STAFF ANALYSIS

MHSOAC Evaluation Staff Analysis of

Resource Development Associates (RDA) Contract #12MHSOAC009

Deliverable 5: Summary Report of Results from Data Analysis/Evaluation and

Deliverable 6: Final Report of Promising CPP Process Practices

September 2014

INTRODUCTION

This paper presents MHSOAC evaluation staff's analysis of the evaluation of the Community Program Planning (CPP) Process conducted by Resource Development Associates (RDA) from April 2013 through September 2014. The paper summarizes findings and limitations of the evaluation, presents staff recommendations regarding next steps in this area, and provides context surrounding the evaluation to further understanding and interpretation of the results.

BACKGROUND

Community Program Planning (CPP) Process

In order to provide community-based mental health services that are client-centered, family-focused, culturally and linguistically competent, and within an integrated system, the Mental Health Services Act (MHSA or the Act) relies upon high levels of local community involvement and planning. Ongoing stakeholder[1] participation and consultation are required in both the statute itself and corresponding regulations. Each county must engage in a Community Program Planning (CPP) process to ensure continuous engagement with the community and improve the likelihood that all community members and various groups[2] within communities have an opportunity to participate in MHSA efforts and provide feedback regarding MHSA decisions on an ongoing basis.

Stakeholders, as defined within the Act, must be included in the planning process; WIC § 5848 further states that counties shall demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement with regard to mental health policy, program planning, implementation, monitoring, quality improvement, evaluation, and budget allocations. In order to support this meaningful stakeholder involvement, training must also be offered (as needed) to stakeholders participating in the planning process (per Title 9, CCR 9 § 3300). Once the planning process is completed and the document is drafted, the Three Year Program and Expenditure Plan/Annual Update must be circulated for review and comment for at least 30 days to representatives of stakeholder interests and any interested party who has requested a copy (per WIC § 5848). The plan/update is not finalized until after the 30 day comment period and the mental health board conducts a public hearing (per WIC § 5848).

Community Program Planning (CPP) Process Evaluation

In addition to planning process provisions, the MHSA also emphasizes stakeholder involvement by requiring that administrative costs include funds "to assist consumers and family members to ensure the appropriate state and county agencies give full consideration to concerns about quality, structure of service delivery, or access to services" (WIC § 5892(d)). This requirement is fulfilled by three-year contracts administered by the MHSOAC to fund activities performed by various stakeholder

[1] Stakeholders are defined within WIC § 5848 as adults and seniors with severe mental illness, families of children, adults, and seniors with severe mental illness, providers of services, law enforcement agencies, education, social services agencies, veterans, representatives from veterans' organizations, providers of alcohol and drug services, healthcare organizations and other important interests.

[2] CCR § 3300 requires inclusion of representatives of un/underserved populations and family members of un/underserved populations, stakeholders that reflect the diversity of the demographics of the county, and clients with serious mental illness and/or serious emotional disturbance, and their family members.

organizations[3]. Historically, the California Network of Mental Health Clients (also known as "The Network") received funding via one of these stakeholder contracts in order to provide a client advocacy voice at the State level. However, once The Network was no longer funded via the Budget Act, MHSOAC staff needed to identify a new contractor and contract deliverables for these funds.

Concurrently, the MHSOAC Evaluation Committee identified the CPP Process as a priority for evaluation, particularly to identify promising CPP practices/characteristics that produced positive outcomes. After discussing the needs of both stakeholder engagement and evaluation efforts, and identifying areas of overlap, MHSOAC staff decided to develop two separate but complementary Request for Proposals (RFPs) and (eventual) contracts: (1) the "Evaluation Contract" to evaluate the impact and effectiveness of the CPP process; and (2) the "Client Contract" to create an inventory of currently used CPP processes, and develop and implement a CPP training curriculum, among other things. The RFP process resulted in the MHSOAC awarding the Evaluation Contract to Resource Development Associates (RDA) and the Client Contract to Peers Envisioning and Engaging in Recovery Services (PEERS), which subcontracted with California Association of Mental Health Peer Run Organizations (CAMHPRO). Together PEERS and CAMHPRO created the Client Stakeholder Project (CSP). For the remainder of this paper, and to reflect their collaboration, these entities will be referred to collectively as CSP.

Together RDA and CSP used a participatory research process[4] to evaluate the impact and effectiveness of CPP processes on outcomes (i.e., those practices that promote positive impacts on MHSA goals, such as those that promote involvement of clients with serious mental illness and/ or serious emotional disturbance and their family members, are wellness-, recovery-, and resilience-focused, and encourage the participation of un/underserved stakeholders in the planning process). The evaluation focused on the planning processes used by counties to prepare for the Annual Update for FY 2012/13 since this was the planning process in which most Annual Updates (which were used as a data source to describe and identify CPP activities) had been received by the MHSOAC at the time (mid-2013).Both contracts required RDA and CSP to collaborate during each stage of the evaluation, but there were also other partners that contributed to this effort. CSP formed a group of "regional partners"[5], or individuals from various regions around the state who were primarily charged with collecting the data used for this evaluation and providing ongoing feedback, and an advisory body called the Community Advisory Committee (CAC), comprised of the organizations currently funded by MHSOAC stakeholder contracts (as described above) and other individuals identified via recruitment process conducted by CSP. In addition, county representatives were asked to review data collection tools and provide feedback; much of which was incorporated and helped to identify issues with the evaluation design (some of which are later described as limitations within the "Recommendations" section of this paper).

[3] Currently, the MHSOAC administers these stakeholder contracts to the National Alliance on Mental Illness (NAMI), United Advocates for Children and Families (UACF), California Youth Empowerment Network (CAYEN), and California Association of Local Mental Health Boards and Commissions (CALMHB/C) via the authority of the Budget Act, and Peers Envisioning and Engaging in Recovery Services (PEERS) via a Request for Proposal (RFP) process.
[4] Participatory research engages with those with lived experience at various stages of the research process, from generating research questions to disseminating findings.
[5] Regional partners include members from Project Return Peer Support Network (Southern counties), Consumer Self Help Center (Central counties), Mental Health Association of San Francisco (Bay Area counties), and an individual consumer activist (Superior counties).

IDENTIFIED PROMISING PRINCIPLES

The promising practices identified via this effort are very broad, and are potentially better described as "principles" instead of "practices". For clarity, the remainder of this paper will refer to what was identified via the current effort as "principles" to further distinguish this effort from future evaluation activities recommended later in this paper to identify "practices" (i.e., specific activities/processes).

For this current effort, promising principles were identified via a review of the literature for existing evidence of effective practices from areas outside the mental health field (see Deliverable 4, *Report of Other Public Community Planning Processes)*, and an evaluation of local CPP processes used across the state (see Deliverable 5, *Summary Report of Results from Data Analysis/Evaluation*, for results of this evaluation).

Below are the 15 promising principles and their descriptions, organized by how they were identified:

- **Identified via Literature Review**

1. Focus on strengths and aspirations - Learn about the community, including their values, hopes, and aspirations, through research and participatory visioning processes. Develop plans based on community strengths and assets, and celebrate small and large successes.
2. Be strategic - Practice thoughtful, deliberate preparation. Establish purpose, priorities and goals before launching the planning process. Use methods and tools based on a clear sense of how they contribute to the process and intended outcomes. Recognize political, social, and market realities to create feasible implementation plans. Engage in systems thinking by considering the interconnectedness of issues and institutions.
3. Develop partnerships - Establish collaborative relationships with all sectors of the community by respecting diversity, encouraging dialogue, seeking points of agreement, and valuing and utilizing local knowledge, strengths and expertise. Seek commitment, and recognize that partnerships are developed and maintained over time. Time and space for face-to-face interaction and deliberation is essential.
4. Build capacity - Develop individual and organizational knowledge and capacity through co-education, dialogue, and opportunities to participate in research and informed deliberation and decision making.
5. Be inclusive - Recognize the value of meaningful participation by those people whose lives are most affected by the issues at hand. Pay special attention to vulnerable populations and those who might not otherwise be included in decision making. At the same time, be conscientious of stakeholder diversity. Frame issues from multiple perspectives. Recognize the rights of clients but also the needs of service providers and other stakeholders. Provide opportunities for people to gather at convenient and comfortable locations at a variety of times and use a variety of approaches and tools that reflect stakeholders' cultures and skills—even if doing so slows the process down.
6. Share responsibility and accountability - Counties and communities should share responsibility and accountability for improving the planning and services of public mental health systems. Counties are accountable to their function as planners and administrators of mental health services in line with MHSA values and principles. Communities are accountable for understanding and voicing their own collective stakeholder needs to the counties. Both counties and communities share responsibility for contributing to the CPP process and their respective counties' public mental health services.

7. Plan for the long-haul - Prepare stakeholders for ongoing and long-term committed participation. Recognize that social transformation takes time and may not follow a linear path, develop strategies for maintaining momentum, and engage and reengage over the years and throughout the planning and implementation process.

- **Identified via the Current Evaluation**

8. Use the MHSA principles as a foundation to develop and conduct all CPP activities - Incorporate activities that are collaborative; integrated; culturally competent; client and family driven; and wellness, recovery, and resiliency oriented.
9. Leverage existing resources - Recognize and utilize the resources within the community to support CPP activities, reduce cost of logistics, and increase community presence and collaboration. Establish flexibility with CPP staffing to allow more full time employees (FTEs) to be allotted for periods with a high volume of CPP activities.
10. Plan and prepare for each CPP activity in advance to ensure that meetings are well organized and conducted in a language that stakeholders speak/understand, and that facilitators are well prepared to lead activities and are respectful of stakeholders' cultures.
11. Be transparent - Model clear, open, and consistent communication. Be direct about roles, responsibilities, and the degree of decision-making authority participants can expect throughout the process.
12. Make the purpose, expectations, and impacts of stakeholder participation explicit - Communicate how stakeholder input will be used.
13. Train stakeholders to meaningfully participate in CPP activities - Ensure that stakeholders have an adequate understanding of county services, functions, and the decision-making process.
14. Use multiple methods of outreach - Developing reaches to broader audiences well help to build trust in the public mental health system.
15. Dedicate efforts to increase accessibility by making reasonable accommodations for those with SED/SMI, limited English proficiency, and/or socio-economic disadvantage. Arrange logistics and prepare events to allow easier access to safe environments throughout the CPP processes.

RECOMMENDATIONS

This evaluation was the first of its kind; both as an evaluation of community-based program planning in general and as an evaluation of the specific CPP process outlined within the MHSA/regulation. As such, it is very much a first step in how the MHSOAC can continue to evaluate local planning processes and use those efforts to support counties and help strengthen their abilities to use planning processes to meet MHSOAC goals, including increasing the likelihood of meaningful stakeholder involvement. Although this project resulted in a list of principles that may be potentially useful in promoting effective planning and services that lead to positive outcomes, there were a number of issues that surfaced during various stages of the evaluation that are worth highlighting as the Commission considers next steps in this area. These issues are discussed below and are paired with recommendations so that future work in this area can more readily build upon what was learned from the scope of this project, including the actual results and lessons learned via the evaluation process.

ISSUE #1: Limited data available on local CPP processes. In order to evaluate the CPP process to identify potentially promising practices, the current effort required an extensive amount of data to be

collected, which may have been burdensome for some counties. Existing data (as provided in the FY 2012/13 Annual Updates) was reviewed and used to the extent possible, although information contained in those reports alone did not fully address the research questions. The data/information requested of counties in the FY 2012/13 Annual Updates to describe that particular planning process (referred to as "instructions") is as follows:

- Description of the local stakeholder process including date(s) of the meeting(s);
- General description of the stakeholders who participated in the planning process and that the stakeholders who participated met the criteria established in section 3200.270;
- The dates of the 30 day review process;
- Methods used by the county to circulate for the purpose of public comment the draft of the annual update to representatives of the stakeholder's interests and any other interested party who requested a copy of the draft plan;
- The date of the public hearing held by the local mental health board or commission; and
- A summary and analysis of any substantive recommendations.

While these instructions[6] were developed by the California Mental Health Director's Association (CMHDA) for the FY 2012/13 local planning process (under Assembly Bill 100[7]), instructions regarding the types of information about the CPP process to be provided in the Annual Updates and the Three Year Program and Expenditure Plans has not changed, despite the MHSOAC's current role in providing such instructions. Furthermore, the MHSOAC is increasingly reliant upon the Three Year Program and Expenditure Plans/Annual Updates for evaluation-related data. Counties expend a good deal of resources preparing these plans/updates yet, from an evaluation perspective, there is inconsistent data reported and/or missing across counties, and often narrative that is not conducive or easily subject to evaluation. The highly limited data that was available for this effort consistently across all counties led to the need for additional data collection. Although this process provided additional data upon which this evaluation was based, the data received were still highly limited. For example, not all counties routinely collected the data being requested (e.g., demographics for CPP attendees). In addition, not all county representatives that were reached could readily provide the requested information (e.g., data collectors often encountered a new county staff who had not been filled in on prior CPP processes, including what had been done and who had participated).

✓ **Recommendation: Strengthen routine data collection regarding CPP practices.** It is recommended that the MHSOAC Evaluation Committee, along with other key stakeholders, begin to consider how to strengthen the State's ability to routinely collect relevant data on local CPP processes and associated outcomes in order to promote ongoing assessment and improvement of the CPP process. Potential areas of exploration should focus on the MHSA values or general standards (i.e., possible measures of community collaboration, cultural competence, client- and family-driven, wellness-, recovery-, resilience-focused service delivery, integrated service experience, and co-occurring disorder services competency). Additionally, work with counties to identify ways in which stakeholder demographic data may be obtained (e.g., a potential compromise may be to develop agreed upon methods of estimating stakeholder membership in various groups). Once consensus among

[6] Please see *MHSA Annual Updates Critical Elements* adopted by CMHDA on January 12, 2012.

[7] Pursuant to A.B. 100, the requirement that the plans/updates be approved by the then Department of Mental Health after review and comment by the MHSOAC was deleted. A.B. 1467 later granted MHSOAC review authority.

stakeholders is reached, consult with the Department of Health Care Services (DHCS) as to possibly revising existing regulations pertaining to the local planning process.

ISSUE #2: The evaluation resulted in broad principles that are not data driven. It was the intention of this effort to identify specific activities conducted by counties that could be linked (via the evaluation analyses) to stakeholder perceptions about those activities and MHSA outcomes; the hope was to identify data-driven practices that were linked with positive perceptions and outcomes that would have the potential to promote positive perceptions and outcomes in the future throughout the state. However, the evaluation resulted in broad principles or themes (e.g., "Be Strategic", "Build Capacity", and "Be Inclusive"), and the analyses were primarily focused on perceptions rather than direct connections with achievement of MHSA outcomes. These principles do not provide clear direction about how to achieve them (e.g., there are many ways to "be strategic" or "build capacity"); nor were they necessarily data driven as intended (e.g., evidence to support the principle "Leverage existing resources" was based on the finding that almost half of counties that responded reported that they do not have adequate resources to conduct their CPP process). This limits confidence that the proposed principle will result in a positive outcome.

- ✓ **Recommendation: Conduct a more rigorous evaluation of CPP Processes in the future to build upon this effort**. Develop more rigorous evaluation of the CPP process to identify data driven practices (i.e., specific action/activities) that impact/promote positive outcomes (i.e., improved mental health services, increased stakeholder participation, strengthened community collaboration in program and service planning). Obtain the data collected by RDA for the current evaluation and further analyze the data. Address areas identified by the current evaluation that call for additional research, for example:
  - Assess CPP processes that promote positive outcomes specifically geared toward engaging un/underserved communities, especially those communities that are comprised of non-English speakers.
  - Examine the possible distinctions between practices used for the Three Year Program and Expenditure Plans (i.e., planning processes) and the Annual Update (i.e., reviewing MHSA programs/services processes), as well as historical effects (e.g., changes in budget/legislation/policy).
  - Conduct more focused evaluation of the Local Review Process (per Title 9, CCR § 3315), specifically investigating how requiring counties to provide a summary and analysis of any substantive recommendations and changes provided by stakeholders to the draft Three Year Program and Expenditure Plans/Annual Update has potentially improved upon service planning and delivery, and stakeholder engagement.

ISSUE #3: Current dissemination activities are geared toward a broad stakeholder audience. Under the current contract, CSP is developing a curriculum and associated training plan based on the evaluation results and identified promising principles. They will soon embark upon disseminating this curriculum and provide in-person trainings throughout the State. Although the evaluation ended up providing more data and assessment of county-facilitated processes, CSP had more interest and skill in developing materials for client stakeholders; this contradiction between the focus of the evaluation and CSP goal for the stakeholder training and curriculum (which was to be based on the results of the evaluation) presented a challenge. In the end, it was agreed that CSP would develop the curriculum for a broad stakeholder audience, emphasizing client stakeholders (their area of expertise). While this effort

is beneficial, there is still a need to provide counties (i.e., those who plan for and implement the CPP process) support to promote CPP processes based on MHSA values/general standards.

- ✓ **Recommendation: Begin to develop actionable support and recommendations for counties.** Establish a pool of subject matter experts (e.g., county representatives) and, using the results of the evaluation, further data analysis, and any identified promising practices or principles, work to identify specific CPP actions that may lead to positive outcomes that can be promoted across the state (e.g., discuss the various ways in which counties are training stakeholders to meaningfully participate in CPP activities, and then challenges and successes with such training methods). Develop practical applications and tangible methods of strengthening planning processes, such as making evaluation/outcomes meaningful to a wide range of stakeholders and promoting data driven decision-making (e.g., using census demographic data and/or assessments of access to/utilization of services disparities to identify priority populations/service foci) . Consider possible sub-groups dedicated to specifically address the unique needs of small, medium, and large counties, as well as geographical differences (e.g., coastal vs. inland, urban vs. rural, etc.). The goal of this effort being to develop training and/or technical assistance materials designed specifically for those administrating the CPP process at the county level.

ISSUE #4: Under-representation of members from un/underserved groups as evaluation participants. While the current project attempted to engage members of the Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), the California MHSA Multicultural Coalition (CMMC), and the California Reducing Disparities Program (CRDP) in an effort to recruit participants for local focus groups and survey responses, the participation of those in traditionally un/underserved groups could be expanded upon. Historically, the MHSOAC has employed methods of engaging these groups by asking state-level organizations to refer participants at the local level; however, we may still not be fully reaching these diverse communities. To demonstrate, it was brought to our attention after the data collection period concluded that a number of un/underserved communities were unaware of the opportunity to participate in this and another MHSOAC-funded evaluation, and despite being heavily invested in and affected by the subject matter, were unable to participate.

- ✓ **Recommendation: Identify ways to better promote opportunities to participate in MHSOAC-funded evaluations, especially to un/underserved communities**. It is recommended that the MHSOAC Evaluation Committee and the MHSOAC Cultural and Linguistic Competence Committee consider new methods for engagement, ensuring that the voices of those with the knowledge, expertise, and lived experience within un/underserved communities are represented within all of the MHSOACs evaluation data and subsequent results. This recommendation is aligned with the ideas generated by the MHSOAC Evaluation Committee's discussion on inclusion of those with lived experience in evaluations, particularly with regard to engaging with county-level department staff and community-based organizations to identify individuals with lived experience, and promoting collaboration in all future MHSOAC-funded evaluations germane to those individuals.

ISSUE #5: Consider and possible policy recommendations. Pursuant to the MHSOAC Evaluation Master Plan, evaluation activities funded by the Commission should serve a quality improvement role, not only influencing practice but also policy "…to ensure that clients and families receive the most effective services possible" (page 4). Policy recommendations should describe who the recommendations are intended for (e.g., policymakers/Legislatures, various State entities, counties, providers), as well as be

framed in an action-oriented and easy to understand manner that would ultimately facilitate potential adoption or follow-through by the appropriate parties. The current evaluation identified limitations with the data currently being report within Three Year Program and Expenditure Plans/Annual Updates. Current instructions drafted by the MHSOAC and guided by existing regulations for these plans/updates are meant to ensure that the MHSOAC receives "information it needs to track, evaluate, and communicate the statewide impact of the MHSA"[8] with regard to the CPP process. In order to ensure such mandates are being met, current regulations should be reviewed and any changes to those regulations that would strengthen the MHSOAC's ability to track and evaluate the statewide impact of the MHSA should be presented to the Commission for approval and brought back to DHCS for consideration and/or adoption.

- ✓ **Recommendation. Consider the implications of the evaluation findings and lessons learned to develop policy recommendations**. It is recommended that the MHSOAC Evaluation Committee or a workgroup review Deliverable 5, *Summary Report of Results from Data Analysis/Evaluation*, Deliverable 6, *Final Report of Promising CPP Process Practices*, and this staff analysis paper to consider and potentially develop policy recommendations that could later be brought back to the Commission for consideration. Potential policy recommendations could focus on the need to improve data collection of CPP processes and outcomes, and other efforts to help strengthen local CPP processes.

CONCLUSION

The promising principles identified via this effort will contribute to the MHSOAC's ongoing evaluation of the CPP process and related activities. While broad in scope, the principles serve as a starting point for additional opportunities to strengthen community engagement and participation, promoting positive outcomes. As a next step, the MHSOAC Evaluation Committee or a workgroup will review this paper and related documents to consider implications resulting from this evaluation and will bring ideas back to the Commission, as needed.

[8] Please see FY 2013/14 MHSA Annual Update Instructions found here: http://www.mhsoac.ca.gov/docs/FY%2013-14%20MHSA%20Annual%20Update%20Instructions%20FINAL.pdf.