

CALIFORNIA ASSEMBLY BILL 3777

Legislation Supporting People Experiencing Mental Illness

What Helps?

Professionals and users of California mental health services talk about what they are learning.

Participating Organizations:
Ventura County Mental Health • Ventura
Village Integrated Service Agency • Long Beach
Stanislaus Integrated Service Agency • Modesto

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**"One time, I ran away from the state mental hospital....
An ambulance brought me back. When we pulled into the
hospital, the ambulance driver turned and looked at me.
'How can you stand being here?' he said. You know, I realized
I'd been in there so long I was actually starting to think it was a
cool place. It's like its own crazy little world. It gets to you after
a while. Now I know better."**

*3777 Project Participant,
Ventura County Mental Health*

**"I've been doing this work for 28 years, and I see the same
people again and again. They get lost for a while and then show
up again in some other program. We've got to get people back
into society rather than circulating them through the systems
and programs for years and years. There has to be a better way.
I'm hoping this is it."**

*3777 Project Employee,
Village ISA, Long Beach*

Introduction

In 1988 the State of California passed Assembly Bill 3777, the purpose of which was to create innovative and cost-effective ways of providing support for people in California who are experiencing serious mental illness. The California Department of Mental Health, designated as the managing agency of the 3777 project, chose three organizations in three different communities to be the project sites. They then challenged each organization to design and deliver, from the ground up, a system of services to help the mental health service users who lived in their community. The organizations weren't required to stick to the conventional ways of doing things and were encouraged to use the best ideas they could come up with. For a mental health agency, this opportunity was the chance of a lifetime.

It is now almost four years later. What has happened in these communities? Were the services these community organizations provided really different from services in other places? How have employees in the organizations changed? What have they learned about what really helps people who use their services? What new skills have they learned?

This booklet takes an inside look at the people who deliver services as part of a 3777 project site. It is also a chance to hear from the people who use those services and find out what they have to say about this new way of thinking.

We hope you enjoy reading this booklet.

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Acknowledgments

So many people have contributed to this booklet. We have repeatedly been moved by the stories of people's lives, both those who use mental health services and the employees of the participating agencies. We hope this booklet accurately tells the story of the 3777 project—what it has accomplished and what it means to learn to provide "client-directed" services. Special thanks to Martha Long, Cathy Geary, and Jody Roberts for helping to coordinate all the interviews. Also, thanks to Dee Lemonds and Vince Mandella for their suggestions on editing and organizing the contents.

Talking with the Project Manager: An interview with Vince Mandella

Vince Mandella has overseen management of the 3777 project since it began. He is currently Chief of the Outcome Demonstration and Evaluation Branch in the California Department of Mental Health, where he has been employed for 23 years. With his early guidance and direction, Vince has provided support for designing and implementing creative new strategies for service delivery in 3777 programs.

How did the 3777 project get started?

In 1986, the Lieutenant Governor convened a task force to look at services for people experiencing serious mental illness. The group was gathered because mental health services just weren't working very well. There was no such thing as a "satisfied customer." It's important not to blame any one party, but the whole system just wasn't working. The primary recommendation that this group developed centered around the idea of something they called an "integrated services" agency. This means that there would be a single agency that would take responsibility for supporting a client in identifying and making the changes he/she needed to make in their life. I mean their whole life, not just whatever mental health services they might request. Because the idea of an integrated service agency was so different from the usual mental health service system, this group decided that it would take an entirely new kind of organization, small in scale, with a totally different perspective on what a "good service" would be like.

What were they trying to fix with 3777?

Many things. They were trying to address a general lack of accountability in mental health services, service provider unresponsiveness to client requests, lack of coordination between

agencies—all the things that happen when large systems start to get out of control.

What would you say is the largest difference between 3777 and other agencies?

One simple thing: The idea that the number and quality of relationships that any person has in their life is really what is most important. The 3777 agencies hold a value that says that they need to help people to build relationships and decrease the isolation and loneliness in people's lives. They believe that the only way service users will become less dependent on systems of care is when they have a larger network of friends and connections to depend on. This is a very major change in philosophy, and one they are still working on to understand and implement. It's not as easy as it sounds because of the many organizational changes that become necessary to really implement this idea.

In what other ways are 3777 agencies different?

In two other primary ways. The first one is hard to describe, but it has to do with a change in the relationships between staff and service users. When you visit one of the three 3777 agencies, you will notice that employees now tend to be in more "equal" relationships with clients: They don't see themselves as being better, or smarter, or more competent than the people they are serving. The organizations hold a value that says that we are all people who live in the same community, we all need some support, and we're in this together. It's not as hierarchical as traditional mental health agencies.

Second, there has been a major shift in what we call "treatment." Staff now

look at the person receiving services as a whole person; they don't just focus on the presenting symptoms. Where the person lives, helping them establish and maintain relationships, working—all of these things are just as important as the treatment for whatever illness they have been diagnosed with.

What is the biggest obstacle in replicating these changes?

The training and retraining needed for staff to be able to implement the values and techniques skillfully. Many mental health professionals are intimidated by taking on any accountability for anything beyond clinical treatment. Most professionals have not had sufficient training to feel comfortable assisting clients in building and maintaining friendships and connections, finding jobs, locating housing.... Many of the changes that employees need to go through challenge ideas they have held as true for many years. There is always a resistance to new things, especially when the new thing threatens the hierarchical systems of authority and control that have existed in the past.

What have you personally learned?

I just mentioned that the most important change in 3777 programs has been the recognition that the whole idea of relationships is really what is important. I have to tell you that I now see that my business—our business—is actually about enabling people to build and keep relationships. That's something that I have learned along with the agencies involved in this project.

Is this going to effect the state system?

It already has. It's not hard for folks to see that the approach rings truer in some ways than do traditional service systems. For many people, the difference speaks for itself. Some counties have elected to adopt the 3777 philosophy, including the values, the organizational structure, and the staff training. Our biggest county, Los Angeles, has just let several contracts that will provide services modeled on the 3777 idea. •

How this booklet is organized

The 3777 programs are built on the idea that all mental health services should be "client-directed." The California Mental Health Master Plan defines seven main principles for a client-directed service. This booklet looks at how each of these seven principles has changed the way the 3777 programs provide services.

Seven principles for "client-directed" services:

1. **Service users have the same rights, privileges, responsibilities, and opportunities as other citizens.**
2. **Service users determine what they want help with, and have authority over all decisions made about their lives. If a service user chooses, family, friends, and others will be invited to offer help and advice.**
3. **People experiencing mental illness must be seen as members of families and communities. Services should be designed to avoid removing a service-user from the place he or she calls home.**
4. **Service users have the right to receive treatment in an environment that most benefits them.**
5. **Service users are fully informed and involved, and voluntarily participate in treatment.**
6. **Service users have an individual and a team responsible for their support and treatment.**
7. **Service users have access to an advocate who helps protect their rights.**

What is the difference between "client-centered" and "client-directed" services?

"Client-centered" services are directed at a person, and assume the person has little choice or control over what happens. Things are done to a person—as "medical treatment"—based on the underlying belief that the service provider knows what is best for a person.

"Client-directed" services means that clients choose, control, and direct the services offered to them. Healthy people exercise choice and control over their lives; it is the service system's job to provide the support necessary to allow clients the same freedom. Client-directed services allow people the dignity of managing their lives.

PRINCIPLE

1.

Service users have the same rights, privileges, responsibilities, and opportunities as other citizens.

Are people who are labeled as experiencing a serious "mental illness" given equal status in your community? When a mental health system labels a person, for some community members it means that the person no longer has certain rights. For instance, some people believe that an individual experiencing a mental illness should not have the right to decide whether to seek psychiatric therapy, or the right to decide whether or not to take medication, or

where and with whom they live. We sometimes forget that a person experiencing a serious mental illness is a person, not an illness.

Each person has the right to decide what is best for him or her, even though these decisions may differ from what family, friends, or professional caregivers believe is best. As people who are labeled as having a serious mental illness become more vocal about their right to live and work in nonsegre-

gated community places, mental health systems are beginning to question the old ideas that have typically resulted in people being segregated into special programs, with rules that confine them and take away their basic civil rights.

This Principle asks that all community members begin to offer each other mutual respect and support as we go through our lives together.

Interview with: Lyle Huntley

Mental Health Worker
Stanislaus ISA

Why do you think it's sometimes so hard for mental health professionals to treat clients as equals?

For two reasons. First, you are taught to be separate in the psychology classes. The teachers tell you not to talk to clients when you see them downtown. They say you won't be able to be objective if you do.

The second reason is harder to talk about, but I really believe that professionals who cling to this kind of separateness have problems of their own. They have never really learned how to form real friendships with anyone, so they find all the reasons they can not to do it with clients, either. I notice it in the office. These folks hardly ever show up at social gatherings of employees. They are quiet in meetings, and don't have any close coworker friends. As long as it's a "therapeutic" relationship, they do great because they don't have to have a

real friendship. They feel safe as long as they can just give people advice or hand out medicine. But the way I see it, their own problems in having real relationships are what is keeping them from being successful in this kind of work. Some of these people tell me directly that I'm crazy for doing what I am doing. They confront me. But I can see they are afraid.

In your current job as a case manager, what has been the reaction to your style from more traditional case managers and therapists?

They told me I was out "on the edge," where I shouldn't be. They said I wasn't supposed to have close relationships with clients and should keep a distance. But I never did believe in that. People still tell me I shouldn't have these

close relationships. I do some things that irritate some other professionals. I really believe that you need to do whatever it takes to spend time with a person right when they are starting to go into a down cycle. That sometimes means you have to meet someone in the evening... I have seen many times that the half hour you spend having a cup of coffee with a person at the beginning of

"I do some things that irritate some other professionals."

"[Some mental health professionals] have never really learned how to form real friendships with anyone, so they find all the reasons they can not to do it with clients, either. They feel safe as long as they can just give people advice or hand out medicine."

Lyle Huntley, Mental Health Worker, Stanislaus ISA

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a cycle can mean their depression doesn't get as deep that time. Heck, I have been known to call my wife and ask her if we have an extra bed that night 'cause I got someone who needs to be with us for an evening.

Lyle, what has enabled you to see yourself as "equal" with people who have been labeled with a mental illness?

I think my learning started for me when I was a Baptist minister. I saw that the church didn't really welcome people with mental illness. Also, I believe that there is a deeper thing going on in some ministers that says that mental illness has some demonic tendency. They wonder if mental illness is maybe evil in some way. But I realized that all people were deserving of friendships, so I started treating everyone as equal and didn't distinguish between people who were labeled with mental illness and everyone else. I really believed that I had to stop seeing these people as unreachable. So, on a day-to-day basis, I started building some friendships—just treating people like neighbors. And I started to see how great it was.

So the major change in you was...

The shift in my mind was that people with disabilities are just as deserving of friendships as I am.

Can you give me an example of the kind of relationship with clients that you are talking about?

My friend David is a young man who, when I met him, was in a Board and Care home—going nowhere and doing nothing. I just started going out and having coffee with him. I didn't have any goals in mind for him or any advice I wanted to give him. I just wanted to sit with him and spend some time. After we did that a few times, he mentioned that he might want to get a

job. So I helped him to get a job at our office doing some janitor work a few hours a week. He slowly started to build up his hours until it was almost full time. After a while, I noticed that transportation was a problem. I asked him about it, and he said he used to have a license and would like to get one again. So we started studying together,

and he got his license back. A few months back, he was over at my house. He looked out the back window and saw my old '78 Honda in the backyard and asked me about it. I told him it had a blown engine and was going to the dump. He asked if he

could buy it, and I told him that he could have it since I wasn't going to fix it up. So now he's working on it and will have it running in a while. As I look back, all these changes in David's life have come about because of our friendship, not because I was his case manager, or because I had some advice or knowledge to give to him. All I did was spend time with him and listen.

"As I look back, all these changes in David's life have come about because of our friendship, not because I was his case manager, or because I had some advice or knowledge to give to him."

"Other people who have suffered from discrimination are often more willing to hire a person with a mental illness. I think it's because they, too, have experienced the pain of rejection and being excluded."

Esther Yelton, Psychosocial Specialist, Village ISA

What professional skills do you think contribute the most to enabling people with mental illness to get equal status? Before anything else you have to believe down deep that there is hope. I think a lot of professionals believe they are baby-sitting people with mental illness—that it's basically a lost cause. Second, you have to be able to think clearly and truthfully. And third, you have to have a good ability to be on the lookout for all the different ways that people can learn. •

Mental health service users tell us...

How does it feel to be shut out from your community and not treated equally?

"I feel cool as ice."

"It makes me draw back inside myself and not fight back."

"I feel like a corkscrew... I go down deeper into paranoia and isolation."

"I feel invisible."

"My symptoms worsen when I am isolated or segregated."

Tell me, Doctor: are patients and psychiatrists equal?

Miller: Part of what makes the therapist look so impressive is the attitude, "I'm only here for you. I'm not here to talk about myself."

Rusk: Which is ludicrous from the coaching point of view. You have a problem with your backhand and you ask your tennis coach, "Can you show me how to do this? How do you hit a backhand?" What if she said, "I'm not here to talk about my backhand. I'm only here for you." Ridiculous!

If I'm talking about myself just because I have a problem today, and I'm unloading it on you so I can feel better, that's obviously not ethical. But often I will bring up some difficulty from my personal experience, and a client will say, "That's exactly like what I'm going through." If I bring up experiences that are like those of my clients—especially if I've resolved those situations to some degree—it's a lot harder for them to see themselves as alone in the world, defective, or cornered with no way out.

Excerpted with permission from "Replacing Therapy, a conversation between D. Patrick Miller and Tom Rusk." The Sun, Issue 201, September 1992

Interview with: Cheryl Rothwell
Mental Health Associate, Ventura County Mental Health

Everyone that we talk to tells us that you have a great ability to see all people as equal: you don't draw any distinction between staff and clients. How did you come across that ability? I know this will sound weird.... It's nice of you to compliment me, but I think that ability comes a lot from being really spoiled as a child. I always just assumed people would do whatever I asked them to do. How that translates into my adult life is that I believe people have the capacity to do whatever they need to do. I don't assume I will be doing it for them.

Also, I think my family was special, in that we had lots of different kinds of friends. My Dad was an artist, and he drew lots of what I would call "characters" to our house. We weren't prejudiced in any way.

"I can tell you right now that my bed is unmade. Does that mean I need a case manager?"

Why do you think that some professionals have such a hard time treating clients as equals?

I think it comes from a philosophy that people with mental illness are children—incapable of doing things for themselves. I fight that in myself, and I can sometimes be very controlling. It's easier for me to tell someone to do something or do it for them than it is to help them to do it themselves. It's much easier for me to pay someone's gas bill than to watch them not pay it, get their gas shut off—and then I have to help them get it reconnected. But the whole point of 3777 is to help people to do things for themselves, and that sometimes means things are harder and take longer.

Part of what's frustrating for me are the traditional guideposts that have been used to assess whether or not someone is "making progress." Some of the assessment items are very foolish. For instance, I can tell you right now that my bed is unmade. Does that mean that I should have a case manager? And would that case manager be mad at me?

If we want to treat people as equals, then we should also start helping clients develop supports that are really an important part of their lives. •

Hey! Where did all my rights go?

We lose personal power if we:

- **Let others speak for us when we can speak for ourselves.**
- **Let ourselves be over-medicated.**
- **Live in an isolated or segregated world.**
- **Let others decide what is best for us.**
- **Are labeled or described with derogatory language.**
- **Believe we don't have any power.**
- **Get help from systems that offer limited solutions.**
- **Aren't listened to when we speak.**

PRINCIPLE

2.

Service users determine what they want help with, and have authority over all decisions made about their lives. If a service-user chooses, family, friends, and others will be invited to offer help and advice.

How often have you been in a situation in which you felt like someone was telling you what to do? How did it feel? Many people experiencing mental illness are told what to do most of their lives. This is because traditional mental health services are designed around the idea that "sick" people need the help of experts to get well. Professionals gather in teams to diagnose and prescribe a cure for a client. These experts typically tell clients what they need to do to improve their lives, and then monitor

the clients to be sure they comply with the advice.

The 3777 programs are doing things differently. The 3777 programs are built upon the belief that clients, when given the opportunity and support, can determine what they want to change in their lives, and what help they will need to accomplish these changes. The progress that clients make is based on life changes *the clients* have said would be good for them to make, not the changes that experts have told them to

make. The 3777 programs also have acknowledged that client's families, neighbors, and friends have important insights to offer, and may be able to use their personal connections to help. If clients choose, program planners help gather these people together to offer advice and help.

This Principle describes how this new planning process can work.

What's Different?

Five planners tell you what they are learning.

Editor's note:

To get an idea about how planning methods are changing, we talked with five employees of 3777 projects. Beth Wallace, Mental Health worker at Stanislaus ISA; Kim Mallock, a former Clinician at Stanislaus ISA; Mary Moore, Rehab Therapist at Ventura County; Laurel Carr, Team Leader at Village ISA; and Karen Richardson, Occupational Therapist at Ventura County.

This Principle is really about how plans are made between the client and the agency. It brings up the questions of what a plan is and who has control of the process. Let's start by trying to define what a plan is. That may be harder than it sounds.

Mary: Plans mean different things to different people. The basic purpose, I think, is to clear up the reasons for doing business together. It also helps clients to understand that there are people here who care about meeting their needs and are aware of who the person is and what their desires are.

Kim: The truth is, though, there can be conflict in planning when the agency needs to get something out of the process that the client isn't there for. There are two ways this can happen. First, when the plan needs to have certain data in it so that the evaluators can measure whether we, as an agency, are doing a good job or not. So we have to ask dumb questions that don't really have much to do with why the person is there. The second way it happens is when staff try to manipulate a person

into including something in their plan that they don't really want. You know, when we started out doing the planning process, the agency attempted to force clients to focus on things that the employees thought the client should be working on. We have gotten better at really listening to the client, though. We learned, I think, that if you give people

a chance and really listen to them, they will come up with realistic goals that we can all work on together.

Karen: Who does the plan serve? The service-user, parents, the agency, MediCal, hospitals, employers—many individuals and companies. As an occupational therapist, I have a holistic—or systems—view of planning. This means that it's important to look at all the factors affecting a given situation in a person's life. Although the service user's goals are primary, the other players' objectives represent potential constraints or opportunities in the person's life. For

"Clients have enough road blocks in their lives without our making it more complicated."

Kim Mallock

example, plans that include advocacy may turn neighbors' complaints or police involvement into needed support. Their involvement may never appear on a plan document but may, in the end, be more crucial than medication in its positive effect on the person.

Other conflicts are harder to deal with. Frequent changes in housing, employment, hospitalization, and police contact may be an expected and necessary part of a person's life experience, but may also be

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at odds with the 3777 project outcome goals. Also, the planning process can be very different, depending on the perspective and values of the staff person who is helping to make the plan. On the whole, I think there are two camps. One is the rehab camp—people who support the service-user in taking reasonable risks and learning new things. The other camp is the traditional medical model camp—people who don't rock the boat; who protect, do for, and take care of. Stability is viewed as good, even if the client is going nowhere. These influences make planning a very complex process. In the end, though, very few service-users get adequate plans and service from us because of expertise and time limitations. Those that do get adequate support, and are successful, give us hope and fuel our persistence.

Laurel: A plan helps you to focus and direct your energy. We have also used it to look back with a client and see how far they have come. It's so individualized... It helps us not to compare one person with another.

How much time do you spend doing what most people would refer to as formal case management plans?

Beth: When you get to know people better, the big planning process isn't as essential as it used to be. It makes everything more complicated than it needs to be. It's frustrating, because the organization is trying to make [the planning process] a tracking tool to show what we are doing, but that doesn't necessarily support the client. The tracking tool is for the organization. Again, we run up against the idea: Who are we really serving here?

But I'm spending more time just developing relationships with people. Just spending time. It seems like we are all shifting more to just day-to-day, because that's how we all live. It makes our bosses crazy, though,

because it's hard to project costs and show what we are doing.

Mary: I'd say that I spend about 90 percent of my time supporting people—talking with them and helping them do things. So that means only about 10 percent of my time is spent in actual

planning. I really see the planning part as an overall framework.

Laurel: We do most everything informally, on an ongoing basis. For

example, if a client wants to spend some time working on an activity, I try to help them figure out what they are trying to learn and what it would take. I just helped a member figure out how to get some artwork framed for sale.

How has planning changed in the last few years? What trends are you starting to see?

Mary: I see the clients' needs changing... As a whole, they have risen a level above basic needs. People really are making progress in the last few years. In many cases we have helped people accomplish their basic needs. Now, clients are starting to want all the things that all the rest of us want—two dogs, two cars... It's a harder thing to work on. The process is getting more difficult.

Kim: It takes a high level of commitment and energy to do good planning. One thing that I have started to think about is the question: How long can you work with a person and not get burned out? It can become a real roller coaster ride because you are so close. Everybody has their own personal boundaries.

Laurel: It's different because I have changed. I found out that members are capable of a lot more than I had given them credit for. I have also started

to understand that people can take risks. I now see that my previous job was to

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"Again, we run up against the idea: Who are we really serving here?"

Beth Wallace

"I now see that my previous job was to shelter people so that they wouldn't decompensate."

Laurel Carr

"When you are helping people to make plans for their lives, accurate diagnosis of the person's illness is very important. When you work on your car, it doesn't help to fix the muffler if the carburetor is broken. In the same way, incorrect diagnosis of a person's illness can lead to non-helpful and sometimes harmful recommendations for treatment. Sometimes, the drugs a person is taking can mask their true symptoms. Let's not forget, these are heavy drugs—they do wonderful things for the people who need them, but if you don't need them, they tend to muddle your thinking and dull your expression. We have seen cases where we took people off medication, and their symptoms of mental illness went away. It took getting the drugs out of their system for them to be able to reclaim healthy thinking patterns and life-styles."

"This is a controversial subject area! The fact is, it's just hard to tell what's going on sometimes with a client. It's not always an exact science."

Jerry Schram, Psychologist
Ventura County Mental Health

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shelter people so that they wouldn't decompensate. Protect them.

Beth: When we started, we thought we would include all kinds of people—like what is called “personal futures planning.” But it has turned into a much smaller scale. It's hard to keep the planning process from being a task and to keep it alive. It's a due date thing. We don't necessarily say yes to everything. We don't do as much for people as we used to—we're not so codependent. The plans are more real.

Do you include families, neighbors, and friends if the service-user wants to? What effect has that had on the planning process?

Karen: The involvement of others happens when the need arises, in a natural way, in the context of life. The greater the circle of participants, the clearer the picture of needs and potential outside resources becomes: plans get better and more relevant as we learn more.

Mary: I've found that very few clients will take the initiative to invite other people to participate. As staff people, if we want it to happen, we have to value that idea and totally support the client in pursuing it. This could be a skill deficit on our part; we're not very evolved in that area yet.

Kim: It's always helpful to have family and friends there. I remember those meetings as being the best ones. In retrospect, those were the plans that were followed through on, and the goals were reached.

Beth: There are some negative things that can happen, also. A lot of times the client will still say what their parents want them to say...

Oftentimes it's things they don't really want to do. We write them down, and they don't ever happen. Then the families get frustrated with us... It has caused us to get into some adversarial relationships with family members. Once those negative relationships start to happen, they can be hard to shake. Also, because we don't rely so much on formal

plans, sometimes the families can begin to get suspicious of us—not believing that we are doing enough for their son or daughter. My team has had some extremely upset family members. I've gotten to a place that you have to let go and have respect for the family who has lots of years with the person. The family is always there and will be there when I am gone. I really value their experience.

Let's get a little more personal. What are you trying to get better at? What skills will help you to do a better job?

Laurel: I am working on increasing my ability to let go of the feeling that I need to be so involved directly in people's lives. Accepting and allowing them to take more control. Not having me do for them all the time. Often, it's the little things. I used to write the plan and have them sign it; now they write it and I sign it. I'm learning that when we let go, it works out.

Mary: I'm working on empowering the client. That's been difficult for me to learn; coming into this process I saw people as needy clients. It was much easier for us to just do things for people. Since we know clients so well... it's almost like having a friend. It's a lot more

“You don't have the same professional boundaries. Some staff have a difficult time with that transition.”
Mary Moore

difficult of a balancing act for us to know what to do. Also, it's different because we go to clients now rather than their always coming to us for day treatment. Clients perceive you differently when you come into their environment rather than they come into yours. You don't have the same professional boundaries. Some staff have a difficult time with that transition. Some service-providers balk at having

real relationships; we're not prepared to do that. The service-provider's level of comfort has a lot to do with the success.

Kim: The key is that you have to believe that you can empower the client. It's really easy to say but not so easy to do. It's something that I found myself asking all the time: Do I need to be doing this? There is such a strong

urge to help, and a lot of the folks expect it of you. Our program created some dependency in some areas because there were close relationships between people. It's just hard to say no sometimes. I'm trying to get better at understanding what empowerment means.

Beth: The most important thing is for the client to believe that you are not going to treat them like the typical mental health system would. I'm trying to get better at helping build the trust between the client and me. •

“We need to avoid resenting the extra work caused by a service-user's mistakes, as they struggle to figure out how to do things and reject our recommendations. We can be clear about the limits of what we are willing to do, without being punitive. For instance, we need to stop saying, “That's your last chance. You can't do that anymore.” As servants, we need to avoid letting our personal experience of the workload influence their plans. What this does is open up the whole thing of doing things right: Can the system accommodate the work involved in really doing it right?”

Karen Richardson

“...we talked about wanting to be nontraditional in planning processes, but we didn't know what that meant. As it turned out, being nontraditional meant not thinking much about formal processes.”

Kim Mallock

PRINCIPLE

3.

People experiencing mental illness must be seen as members of families and communities. Services should be designed to avoid removing a service-user from the place he or she calls home.

Too often, treatment for people experiencing mental illness is designed as if the person has no life outside of their illness. It's as if what matters is only the illness and controlling it. In many cases, clients are removed from their families and neighborhoods to receive treatment in a special place for people who have a mental illness. This may mean going to a large institution in another part of the state or moving to a boarding home on the other side of town. Regardless of the

size, these places may afford little opportunity for the person to maintain contact with home, neighborhood, and friends. Over time, clients lose their connections with their home community. As their isolation grows, the symptoms of mental illness often increase, making day-to-day life difficult.

Clients need to be recognized as whole people. Their illness is only a small part of who they are. When services are

focused exclusively on containing the illness, it is hard for clients to see themselves in a healthy way. Supporting clients in maintaining their ties and staying in their own community has become a critical part of what clients say is helpful to them.

In this Principle we hear about how hospitalization can be avoided—and why it should be, if possible.

**Interview with:
Guadalupe Denette**

*Mental Health Associate
Ventura County Mental Health*

You have been able to reduce hospitalization in many cases. How have you done that? What have you found that helps?

We do it by having many contacts—constant interaction with people. After a while, you get to know the person—you develop a relationship. Once you have a relationship, you start to build trust with them. When there is trust, then you can start to work well. They will be more open and sharing with you—more willing to tell you what is really going on. It takes time, but it's worth it. If one of my clients is experiencing paranoia, he/she knows that she can call me and communicate her fear rather than wait until it's too late. I believe that trust can override paranoia.

Some people will say that what you are talking about isn't true. They will say it doesn't make that much of a difference: the client will cycle no matter what you do.

No! Wrong! With proper support not everyone should cycle in and out of the

hospital. People with bipolar illnesses need extra support because they tend to cycle up and down, but they need not go to the hospital every time. It takes planning, preparation, and family support.

Can you give me an example of a time when you have avoided sending a person to the hospital?

You know, I have a lady who refuses to go to the hospital. She says to me, “Don't ever send me to the hospital. I had a horrible experience there once.” So we have that understanding with her husband and her children. So when she starts into her cycle, we now treat her at home. The doctor in 1990 said she should go to the hospital. But she said no. We talked to the husband, and he agreed to keep her at home. I recruited her two daughters—they are in their thirties—and they said, “Hey we'll take care of Mama at home.” So we developed a plan of support with the doctor, we stayed in close contact with the client, and we told the family exactly what to do. It all worked out well. If you have people who will stand by you to help, you can do it.

“When I was in the state hospital, I felt like I was dirt. The other people there were disrespectful, food was thrown at me, and people were always making assumptions about me because I have a mental illness. A lot of the staff were good, but some of them don't have their buttons about them. It's time for the federal government to come to its senses. Clinton should shut that place down. The help I need is out in the community. It is more realistic. You know, I think I might write to Clinton and ask for reimbursement for my time in the hospital and all the services I didn't get.”

Joy Makelim, Service User,
Ventura County

Continued on page 14

Continued from page 13

Some of the clients we talked with told us that it was easier to get well when they weren't in the hospital. What has your experience been?

The environment at hospitals can be detrimental to recovery. When I walk inside I can feel the impact. My senses feel that change—it's depressing. Let me tell you something. There is a young girl I know who was hospitalized for almost 50 days and she wasn't getting well. They were going to send her to a locked facility and we said "no." We made arrangements for her to go home and figured out a way to help her there. She went home and got well. At the hospital she often refused to go out of her room. Once she got home, she improved tremendously. We don't talk about it too much, but in this case, like many cases, I think there were language and cultural barriers in the hospital that prevented her from getting well. We need to learn more about that. •

We have all known the long loneliness, and we have learned that the only solution is love and that love comes with community.

Dorothy Day,
The Sun, Issue 207,
March 1993

"Recovery can only take place within the context of a sane environment, an environment of compassion and appreciation. One's home can become a household for recovery."

Edward M. Podvoll, M.D.
The Seduction of Madness

**Interview with:
A Service User**

Ventura County Mental Health

What did you think about yourself as a person when you were in the State hospital?

Well, you get so few choices about anything that you get introverted... I didn't really care about much. The staff people are mostly nice to you, but you get the feeling like they think you are in there because you can't get it together, so why should they bother spending time trying to help? It doesn't make you feel like a good person. Another problem I had was that my head was screwed up, so I couldn't keep my facts straight. I had some trouble with some people in there, but I couldn't keep my facts straight in order to explain to them what was going on. It was so confusing.

What about your friends? How did they act when you were hospitalized?

I didn't want to tell them where I was. I didn't want them to see me like that. One friend came to visit, and it really hurt. I was in my pajamas, with leg restraints on. You just don't want

people to see you like that. I didn't even want to see my sister. You just can't talk to people.

Could you have gotten the same services in your own community?

I think so. Now I get therapy, just like in the hospital. I don't know what they do in the state hospital that they couldn't do at home. Listen to this: I went to the hospital because I tried to commit suicide. When I got there, they told me I could only smoke every two hours at the hospital. In the condition I was in, that made me want to do myself in even more! I know that sometimes I need someone to watch me, but if they could have smaller places, where people could really know me, it would be better.

"I know that sometimes I need someone to watch me, but if they could have smaller places, where people could really know me, it would be better."

Service User, Ventura County

What has helped you to stay out of the hospital?

I stayed out so long now because I'm getting a social life in the real world. If you want to hang around with normal people, you have to do normal things. I can't develop new friends when I go to the hospital. I've been in

the hospital about five times in the last five years. I think I'm going to make it this time... I'm doing real good. I've got a job, and I'm making friends with new people. •

PRINCIPLE

4.

Service users have the right to receive treatment in an environment that most benefits them.

The 3777 agencies are working to change four central elements of what has traditionally been called "treatment"—how outcomes and plans are developed, the philosophy and practice of mental health professionals, the locations where mental health services are provided, and the community attitude that often labels people with mental illnesses as second-class citizens. These new characteristics of treatment are, in many ways, similar to what San Diego psychologist Tom Rusk calls "guided self-change." Guided self-change depends on two modifications in perspective. The first is a new feeling of equality between client and therapist. Creating healthy, equal relationships

between clients and therapists depends in part on increased self-disclosure from the therapist. The second change is a shift from a medical diagnostic model to an educational model. This is a very important change because it means that one addresses the mental illness issues within the larger context of the person's life-style, not as an illness that is somehow separate and treatable only in the confines of the therapy session. To do this, one must have a picture of the whole person.

John O'Brien, an international human services consultant in Atlanta, talks about creating a framework for this kind of help by thinking of five areas in which to take action:

- Increasing the number of relationships in one's life
- Participating more in the community
- Gaining the power to make choices in one's life
- Improving self-esteem and how one is perceived by the community
- Learning new things

The 3777 programs are helping clients to think about these life-style areas and, within this context, address mental illness issues.

This Principle includes three themes: how treatment is changing; creating equal status and believing in oneself; and supporting desired life-styles.

How is treatment changing?

We have been challenged to reconsider the whole idea of what "helping" means. None of our education or experiences really prepared us to do and try things in this new way. For a while it was like we were faking it—privately feeling like everyone else must know but "I don't have a clue." Once we could be honest [about being] uncertain, it took a lot of pressure off and made us more supportive of each other. Now we feel like services have improved.

There was a letting-go of skills from our training and values—not just adding new skills. We had to let go of needing to be in control. It is a constant challenge.

We don't think of providing treatment anymore—the members don't think of themselves as receiving treatment. This is more of an adult learning place. People are living their lives and we are helping to solve problems and empower people to take control of their lives.

Wayne Munchel, Team Leader, Village ISA

"It's all about relationship-building... that is therapy."

Dennis Cain, Supervisor, Ventura County

The staff now are a godsend for me. I can't thank them enough. They treat me as a friend, really, like we are equivalent. Staff are open, honest, realistic, and help me with day-to-day problems. I'm a prime candidate for a job now.

Joy Makelim, Service User, Ventura County

How is treatment changing?

(continued)

We don't do treatment; we have moved from a clinical treatment model to a rehabilitation recovery model. There is almost no individual or group therapy. The medications are always designed for a functional goal. I teach people about their symptoms and their medications and empower people to decide how to handle them. It is a holistic approach or a life-style approach, where I help people with real issues such as housing, relationships, work, money issues, school, etc. The medication consultation is always intertwined with these real life issues. From a professional side we call this process rehabilitation; from the service-user side, they call it recovery. It is recovery in the sense we are helping people to recover pieces of their life.

Mark Ragins, Psychiatrist, Village ISA

Treatment is very different now—different in who we are serving and in how we are providing it. It is very different to serve people with chronic schizophrenia or who are chronically mentally ill than previous service users who had more situational stresses. My day looks so much different now: It is much more hands-on and I am almost always in the community—in cafes, people's homes, or in teaching people how to use community resources like libraries. Also, I share responsibility for each person with my team. I have been challenged to change my idea of what a social worker is. It helps to have a great deal of flexibility!

Leslie Thompson, Social Worker, Ventura County

We used to use an office-based medical model treatment system. Service users came to us, we basically told them we would try to cure them by providing therapy. With our change to small community-based teams, the emphasis has shifted. Therapy is still an important part of what we do, but now we are trying to help people to reclaim the benefits of being a part of our community—like trying to help them get the things they have been excluded from, like housing, friends, jobs. We have found that the therapy part of what we do has become even more effective as we have added the community component to what we do. Now the relationships are not confined to an office, but expanded to the community. The bureaucracy doesn't confine service providers and allows the creative stuff to flow. This has meant better outcomes for people who use our services.

Dennis Cain, Mental Health Supervisor, Ventura County

One of the new ideas we are struggling with is having service users help other service users, particularly during a crisis. Service users may, for example, respond to another service user's home when there is a crisis or possible hospitalization. A service user who has the time and also has a relationship of trust may be able to stay with another service user during a crisis, even for a few days. Of course, there are liability issues to work on here.

Jody Roberts, Program Director, Stanislaus ISA

"The beauty began to evolve for me when I realized I was going beyond my clinical skills, letting [service-users] get to know me, and getting to know them and develop trust. I increased my self-disclosure. I have used real-life examples of how I have solved problems similar to what I see people struggling with. I show them my vulnerabilities. It is a revelation sometimes to people to see that we are similar and that because they have a mental illness doesn't mean that they or their problems are so different. I think our relationship has to be more equal before we can assist people in solving some of their day-to-day life problems. We get creative in developing these relationships: We have gone whale watching, out to comedy clubs, dancing, the zoo. All of these activities help people to talk, to express their feelings and frustrations, and to get to know themselves."

Jody Roberts, Program Director, Stanislaus ISA

Creating equality, believing in ourselves:

If we want people to act more responsibly and independently, we need to act less arrogant and realize we don't have all of the answers. It takes some time for a service-user to stop looking to you for the answers.

I have a great story that shows the point. I was in training at Menninger's in Topeka, and a psychiatrist told a story that I didn't understand at the time. Now it means a lot to me. It was winter and he was taking the service users for a walk. One guy, let's call Joe, who was 20 years old and catatonic, was along. The psychiatrist kept slipping in the snow and Joe helped him several times and watched out for the puddles for him. When they returned the psychiatrist adjusted his tie, returning to his role; and Joe went back into silence and walked away stiffly, returning to his role.

I've always had this kind of approach, but I have noticed some more subtle changes with myself recently. I changed my appointment slip to read "Mark Ragins" instead of "Dr. Ragins." It reflects my interest in trying to even up the status between myself and people I help. I wear casual clothes, am informal, play volleyball and piano, and watch the Lakers with them. The response of some service users is "You have come down to our level," and I say "No, you have come up."

Mark Ragins, Psychiatrist, Village ISA

Some people need to be weaned from the staff making their choices. We want treatment to be only a small part of their life. Some service users embrace this, and others do not want it and have become very comfortable with being taken care of. In the old way, staff felt good because we thought we were needed for everything.

Marcia Yeto, Case Manager, Ventura County

I am trying to lose the big words, the mental illness jargon. It has no place in helping people. We need to get ourselves out of the role of authority and into the role of being real people who also have problems to solve. You can't get to know someone from a position of authority.

Jody Roberts, Program Director, Stanislaus ISA

Our goal is to promote independence. Years of paternalistic treatment has created some monsters in the system—not personally, but we have institutionalized people in the community, holding hands and doing things for people that they could do themselves. We have short-changed them.

Marcia Yeto, Case Manager, Ventura County

Supporting chosen life-styles:

How I spend my time is changing. Most people are calling me for help solving real-life problems. If you were to give a knowledge quiz to my service users about their medications and symptoms, most would get an "A." For example, someone called and said he took an extra Navane to help the symptoms and now it was okay again, and by the way, could I help figure out a relationship issue? It is more practical to help people with their lives when you are in real-life settings, instead of in a hospital.

Mark Ragins, Psychiatrist, Village ISA

We want service users to make their own decisions about taking medications. Yet if this results in a hospitalization, it is very difficult. Maybe it is a step for a service-user to learn about taking their medication, and the next time they may make a different decision.

Jody Roberts, Program Director, Stanislaus ISA

When you start looking at people's lives and independence, you take some steps, like helping someone move from a Board and Care to their own apartment. We had great resistance from some families at first. For example, one person wanted to move to his own apartment and his mother really battled every inch of the way. Now she comes in and tells us how clean and nice it is. The move has brought the two of them closer together.

Marcia Yeto, Case Manager, Ventura County

Helping people to get jobs, better housing, medical care—that's what we are about. The old way of providing service, which relied only on office-based therapy, just isn't enough. You need staff that know the community, and are motivated to help people to access community resources. This can't be done in an office.

Dennis Cain, Mental Health Supervisor, Ventura County

PRINCIPLE

5.

Service users are fully informed and involved, and voluntarily participate in treatment.

Most businesses understand that it is important to offer services that make sense to the customer to ensure their involvement and satisfaction. What does this idea mean to mental health service agencies? Are they businesses too? Of course they are, and they have the opportunity to either please or irritate their customers, depending on the quality of the services that they offer.

The three 3777 programs have been working hard to expand the idea that the supports offered by a mental health organization should be voluntary. They are learning how to reduce the incidence of clients being placed, against

their will, in a locked institutional setting. It takes an understanding of what a good service is to reduce involuntary placements. As these programs have grown, service providers have learned that it takes the involvement of people who use the services in order to really define what "good service" means. They have to listen carefully to the customers and structure the agency's services to meet their customers' expectations.

In order to provide a mechanism for listening and discovering what is really helpful, all three organizations involve service users at different levels of organizational planning. This involve-

ment provides service users with a feeling of empowerment, knowing that they will help to determine the choices of service available.

There are two primary themes to this Principle: client involvement in their own individual plans, and client involvement in overall organizational planning and direction. Because several other principles in this booklet focus on how to involve service users in their individual plan and supports, we have chosen to use Principle 5 to highlight some thoughts about involving service users in organizational planning.

Most of our meetings at the Village include service users, who contribute lots of good ideas. As we began integrating people into the decision-making process of the organization, at first there was some anxiety. Some of us were wondering how it would work out. It actually has happened quite easily and naturally, and has improved the morale and creativity of the agency.

Although each service user has his or her own Personal Service Coordinator, he or she can utilize the services of all staff members on the team. This increases the service user's choices and leads to empowerment.

The Village Council is the governing board run by the members. It has officers and by-laws, and includes one staff and two service users who act as representatives from each team. The Council has its own budget made up of

contributions and proceeds from fundraisers. Recently the service users on the Village Council decided to have one extra monthly meeting without staff. A result of this has been the "Staff of the month" award, which is presented at the same meeting as the service user "Employee of the month."

"Integrating people using services into the decision-making process of the organization has improved the morale and creativity of the agency."

The Village Policy Advisory Board also includes members.

We have meetings every Wednesday morning where we make announcements and share information. Service users were invited but generally

did not attend until we decided to move the meeting to the dining room in the café. Now many service users attend and participate.

Joyce Thompson, Nurse, Long Beach

"We have worked hard to involve service users in the planning of the organization. Sometimes I wonder if we are trying too hard. Often people don't want to focus on their status as a consumer, are moving away from this identity and are getting on with their lives."

Martha Long, Director, Village ISA

In any planning you do, the first thing to remember is that the organization has to value the input of the consumer. In a large organization, like Ventura County, sometimes it feels like it's hard for individual points of view to be heard. There are so many employees and so many consumers that unless there is a formal structure for receiving input, it just doesn't happen. Our Mental Health Advisory Board was restructured this year to include a greater number of clients and families in its membership. I am hopeful that they will be able to guide and advise us on what we can do to improve services.

Each one of our teams also has an advisory group composed of business people, consumers, and mental health workers. I think these advisory groups are doing great work. It's easy to see why. First, it's a small group of people, so each person can be heard. Second, they have a feeling like they can directly influence what happens to their team. And third, they all know each other, so over time there are relationships and trust established.

I have to say that the process of empowering consumers and including them in organizational decision-making has not been a strong point in mental health systems in general. The idea that clients know what is best for them and can make good decisions about their lives is a fairly recent one for us all. It is clear that we must move away from a "we know better" perspective before client and family input really becomes an integral part of the organization's planning. We, in Ventura, have already learned a great deal from our clients on this issue. In addition, the chance to get to know and spend time with staff and members of the two other integrated service agencies has been invaluable. It becomes clear that you have to get rid of some of the professional authority and control before any consumer input really becomes valued by the organization. I think all the 3777 agencies are working on that issue on an ongoing basis.

Cathy Geary, Chief of Adult Services, Ventura County

We are working to help service users to learn to use the community on their own and to rely less on the clinic. We have an advisory group called Friends of Main St. Company, the mid-Ventura team. This group includes service users, parents, business people, and some staff. The purpose of the group is to educate the community about what the team is doing and to help service users participate more in the community. We are always working toward jobs, independent living situations for people, and encouraging people to have pot-lucks and friends over for visits. Any activities that lead in this direction we celebrate as accomplishments.

Cheryl Rothwell, Ventura County

It is surprisingly hard to get people involved in organizational planning. They aren't used to having that capacity, and it is so important to keep trying. It is really at a grass roots level here.

Marcia Yeto, Case Manager, Ventura

Every policy in our organization has to be approved by our Policy Committee, with equal membership of service users, families, and professionals.

Service users in our organization are empowered. People organized themselves around a transportation problem, which resulted in the creation of a new position for a driver, which was filled by a person who uses our services.

People who use our services are represented on several levels: the general service membership monthly meetings; every committee that is established, such as a new committee just formed to look at finding a new building; the board of directors; and interview panels for hiring mental health professionals. We have done surveys to determine how people feel about services and what changes they want.

Jody Roberts, Program Director, Stanislaus ISA

Do service users' stories help us to know what a good service is?

We use our stories like maps or models: we find our way with stories in hand; we use them as our fundamental way of locating ourselves.

William Kittredge

PRINCIPLE

6.

Service users have an individual and a team responsible for their support and treatment.

One of the primary changes in the 3777 projects was in how clinical teams are organized. Each service user is assigned to a specific employee of that agency. That employee is also a member of a team. Thus, one employee has primary responsibility, but the person receiving services also benefits from the support of the whole team.

Reports from the 3777 projects indicate that the teams are beneficial to everyone involved. The team concept reinforces

the notion that regardless of our training and experiences, having several people working on a problem is always better than having just one. As staff members individually move toward using a community treatment model, the teams offer everyone an opportunity to reflect on the new approaches they are trying. Teams also encourage members to get support and suggestions from one another. As one team member said, "The time for one

person to have *the* answer is in the past." These teams are one more way that decision-making and power are extended to everyone—service users and mental health staff.

The theme of this Principle is teamwork—how it happens, and how well it works.

The time for one person to have *the* answer is in the past. If we have learned anything, we have learned that the teams work!

Our team really works. Particularly at a time when you are in new territory—you are struggling with boundaries, ethical issues, and transference at the most intense levels. To be able to trust your team and get both positive support and constructive criticism is so valuable. Our team actually shares an office together and we pick up on all of the phone conversations and everyday issues that we are experiencing. This office structure has actually kept our communication more efficient and clear. It also allows us to be very responsive

to each person because any of the team can jump in and help out. The team is what works for me.

One of our struggles since the beginning has been working out the roles of the clinician and mental health workers. All of this gets worked out with each team. Ideally, each team would have one psychiatrist who would also do lots of home visits and community work. The way it works now is that the three

teams share one psychiatrist who is actually doing more and more community work. Before, we kept him locked in the office, but that is changing.

What does member-driven mean? How far do you let people go before you say it's too risky? There have been so many philosophical shifts for us as a team. The continual struggle is focusing on the question: What does "member-driven" mean? You empower people to

make choices, and then they make some decisions that are great, some decisions that are risky. One example is medication issues. We want each person to make their own decisions about taking medications. Yet, if this results in

hospitalization, it is very difficult. Maybe it is a step that a service-user must take to learn about their medication, and the next time they may make a different decision about the medication.

Jody Roberts, Program Director, Stanislaus ISA

"The continual struggle is focusing on the question: What does 'member-driven' mean?"

"For some clinicians it's like working without a net—it's damn scary. For others it's liberating and empowering. For my team, we got through the scary part; we like it on the edge."

Dennis Cain, Mental Health Supervisor, Ventura County

As much as I have said about what we have learned, it is never completely resolved. The member-driven part of it requires an on-going vigilance. We want people to learn by natural consequences as much as possible. When it comes to risks, it is worse for the parents. It is their own flesh and blood and it is difficult to watch their son or daughter learn hard lessons that are risky.

Wayne Munchel, Team Leader, Village ISA

Building trust within the team took time. Staff, just like service-users, needed to trust each other before they opened up about their struggles. After we realized that none of us are totally capable at every moment, we were able to be a team. Now, teams have their own budgets, don't need to clear every decision with me and it all works pretty well.

Martha Long, Director, Village ISA

The human exchange is treatment.

Marcia Yeto, Case Manager, Ventura County

One of the struggles that our teams are thinking about is how to document outcomes that relate to a person. For example, maintaining a job is one example of an outcome, but equally important (and harder to measure) is deciding to seek employment, get to the interview appointment, and be on time. Another process outcome is a person developing enough self-esteem to begin to build relationships. That is a huge success, but we know we really don't show these outcomes. Outcomes of equal importance involve the process of setting, striving for, and achieving goals.

We are always working on relationship issues as the teams struggle with working toward more equal relationships with people who use services. We have learned that it is very difficult to develop a good relationship with a person if you are a payee. We have disengaged team members from having payee responsibility.

Jody Roberts, Program Director, Stanislaus ISA

We are very proud of our team, and each of us has different opinions and different personalities. It takes each of us to make it work. Some staff had a tougher time coming around. Those who couldn't do it left. I had done traditional case management for seven years, and I was unsure how things would work. It has turned out much better than I had anticipated.

Marcia Yeto, Case Manager, Ventura County

The staff on our team are remarkably resourceful. One person is the main liaison with the person, and then the team is always there to help figure it out. It actually works great for us.

Dennis Cain, Mental Health Supervisor, Ventura County

What is a good working team?

If a stranger were to observe such a team in session, he would not be able to discern who is the superior and who are the subordinates. Every member would be contributing information and expertise as needed: Status distinctions and other irrelevant criteria would not be influencing the way in which important issues were being addressed and then resolved.

*Ralph H. Kilmann
Managing Beyond the Quick Fix*

PRINCIPLE

7.

Service users have access to an advocate who helps protect their rights.

The value of peer advocates in the mental health, disability, and health-related fields has been evident for years. People who share common experiences are of a great benefit to others who are going through similar experiences. Many people believe that the role of the advocate is to ensure the

legal rights of the client. Although they may spend time in that role, an advocate can support a client in many other ways. Trust, reassurance that one is not alone, and factual information are just a few of the things that an advocate can contribute to a person who is going through a tough time. As mental health

agencies work towards returning power and control over their lives to service users, the use of advocates has increased.

This Principle is about supporting service users in claiming their basic civil rights.

**B.J. Morganti's story:
Claiming the power to help yourself and help others**

Editor's note: B.J. Morganti is an advocate and a service user at Stanislaus ISA. In the past few years, she has taken an active role in speaking out about the role of personal change and advocacy in the lives of people who experience mental illness. The following article is a condensed version of her story, which she tells to people on her speaking engagements across the country.

Empowerment is having the inner authority to act as a free and useful person. I have a paper I wrote about my personal steps toward empowerment. I enjoy doing speeches about my process, both locally and nationally. It is like a spiritual journey of increased decision-making and believing inside that you can do it. I help others to make little decisions, and to feel good about themselves, getting what they want for their lives. For example, recently someone wanted more money for social

activities, and I helped her with her budget until she had the extra money to plan social events. She made all of the decisions; I was kind of a guide to help her get what she wanted.

Advocates do many things—we offer peer support about issues such as social security, patients rights, landlord-tenant rights, giving information about advocacy. We provide education and peer counseling. Advocates have more of an allegiance because we also use services; there is an assumed trust there. By providing all of these services, I believe we are there to help people with empowerment, to make decisions for themselves. There were many people along the way who gave me encouragement and support.

My own story illustrates three important things that an advocate can give to a person who is trying to get more control over their life.

- **Inspiration.** My friend Jay's recognition and encouragement was an important influence and led to my enthusiasm about work. I

felt excitement about the beginning of a journey, a little scared, not sure about

"Many other things happen when you decide to begin the process of becoming more powerful as a person. These things all help, although you didn't plan on them to come along."

B.J. Morganti

"There is a time when you break through to the other side... when you feel like you are going to make it. Advocates can help you through that time."

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what kind of personal change might occur. It was the beginning of new relationships for me. He gave me the initial push and inspiration that I needed.

- **Heightened awareness.** People taught me about my capabilities and value. I felt listened to, respected, treated as equal. Lynn, Laurie, Coni, Lisa all helped. It was new and scary. I felt a little afraid of failing but also encouraged to go on. I had an increased awareness of the dangers and impact of labels. Lynn, a consumer, was a role model and advocate for me—warm and successful. Success is scary. Family enthusiasm, encouragement, friendliness, and support helped.

- **"Breakthrough."** There is a time when you break through to the other side... when you feel like you are going to make it. Advocates can help you through that time. I had role models to

help me see what was healthy and what was not. There were many caring people who stood by me. I had to do many things: acknowledging self-strengths and being acknowledged by others; fighting to get success and respect back; identifying barriers and overcoming them; confronting fears; networking with others; and friendliness and acceptance by others. I developed a new strength of increased humor and expressing self freely. Bruce helped me to get in touch with my core self and what I wanted by teaching me a method to solve problems and warning me about staying away from stereotypical solutions and labels.

- **Other helpful events.** Many other things happen when you decide to begin the process of becoming more powerful as a person. These things all help, although you didn't plan on them to come along. Some students were interested about mental illness at University of California. I gave a speech

and realized that it gave me a sense of identity. I also felt more powerful when I realized they were open to my ideas about improving the mental health system. Coni was a role model by being candid, concerned. She educated me about my medications and encouraged my search for direction. She shared experiences, and told me about herself as part of my therapy. She was open and honest with love, gave me confidence in myself, and encouraged trust by treating me like a valued person. Also, the self-help groups on peer counseling—Laurie's classes where everyone was treated as equals and learning skills. I learned a lot about being an advocate at those classes.

My ego is coming back; sometimes I don't know what to do with my new-found power. I am becoming a role model for others and am viewed by others with trust and respect.

An advocate says:

I decided to become an advocate about five years ago, after I heard a person from the California Network speak to a group. She really moved me. One thing I knew was that her story was harder than my own. I decided that my situation wasn't so bad and that I, too, could help other people. I started out as a volunteer and started a group at the Episcopal church. I also

"One thing I knew was that her story was harder than my own."

began to participate on a lot of groups like the central planning committee of the 3777 Project, and the Mental Health Advisory Board. Now I have worked for about three years doing advocacy and self-help groups. I feel like I am a good role model to people, but, most of all, I feel like doing self-help groups and advocacy really helps me with my illness. My learning is always continuing and I know there is more to learn. The hardest part for me is the assertiveness. I know some things, but I am always learning more. We do quarterly workshops for staff and clients together. They are great because the staff can hear, first hand, the personal stories of people and the struggles and successes they are having.

Cathy Higgins, Advocate, Ventura County

"How does it happen that many, if not most, people act out an assigned, or stereotypical role, rather than discovering their own authority and potential?"

Leah Palki McDowell
ACC Journal, Spring 1992

An advocate says:

I enjoyed the role of advocate; it is rewarding to help other people. Members would come to me with a variety of different issues—about their treatment or problems they were having. I would listen to them carefully and encourage them to solve their problems and to communicate with the staff. I guess they felt a stronger compatibility with me and would say things that they didn't want to say to staff at first.

Kevin Perkins, Former Advocate, Village ISA

Conclusion

Regardless of our own label—whether we are service users, psychiatrists, program managers, social workers, secretaries, or nurses—it is possible for us to learn from the hard work being done in these three communities. These programs have faced enormous obstacles and challenges in trying to rethink what a good service really means—fighting off bureaucracies that refuse to change, employees questioning lifelong personal values that are painful to alter, questioning the usefulness of the professional titles and authority given by established systems, and the inevitable upheaval that happens in organizations that are stressed to the breaking point by the uncertainty that change always brings. There have been major setbacks along the way, but all three of the programs also have incredible success stories to share.

A common thread runs through this booklet. Time and time again, when we stripped away the organizational structure, processes, and paperwork, we found that the most dramatic changes were occurring in the personal beliefs of the people doing the work. They really are seeing things in new ways. Over time, the distinction between the labels of “employees” and “clients” has lessened; it is slowly becoming just “us.” As you read these pages, we hope you see that there can be a difference. Services have changed in these three communities. The answer, in the end, may be in unlearning what the systems have taught us about the way things should be. We are beginning to remember what we have known is true. There really is no us or them. It’s just all of us, together, living out our lives in our communities.