services, systems, and so forth, through a newsletter or some other format, either electronically or by mail. Youth, families and providers may be recipients.
  - d. Support Groups: Facilitated groups, attended by family members/youth, for the purpose of offering information or support.
  - e. Individual Advocacy Support: One-to-one assistance provided to a family member/youth by a family partner staff. Assistance, support in an IEP or care planning meeting, filing an appeal, and so forth. Distinguished from Direct Service because Individual Advocacy is independent of the youth's service plan, whereas Direct Services are part of the service plan.
  - f. Web-based Information: Responses or "hits" to a family partnership program's website. Youth, families and providers may be recipients.
  - g. Outreach and Celebrations: Community events either sponsored by the family partnership program or sponsored by others, in which the



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- family partner is a participant. Events may be celebrations, like “Mental Health Month” or educational, like a “Service Fair”.
- h. Administrative Activities and Program Oversight: Family members/youth who actively participate in administrative meetings, planning committees or other program oversight activities sponsored by a provider agency.
  - i. Inform/Influence Legislators and other Policy Makers: Participation in efforts to educate or influence an elected official concerning a mental health or related issue.
  - j. Direct Service: One-to-one service or support provided by a family partner of the local partnership program who is part of a treatment team. The direct service or support is part of the youth’s service plan.
2. A unique and key feature of a children’s system of care planning model is family involvement. The best way to achieve outreach to families so they recognize the early signs of potentially severe and disabling mental health conditions in their children is by a peer-to-peer, or self-help, approach. The statewide family organization should be utilized to provide training to local family partners using a standardized family educational curriculum designed to be taught to family members by other family members.
  3. The statewide family organization should be utilized to provide ongoing technical assistance to local family partnership programs to assist the local family-run program in building capacity to provide advocacy, educational, and support services to local youth and their families.
  4. In order for family members to work within a public child-serving agency to help improve outcomes for children and their families, they will require training in the core skills necessary to be competent in a “parent partner” role. The statewide family organization should be utilized to provide a training curriculum designed to provide parent partners, and the practitioners with whom they collaborate, the core skills necessary to be competent in their roles within family partnership programs.
  5. In order to increase the number, capacity and effectiveness of local family partnership programs, the statewide family organization should be utilized to evaluate the effectiveness of the local family partnership programs. Outcome data reports can be used as part of trainings and newsletters, and to enhance efforts to influence legislators and allocations to build the capacity of family partnership programs in California.

## 5. Stigma and Discrimination Awareness

The Mental Health Services Act provides Californians with an opportunity to address the discrimination and stigma associated with mental illness.<sup>11</sup>

<sup>11</sup> Mental Health Services Act, Section 4, 5840 (a), (1) (3) (4)



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Stigma and discrimination related to children with emotional, behavioral, and mental health conditions undermines effective access and use of mental health services in the community. Regrettably, stigma and discrimination is often pervasive, both in the community and among mental health care workers, and forms a real barrier to quality care.

The negative consequences of stigma include discrimination in education, health care, at home, in school, with peers, in organized community recreation, in clubs and associations, and leads to loneliness and increased feelings of hopelessness. The end result is that children and youth are reluctant to seek help, less likely to participate in their own treatment, and are slower to recover their self-esteem and confidence. Tragically, this can lead children and youth to suicidal behavior. Therefore, we must appreciate that stigma and associated discrimination form a real barrier to positive outcomes and can even be fatal. There is a real need to find and develop more ways to combat stigma and discrimination in order to generate action to prevent or eliminate stigma and discrimination from the community and in the mental health care work environment.

## **Recommendations:**

1. The public mental health system should take the lead in undertaking a review of their policies, professional codes of conduct and practices and make appropriate changes to eliminate stigma and resulting discrimination in the public mental health care system. Procedures for taking action against those who discriminate should also be put into place. The monitoring of such policies, professional codes of conduct and practices should form part of the county reports to the State Department of Mental Health.
2. Training of mental health care providers on dealing with stigma and discrimination should be undertaken, and should be provided by client and family organizations.
3. This effort should reach out to professional bodies such as psychiatric associations, nurses associations, social work and child and family therapy associations, union organizations representing mental health care workers, business coalitions, and other associations related to mental health care encouraging them to adopt codes of conduct with respect to stigma and discrimination among the population they serve.
4. The State Department of Mental Health Ombudsman Office should strengthen mechanisms whereby people who have been stigmatized and discriminated against can confidentially make their complaints.



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5. Every agency and program should develop an outreach program to discuss stigma, discrimination and any human rights violations. Client and family organizations can provide training on how to address the issue of stigma and discrimination in the daily work environment. Fear, one of the building blocks of stigma, can be reduced when people see that having a mental health condition does not define one's life.
6. People living with, and affected by, mental health conditions bear the consequences and face the impact of stigma and discrimination continually throughout their lives. Sharing such experiences allows for community understanding of how mental health conditions changes peoples lives, humanizes the disability and allows people to reflect upon how they and their society respond to mental illness. Mechanisms to formally share this information should be put into place.
7. Documentation of stigma and discrimination should be encouraged. The web sites of agencies and programs working in public mental health should be encouraged to carry a page on stigma and discrimination, outlining the basic issue, programs and projects, and the successes and failures of these programs and projects. These sites should also contain space for reporting on acts of discrimination.
8. General public information campaigns should be put into place, both at the state and local levels, decreasing the myths and misconceptions about mental health conditions. There is a continued need to let people know the basic facts. Ignorance of the facts leads to fear, which, in turn, adds to stigma and discrimination. As part of this process, general public information campaigns on the etiology of mental health conditions and on effective prevention and intervention services are essential.