Mental Health Services Act (MHSA) Expanded Statewide Evaluation

PARTICIPATORY RESEARCH EVALUATION PROPOSALS

Phase III Deliverable 2.a1 and 2.b1

Submitted by:

UCLA Center for Healthier Children, Families & Communities

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Table of Contents

Table of Contents i

INTRODUCTION 1

Description of Deliverables 1

Overview of Proposals 2

PARTICIPATORY PLANNING PROCESS 3

Participatory Approach 3

Design 4

Recruitment 5

Conducting the Regional Planning Meetings 6

Conducting the Statewide Webinar/Conference Calls 9

Participant Satisfaction Survey 9

Input from County Data Informants 9

Analyzing Participant Input 10

PLANNING PROCESS RESULTS 11

Participants for Regional Meetings 11

Participants for Statewide Consumer and Family Member Webinar/Conference Call 17

Participant Satisfaction Survey Results 17

Programs Recommended by Participants 18

GSD Programs: Recommendations 19

MHSA Programs: Recommendations 20

Outcome Indicators Recommended by Participants 21

Research Methods Recommended by Participants 23

Recommendations from County Data Informants 23

STUDY PROPOSALS 24

Participatory Evaluation Approach 24

The Spectrum of Participatory Approaches to Evaluation 24

Participant Selection, Roles, and Responsibilities 25

Training and Compensation of Participant Evaluation Partners (PEPs) 27

Preview of Study Proposals 28

Study #1: General System Development Programs 28

Study Questions 28

Methods 29

Sample 30

Recruitment Procedures 31

Measures 32
Data Analysis 32
Human Subjects Protection 33

Study #2: MHSA Programs *33*
Study Questions 34
Methods 34
Sample 35
Recruitment Procedures 36
Measures 37
Data Analysis 37
Human Subjects Protection 38

APPENDIX A *39*

APPENDIX B *41*

APPENDIX C *43*

APPENDIX D *55*

APPENDIX E *64*

APPENDIX F *65*

APPENDIX G *67*

INTRODUCTION

Description of Deliverables

The Mental Health Services Act (MHSA or "the Act") Statewide Evaluation is a multi-phase effort to examine the Act's impact on mental health consumers and systems. The Mental Health Services Oversight and Accountability Commission (MHSOAC) directs this effort, which is implemented by the University of California Los Angeles (UCLA) evaluation team at the Center for Healthier Children, Families and Communities. As part of the effort, the evaluation team has been charged with carrying out a pair of participatory evaluation studies. The team's specific charge, per contract language, is as follows:

Deliverable 2, Phase III – Using participatory research with individuals living with mental illness, their family members and personal caregivers, ensuring participation of traditionally un-served and underserved communities across the life span:

> a1. Determine the impact of at least one type of service/strategy[1] funded with General System Development (GSD) funding category on at least one outcome prioritized from the MHSA/System of Care statutes at the individual/client level.[2]
>
> b1. Determine the impact of involvement of individuals living with mental illness, their families and personal caregivers in the public mental health system on at least one outcome prioritized from the MHSA/System of Care statutes.[3]

The participatory planning process, as noted in MHSOAC RFP 10-70134-000 (page 12), states "...all aspects of the research shall be developed through a partnership between researchers and individuals living with mental illness, their family members and personal caregivers, ensuring participation of traditionally unserved and underserved communities across the life span. This collaborative process determines priorities for Deliverable 2 regarding what is to be studied, where, when and how it is to be studied. All partners contribute their expertise to enhance understanding of the research question, design, implementation and interpretation of results."

Consistent with this direction, the principal goals of the participatory planning process carried out by the UCLA evaluation team were to determine:

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[1] The terms "programs", "strategies", and "services" are used interchangeably throughout this document.
[2] The MHSOAC's Initial Statewide Evaluation of the MHSA is expected to provide a summary of GSD activities and expenditures that can be used as base information for this analysis.
[3] This refers to any service or strategy (under any MHSA funding stream) that involves consumers, their families, and caregivers in the public mental health system.

1. The programs or activities to be the focus of *two* evaluation studies - one specific to a GSD funded program, and the second specific to programs for consumers, family members, and caregivers involved in public mental health services (herein referred to as "MHSA programs").
2. The outcomes to be investigated in each of the studies.
3. The methods to be used in conducting each of the studies.

Overview of Proposals

The participatory planning process involved a broad and diverse group of consumers and family members who participated in one of eight regional meetings or a statewide webinar/conference call. Participants were highly engaged and enthusiastic about the initiative, in general, and their involvement in the planning activities, in particular. Discussions around the selection of programs, outcome indicators, and research methods were thoughtful and nuanced. Priorities and recommendations by participants across the planning meetings showed high levels of convergence and provide clear parameters for the two studies being proposed.

The first section of this report, along with corresponding appendices, describes the participatory planning process. This section details how the planning process was designed, efforts to recruit consumers and family members to participate, procedures for conducting the meetings and webinar/conference call, assessment of satisfaction with the planning meetings, strategies used to analyze results from the planning meetings, and establishment a process for input from county data informants.

The second section of the report, along with corresponding appendices, presents the results from the participatory planning activities. This section summarizes information about the consumer and family member participants, including breadth of representation in terms consumer or family member status, MHSA age groupings, gender, race/ethnicity, underserved communities, and "statewideness". In addition, recommendations concerning programs to be studied, outcomes to be measured, and research methods to be used are presented.

The final section of the report describes our participatory evaluation framework and includes two study proposals. Based on recommendations from the participatory planning process, we propose one evaluation that focuses on crisis intervention and peer counseling programs and another evaluation that focuses on employment services. Outcome indicators to be examined in these studies will include (1) appropriateness of care; (2) paid and unpaid employment; (3) consumer wellbeing; (4) recovery, wellness, and resilience orientation; (5) consumer/family perception of access to services; (6) housing situation; and (7) continuity of care.

A two-pronged approach for gathering data for these two evaluation studies is proposed. The first prong will rely on a survey to be completed by consumers (or their family members or representatives if consumers are unable to directly participate) in regards to their experiences with the crisis intervention, peer counseling services, and employment services. The second prong will be a set of in-depth interviews conducted with a subset of consumers who complete the survey. These study methods are in keeping with recommendations from participants and are particularly well suited given the focus of the proposed studies. For example, they overcome limitations presented by the service and outcome data that are currently available across the state.

Notably, our proposals call for the formation of Participatory Evaluation Partners (PEPs), consisting of a subset of individuals who participated in the participatory planning process. The PEPs will work collaboratively with the evaluation team to: (1) develop the survey and interview protocol, (2) assist in recruiting consumers and family members to complete the survey and interviews, (3) jointly conduct the interviews, and (4) assist with analyzing and interpreting the results. In this way, the evaluation team will ensure that the studies are participatory from start to finish.

PARTICIPATORY PLANNING PROCESS

Participatory Approach

Participatory evaluation, which entails developing and carrying out evaluation efforts in partnership with stakeholders, is inherently compatible with and an extension of MHSA values. This approach to evaluation holds tremendous promise for focusing efforts on fresh and relevant topics and encouraging the use of research methods that inform actionable program and system improvement activities.

The participatory planning process is the first step in partnering with consumers and family members around developing and executing these two research studies. Moreover, the two study proposals build upon and expand this partnership into every phase of the proposed studies. The participatory planning process described below relies upon the lived experience of consumers and family members in regards to recovery, wellness, resilience, and mental health services in order to focus and shape these studies so that the evaluation methods are credible, and the results are accurate, meaningful, and actionable.

Design

The research team initiated a participatory planning process designed to gather opinions and recommendations from a diverse group of consumers and family members representing a broad range of communities. Specifically, the process was designed to gather input from individuals representing all four MHSA age groupings (child, transition age youth, adult, and older adult), varied geographical regions (Superior, Bay Area, Central, and Southern) and population densities (rural, urban, and suburban), diverse racial/ethnic groups, and underserved populations (e.g., Lesbian, Gay, Bisexual, Transgendered, and Questioning [LGBTQ] and veterans). The primary planning activities consisted of a set of regional meetings supplemented by a statewide webinar/conference call.

A total of eight regional meetings[4] and one statewide webinar/conference call were convened for consumer and family member participants. As displayed in Table 1, five of the meetings were conducted in English and three of the meetings were conducted in Spanish. One of the meetings was conducted in the Superior region, two in the Bay Area, two in the Central region, and three in Southern California.

Table 1
Participatory Planning Regional Meetings
Locations and Languages

Region	Meeting Location	Language
Superior	Redding	English
Bay Area	Alameda	English
Bay Area	Salinas	Spanish
Central	Sacramento	English
Central	Fresno	Spanish
Southern	Santa Barbara	English
Southern	Los Angeles	Spanish
Southern	Santa Ana	English

[4] Originally, seven regional meetings were planned (as described in the project description letter in Appendix B). An additional meeting, convened in Alameda, was added at the request of consumer and family groups.

Recruitment

Consumer and family members were invited to join the regional planning meetings and the statewide webinar/conference call through email correspondence directed at four categories of stakeholders as follows:

1. Mental health consumer and family member advocacy organizations[5]
2. County mental health agencies and provider organization associations
3. Community organizations and committees focusing on the needs of underserved populations
4. State agencies, County associations, and training centers.

Email invitations were distributed to a broad group of mental health stakeholder agencies, associations, and committees within these categories, including:

1. Nine mental health consumer and family member advocacy organizations
2. Eight provider associations
3. Eight community organizations and committees that focus on the needs of underserved populations
4. All county mental health directors and their MHSA Managers[6]
5. Five state agencies, County associations, and a training center.

The email invitations were then widely distributed by these groups to their members and other interested parties. For a list of the target agencies, associations, and committees, see Appendix B.

The email invitations included a detailed project description that summarized the intent of the participatory evaluation and provided information on how to participate in one of the regional meetings or the webinar/conference call. Prospective participants were informed that they would receive a $75 VISA gift card for attending the regional meeting in order to compensate them for their time and expenses. The project description was prepared in English and Spanish. For a sample invitation email correspondence and the project description, see Appendix C.

Prospective participants indicated their interest in participating in a regional meeting or the webinar/conference call by contacting one of the evaluation team lead facilitators either by email or telephone. The lead facilitators responded to prospective participants by reviewing the project goals, answering any questions, and formally registering them

[5] Email invitations were disseminated directly to consumer and family organizations (i.e., Consumer Client Network, United Advocates for Children and Families) and to intermediary agencies (i.e., community based organizations and county mental health departments, who in turn forwarded to consumer and family member groups and individuals).

[6] Email invitations to the County Mental Health Directors and MHSA Managers were distributed by The California Mental Health Directors Association on behalf of the evaluation team.

to attend either a meeting or the webinar/conference call. In some cases, County mental health staff facilitated registration for interested consumers and family members. Email reminder notices were sent to individuals who were registered to attend a meeting or a webinar/conference call.[7]

Regional meetings were intended to have a maximum of 10 participants each to allow ample opportunity for the evaluation project and goals to be fully reviewed and to ensure that all participants could actively discuss and provide informed opinions and recommendations.

Conducting the Regional Planning Meetings

The regional participatory planning meetings were three hours in duration and each was facilitated by at least one senior member of the evaluation team. All meetings were audio recorded.[8] At the beginning of each meeting, participants completed a sign-in sheet that gathered contact and background information.

As mentioned above, the overarching purpose of the meetings was to gather input to help design two future evaluation studies of programs or strategies funded by MHSA. The meetings focused on gathering input and recommendations for three sets of decisions as follows:

1. The programs or strategies that should be the focus of the two evaluation studies
2. The outcome indicators that should be used to evaluate the selected programs or strategies
3. The research methods that should be used when conducting the two evaluation studies.

A two-step facilitation process, characterized by robust brainstorming and participant ranking exercises, was utilized for these meetings. Moreover, a cascading procedure was employed in which recommendations from preceding meetings were shared following the brainstorming phase in order to provide participants with a broader context in which to consider and make their recommendations. In this way, each successive meeting had the opportunity to benefit from and build upon the perspective of participants from earlier meetings. For a complete set of the meeting materials including sign-in sheet, agenda, ground rules, and handouts on key content areas (e.g., GSD programs, priority outcomes indicators, and research methods), see Appendix D.

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[7] Reminder notices were sent to individuals who had provided an email address when registering for meetings or webinar/conference calls, which was the case for many, but not all, of the participants.
[8] All participants were advised of audio recordings in the invitation project descriptions and at the outset of each of the meetings.

Each of the regional meetings followed these steps:

Step 1: Meeting Overview and Introductions
Each meeting began with a welcome and introductions followed by a brief description of the meeting goals and the three sets of decisions (e.g., programs, outcome indicators, and methods for the two studies) that would be the focus of the meeting. The facilitator referenced a handout that included a brief review of the Mental Health Services Act, Community Services and Supports, and General System Development activities, provided context for the evaluation activities.

Step 2: Brainstorming and Discussion of GSD Programs
In preparation for making recommendations concerning the focus of the first study, the facilitator briefly explained each of the programs and strategies that have been supported with GSD funding.[9] A facilitated discussion followed the brief presentation, concluding with each of the participants indicating their preferences. Specifically, participants were asked to share which of the programs listed they would like to see as the focus of a statewide study and why. They were encouraged to share their experiences with any of the programs.

Step 3: Ranking Exercise – GSD Programs
Once the discussion had concluded, participants were asked to select their top two choices from among the list of GSD programs. They were asked to make two check marks on a form either by choosing two different programs that they thought deserved consideration or by applying both check marks to one program. The rankings were tallied and the results shared with the group for reference when selecting outcome indicators.

Step 4: Brainstorming, Discussion, and Ranking of MHSA Programs
The process of discussion and ranking was repeated in reference to the second study; however, the focus was on selecting a program or strategy (within the MHSA/Systems of Care statues) that improves involvement of consumers, family members, and caregivers are involved in public mental health services.

Step 5: Brainstorming and Discussion of Priority Indicators for Selected GSD Program Evaluation
In preparation for making recommendations concerning outcome indicators for the first study, the facilitator briefly explained each of the priority outcome

[9] Description of programs funded under GSD was based on the *California's Investment in the Public Mental Health System: Proposition 63 – Brief 4 of 7: Providing Community Services and Supports through General System Development*, which was an embargoed report at the time materials for these meetings were being prepared.

indicators.[10] Again, a facilitated discussion followed the presentation, and concluded with each of the participants indicating their preferences. Specifically, participants were asked, when thinking of the program that was selected by them as a group for the first study, what indicators would be important to measure or highlight? They were encouraged to consider which indicators they thought would be most useful in evaluating the program selected by them for the first study. The program receiving the highest ranking, from step 3, was the focus of this discussion.

Step 6: Ranking of Priority Indicators for Selected GSD Program Evaluation
In reference to ranking decisions, each participant was asked to select their top four choices, which were indicated on a form listing all of the outcome indicators. They were asked to make four check marks on the form either by choosing four different indicators that they thought deserved consideration or by applying more than one check mark to the same indicator.

Step 7: Brainstorming, Discussion, and Ranking of Priority Indicators for MHSA Programs
The process of discussion and ranking was repeated in reference to the second study; however, the focus was on selecting outcome indicators specific to the program that was selected by the group for the second study.

Step 8: Brainstorming and Discussion of Research Methods for Selected GSD Programs and Programs for Consumers Involved in Public Mental Health Services
In preparation for making recommendations concerning research methods to be used for the two studies, the facilitator briefly provided examples of research strategies and study designs. A facilitated discussion followed, and recommendations made by the participants were recorded. Specifically, participants were asked to share their thoughts and recommendations on the following three areas: types of information that could be used in these studies, ways of gathering the information, and ways of comparing the information. Given the multitude of possible research methods for investigating the programs and indicators selected, there was no ranking exercise. Rather, participant comments and recommendations were recorded and analyzed for themes.

[10] Priority outcome indicators were based on the list initially created under a process convened by the California Mental Health Planning Council, and documented in the following two reports: *Mental Health Services Act Evaluation: Templates for Reporting Priority Indicators – Contract Deliverable 2A*, prepared by UCLA/EMT, June 30, 2011 Draft Report for Stakeholder Review, and *Mental Health Services Act Evaluation: Compiling Data to Produce All Priority Indicators – Contract Deliverable 2C, prepared by UCLA/EMT*, June 30, 2011 Draft Report for Stakeholder Review.

Conducting the Statewide Webinar/Conference Calls

In addition to the regional meetings, a statewide webinar/conference call was convened for consumers and family members. The webinar/conference call was intended to be a supplement to the regional meetings, allowing for recommendations from a larger group of consumers and family members to be considered. The webinar/conference call was scheduled for 90 minutes. The focus and process of the webinar/conference call was an abbreviated version of that used for the meetings. A PowerPoint presentation (see Appendix E) was used in lieu of the meeting handouts, and the facilitator recorded comments and recommendations from the participants.[11]

An additional pair of conference calls, one targeting individuals from community organizations representing underserved populations and the other involving representatives from County mental health programs, were also conducted. The purpose of these calls was to share preliminary results from the regional meetings with consumers and family members and to assess the extent to which those results resonated with these representatives.[12] However, the study proposals are based entirely on the results from the consumer and family member regional meetings and statewide webinar/conference call.

Participant Satisfaction Survey

At the end of every regional meeting, a survey was completed by each participant in order to gather feedback about the degree to which the meeting goals were clear and whether the participants felt they had adequate information and opportunity to make informed recommendations. For a copy of the post-meeting survey, see Appendix F.

Input from County Data Informants

Research methods and choice of data sources for the two proposed studies was guided by the following factors:

1. Correspondence with recommendations from the participatory planning process
2. Correspondence with MHSA values
3. Relevance and credibility to public mental health stakeholders
4. Consideration of existing county evaluation efforts and priorities.

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[11] In order to provide participants who joined the webinar/conference call additional time to share their recommendations, one of the lead facilitators offered to convene individual calls. Two of the 17 participants from the webinar/conference call participated in an individual follow up call.

[12] There were four participants from community organizations and only one participant from a county mental health program. All participants affirmed that the recommendations from consumers and family members were consistent with the priorities of their respective organizations/programs.

The first three factors were specifically addressed in the design and execution of the participatory planning process. The fourth factor has been addressed by incorporating findings from the research team's previous work with state and County-level data specialists,[13] and through a process of gathering input from County data informants. To this end, the research team convened discussions and correspondence with individuals from seven counties[14] concerning the programs, outcome indicators, and study methods that were prioritized through the participatory planning process. Input was gathered about the relevance of the programs and indicators, availability of existing data, and recommendations concerning study methods.

Analyzing Participant Input

The participatory planning process was designed to inform three key study decisions, as follows:

1. Programs to be the focus of the two evaluation studies
2. Outcome indicators to be investigated
3. Research methods to be employed.

Results from the planning process included the "votes" cast in regards to program focus and outcome indicators, as well as major themes or recommendations made by participants in regards to research methods. Recommendations from participants were staged, first focusing on programs, then outcome indicators, and finally methods. Selection decisions, at each stage, were based on consideration of: (1) preponderance of support from across all participants; (2) convergence in priorities across regional meetings; and (3) the degree to which priorities were clearly differentiated.
The first criterion, preponderance of support, was measured as the total number of votes cast for a specific program (in the case of the first set of decisions) or outcome indicators (in the case of the second set of decisions).

The second criterion, convergence in priorities across regional meetings, was measured by the number of times a program was ranked highest by the different meetings. This criterion is important to ensure that decisions not only reflect the most "popular" programs but also ensures that decisions are shared across the diverse groups of participants that joined the regional meetings.

The third criterion, degree of clarity, refers to scatter and clustering of votes – that is, the degree to which the selected programs and indicators received more votes (higher

[13] In response to Phase II deliverables, 2a-2d.
[14] Input was gathered from individuals in the following counties: Los Angeles, Nevada, Riverside, San Francisco, Santa Barbara, Shasta, and Ventura

preference or priority) relative to the other options. This criterion was applied by identifying "natural" breaks in the ranking patterns such that the selected programs and criteria were the clear top choices.

Specifically, decisions concerning which programs to select were made first and served as the foundation for the subsequent recommendations. Program choices represented largely exclusive (non-overlapping) service categories such that voting for one category was independent of any other. As a consequence, the criteria of preponderance of support and convergence were employed. Programs were selected based on being a top choice by participants in general (aggregate votes across the eight meetings and webinar/conference call in regard to the GSD and MHSA programs, respectively), and being the top choice for multiple meetings.

Decisions concerning which outcome indicators to select were made second and in reference to the program selected by the participants in each meeting. However, the outcome indicators had broad relevance across programs. For example, the indicator "paid and unpaid employment" has obvious relevance in evaluating employment services, but also has relevance when evaluating crisis intervention programs. Similarly, the indicator "perception of access to services" has relevance in evaluating virtually any of the program categories.[15] As a consequence, outcome indicators were selected based on preponderance of support alone, based on the total votes from participants across all meetings.

Decisions concerning which research methods to employ were made third, and like the indicators, research approaches had broad applicability across programs and indicators. For example, surveys are a viable strategy for evaluating "continuity of care" or "recovery, wellness, and resilience orientation" whether in regards to peer counseling or employment supports. As a consequence, decisions about research methods were based on preponderance of support based on the frequency of participants' recommendations.

PLANNING PROCESS RESULTS

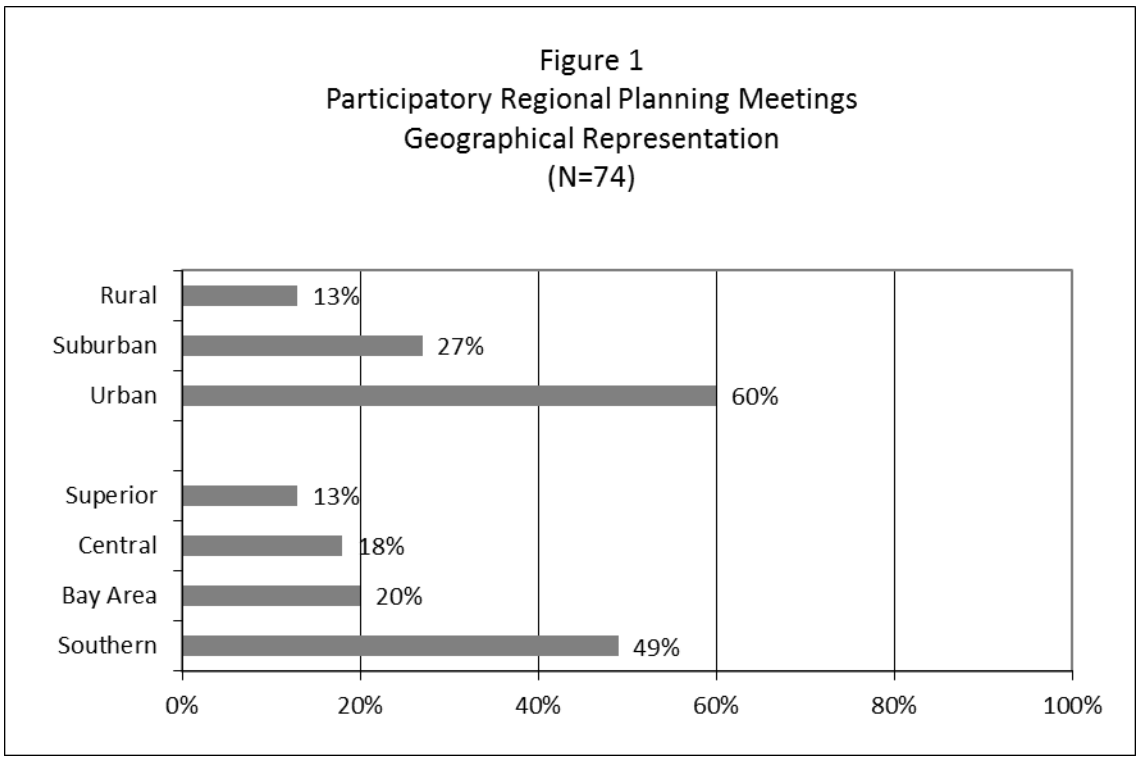
Participants for Regional Meetings

A total of 74 individuals participated in regional planning meetings, which is 92% of the 80 individuals (10 individuals per meeting) that were projected for the in-person meetings. The numbers of participants per meeting are listed in Table 2.

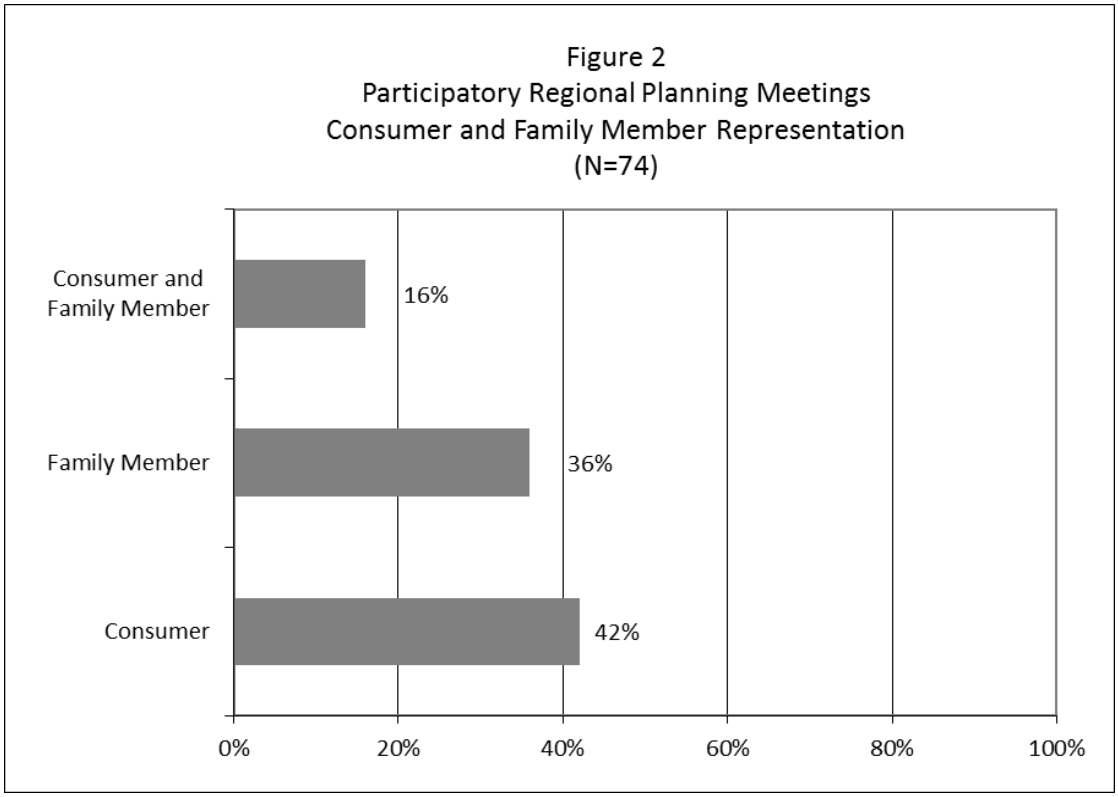
[15] An analysis of the top rated outcome indicators, from across meetings, comparing groups that selected the same or different program focus, shows high levels of convergence, consistent with the view that top rated indicators have broad relevance.

Table 2 Participatory Planning Regional Meetings Number of Participants by Meeting Location	
Meeting Location	**Number of Participants**
Redding	10
Alameda	7
Salinas	8
Sacramento	10
Fresno	3
Santa Barbara	12
Los Angeles	9
Santa Ana	15

Participants were representative of all regions of the State and primary population densities. As presented in Figure 1 below, 13% of the participants were from the Superior region, 18% from the Central region, 20% from the Bay Area, and 49% from Southern California. Moreover, 13% of participants were from a rural community, 27% from suburban community, and 60% from urban areas.

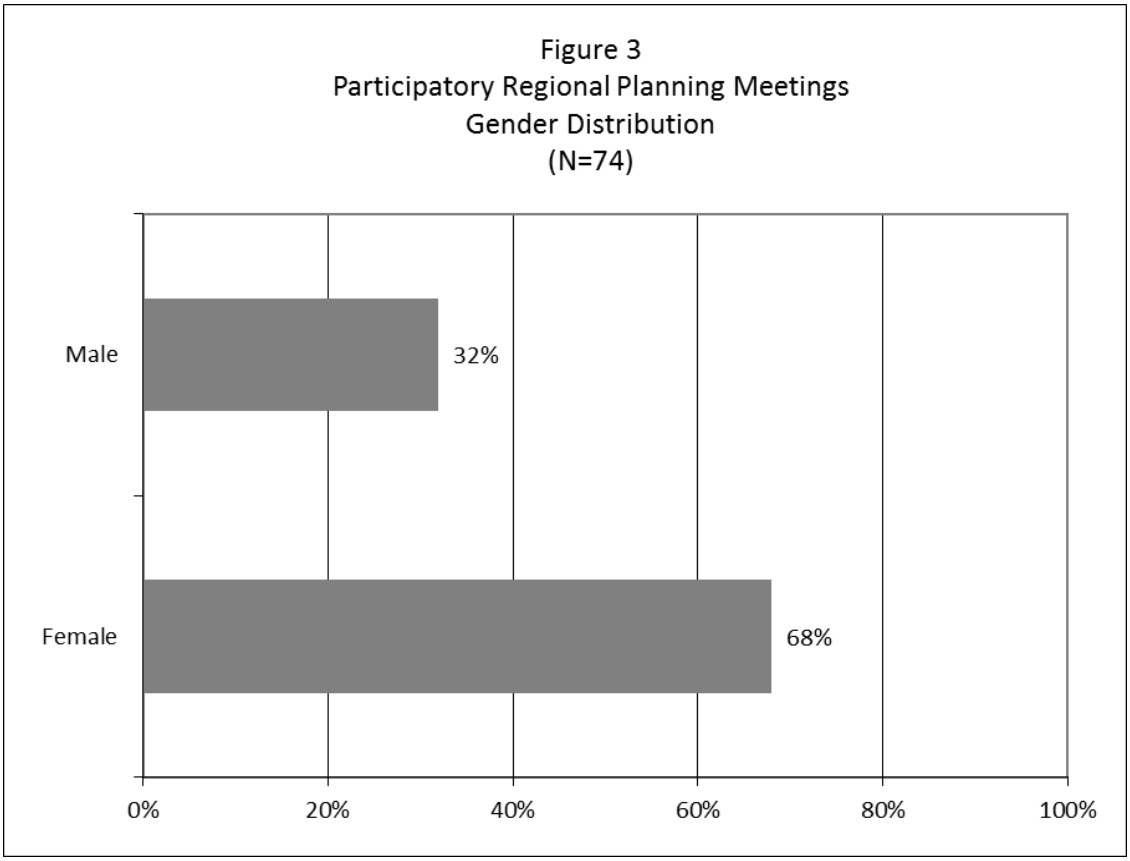


Participants were highly diverse. Forty-two (42) percent of participants indicated that they were a consumer, 36% a family member, and 16% both a consumer and a family member (see Figure 2).[16] As a group, they had an average age of 50, ranging from 21 to 75 years of age.[17] Sixty-eight (68) percent of participants were female and 32% were male (see Figure 3).



[16] The total does not equal 100% because four of the participants did not indicate their status as a consumer or family member.

[17] Average age is based on information from 54 of the participants. Age was not available for 20 of the participants.



The majority of participants (42%) identified their race as Latino, followed by 38% who identified themselves as Caucasian, 11% as African American, 9% as Asian American,[18] and 3% as American Indian (see Figure 4).[19] In addition, the majority of participants (75%) identified English as their primary language. Twenty (20) percent of participants identified Spanish, 4% identified Korean, and 1% identified Vietnamese as their primary language (see Figure 5).

[18] The Asian American category includes individuals who identified themselves as Chinese, Filipino, Korean or Vietnamese.
[19] The total exceeds 100% because two individuals identified themselves as being mixed race.

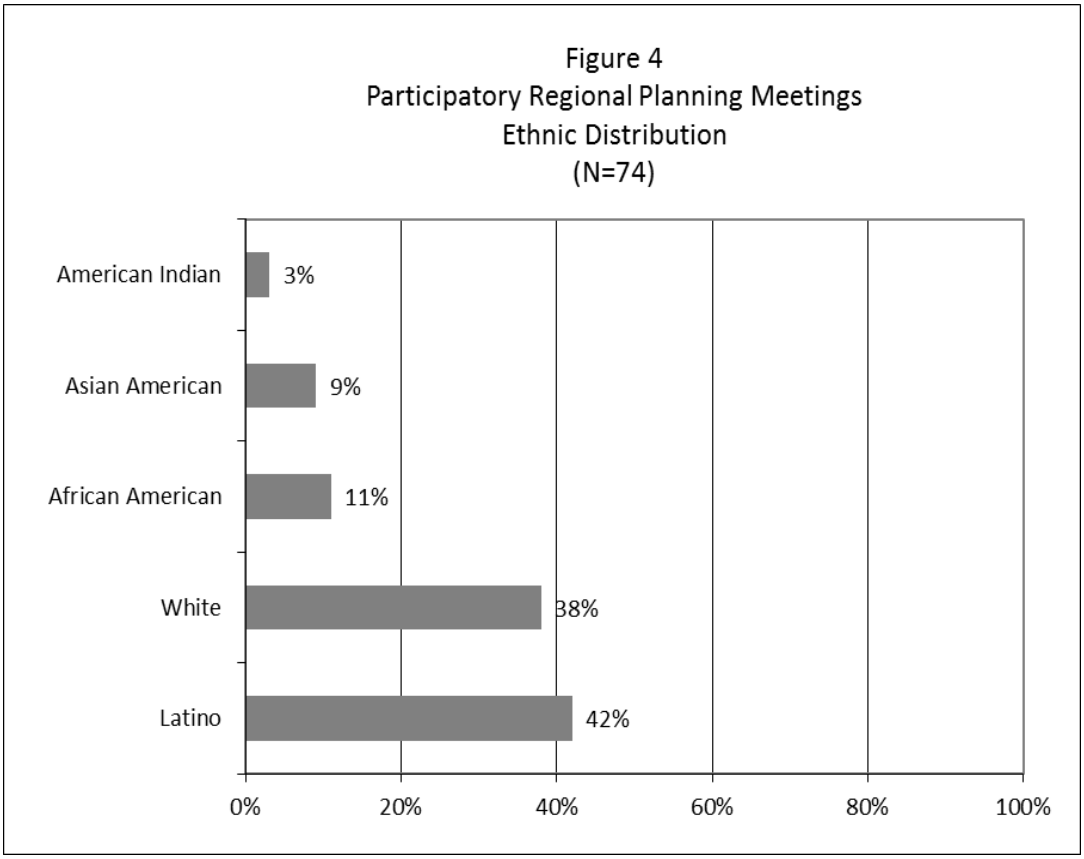


Figure 4
Participatory Regional Planning Meetings
Ethnic Distribution
(N=74)
American Indian
3%
Asian American
9%
African American
11%
White
38%
Latino
42%
0%
20%
40%
60%
80%
100%

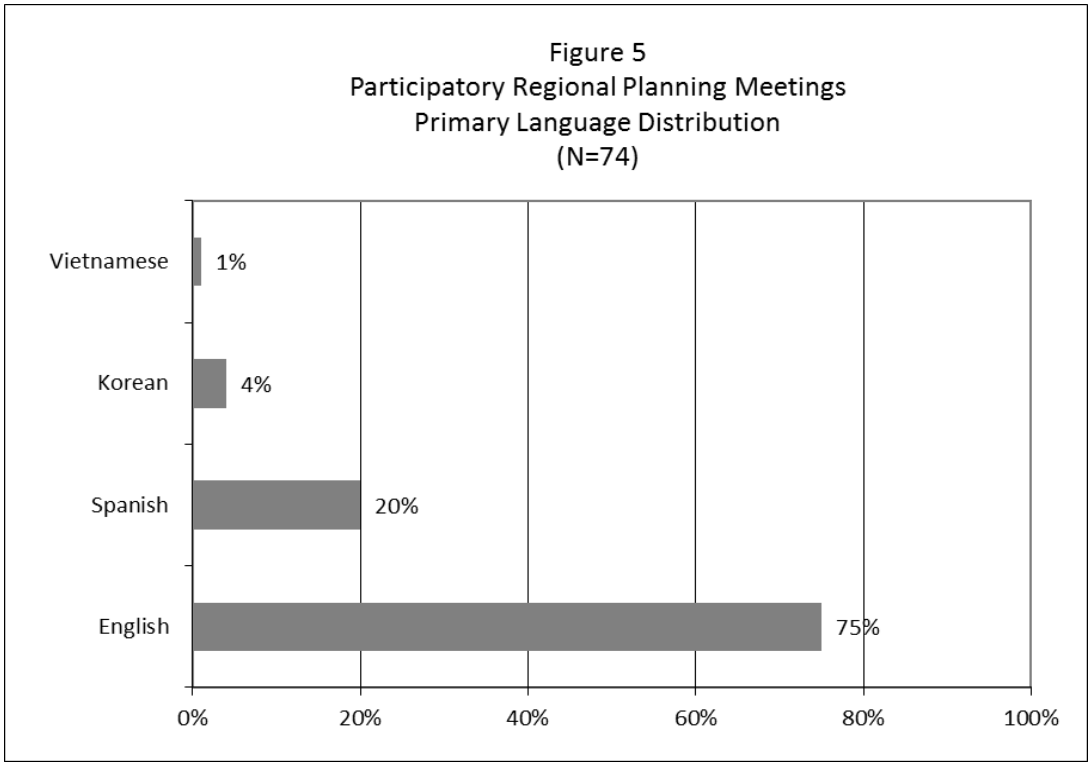
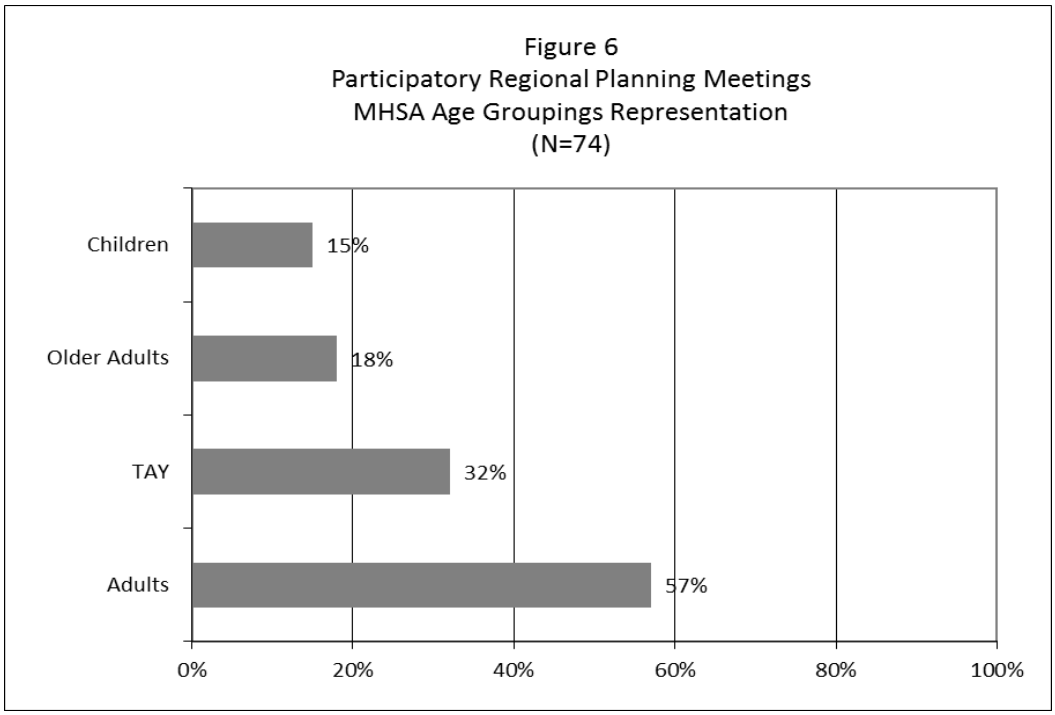
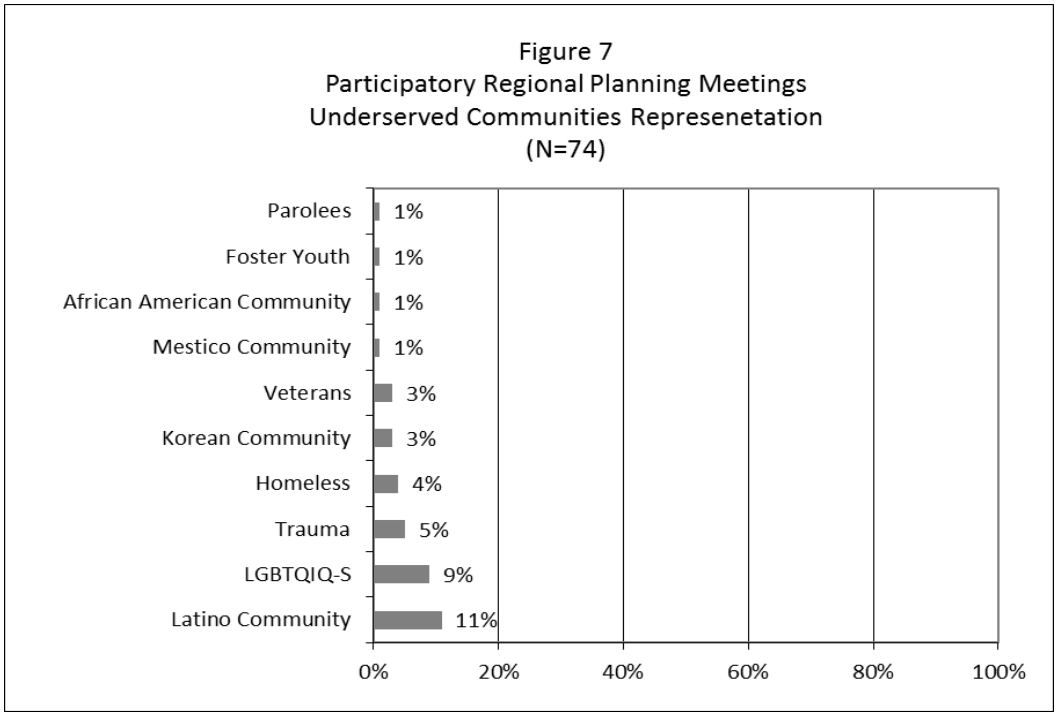


Figure 5
Participatory Regional Planning Meetings
Primary Language Distribution
(N=74)
Vietnamese
1%
Korean
4%
Spanish
20%
English
75%
0%
20%
40%
60%
80%
100%

All four MHSA age groups were well represented by meeting participants, with 57% representing adults, 32% transition age youth, 18% older adults, and 15% children (see Figure 6).[20] In reference to underserved communities, 24 participants (or 32% of all participants) responded to the open ended question about representing underserved populations.[21] Eleven (11) percent of the 74 participants indicated that they were representing the Latino community, 9% the LGBTQ community, 5% individuals who had experienced trauma, 4% individuals who were homeless, 3% the Korean community, 3% veterans, and 1% indicated that they were representing the Mestico, African American, foster youth, and parolees communities, respectively (see Figure 7).



[20] The total exceeds 100% because 13 individuals identified themselves as representing two or more of the age groups, and four individuals did not indicate which age groups they were representing.
[21] Two of the participants indicated that they were representing 3 underserved communities each, and 2 of the participants indicated that they were representing 2 communities each. The remaining 20 participants indicated representing a single community.



Participants for Statewide Consumer and Family Member Webinar/Conference Call

A total of seventeen individuals participated in the statewide webinar/conference call for consumers and family members. Forty-one (41) percent of these participants identified themselves as a family member, 35% as a consumer, and 24% as both a consumer and family member. In addition, 70% of participants reported that they were representing adults, 12% transition age youth, and 6% older adults. None of the 17 individuals on the statewide webinar/conference call for consumers and family members indicated that they were representing children.[22]

Participant Satisfaction Survey Results

Results from the post-meeting survey[23] show that the vast majority of participants thought that the meeting goals were clear and that they were provided adequate

[22] The total does not equal 100% because three individuals did not indicate which age groups they were representing, and one individual identified him/herself as representing two of the age groups.

[23] The survey was submitted by 73 of the 74 participants in the regional meetings. In each case, all items requiring a rating were completed, in addition, 41 of the participants included a response to the following open-ended item: *In the space below, please add any other comments about this meeting that you think would be important for us to know.* The survey was not administered to participants who joined the statewide conference call for consumers and family members.

information and opportunity to make informed recommendations specific to the three primary topic areas. Each of the four items was rated on a scale from a low of "1" indicating "*not at all*" to a high of "5" indicating "*definitely*". All survey items received an average rating of 4.7 or 4.8 (see Table 3).

Comments provided by participants in response to an open-ended question on the post-meeting survey were, in the vast majority of cases, very positive and consistent with the favorable ratings described above. For all comments provided on the survey, see Appendix G.

Table 3
Participatory Planning Regional Meetings
Post-Meeting Survey Results

Survey Question	Average Rating (1 to 5)
The meeting goals were clear.	4.8
I was provided the information and opportunity to make informed recommendations about which *General System Development and consumer involvement programs* should be the focus of evaluation.	4.7
I was provided the information and opportunity to make informed recommendations about which *outcomes and indicators* should be the focus of evaluation.	4.8
I was provided the information and opportunity to make informed recommendations about which *study methods* should be used for an evaluation.	4.7

Programs Recommended by Participants

The GSD Programs are programs funded within the Community Services and Supports component of MHSA. The list of GSD programs from which participants selected evaluation priorities was derived from a list of the most commonly funded GSD programs across the state. The MHSA Programs are programs within the MHSA/Systems of Care statutes that include GSD programs but are broader to encompass MHSA programs and strategies that improve the involvement of consumers, family members, and caregivers in the public mental health system. Participants were not provided a list of such programs; rather, they were asked to identify any MHSA program or strategy that they believed should be prioritized in the evaluation study.

Recommendations from the participatory planning process were consistent across the eight regional meetings and the statewide webinar/conference call. Specific programs and the corresponding outcome indicators to be the focus of the two research studies

emerged from the participant rankings. Moreover, there was clear direction around the choice of research methods to be used.

GSD Programs: Recommendations

For the GSD funded programs, participants indicated a preference for evaluating either *crisis intervention/safety plans* or *peer counseling programs*. Rankings for each of the GSD program categories are presented in Table 4, organized by meeting location. Crisis intervention/safety plans and peer counseling categories received the largest number of rankings across the eight regional meetings and statewide webinar/conference call.[24] Moreover, crisis intervention/safety plan services were the top choice for half of the regional meetings and the statewide webinar/conference call. Peer counseling was the first choice for one of the regional meetings and a close second for two of the other meetings plus the statewide webinar/conference call.

Table 4
Participatory Planning Regional Meetings
GSD Program Evaluation Priorities

Program Type[25]	Meeting Location								
	Redding	Alameda	Salinas	Sac-ramento	Fresno	Santa Barbara	Los Angeles	Santa Ana	Total
Crisis Intervention Supports and Safety Plans	**8**	1	**6**	**7**	0	2	**6**	3	**33**
Peer Counseling	2	0	**5**	**6**	0	**9**	4	1	**27**
Housing Supports	2	1	0	0	**3**	4	0	**9**	19
Wellness and Recovery Centers	4	1	1	3	0	5	0	**9**	23
Outreach and Engagement Activities	1	**7**	0	4	0	1	2	5	20
Educational Supports	0	3	3	0	**3**	1	4	3	17
Wraparound	3	1	0	0	0	2	0	0	6

[24] The statewide webinar/conference call was an abbreviated opportunity to provide recommendations. The results from this call were similar to those from the regional meetings. The top rated focus for a GSD research study was crisis/safety plans intervention (nine votes), followed closely by peer counseling (seven votes).

[25] Based on feedback from meeting participants, similar GSD categories were combined as follows: (1) crisis intervention and safety plans, (2) wellness and recovery centers, and (3) outreach and engagement activities.

MHSA Programs: Recommendations

For all MHSA funded programs, there was a clear and strong preference for evaluating employment support programs (see Table 5). Employment supports received the largest number of rankings across the eight regional meetings. Moreover, employment supports was the first choice for half of the regional meetings. Wellness and recovery centers, outreach/engagement, consumer advocacy/empowerment councils, in-home services, and family resources centers were the first choice for one meeting each.

Table 5
Participatory Planning Regional Meetings
MHSA Program Evaluation Priorities

Program Type	Meeting Location								
	Redding	Alameda	Salinas	Sacramento	Fresno	Santa Barbara	Los Angeles	Santa Ana	Total
Crisis Intervention Supports and Safety Plans	0	0	1	0	0	1	0	0	2
Peer Counseling	3	1	0	0	0	0	0	0	4
Housing Supports	1	2	0	0	0	0	3	3	9
Wellness and Recovery Centers	**6**	1	0	4	0	0	1	4	16
Outreach and Engagement Activities	3	2	**10**	2	0	0	4	0	21
Educational Supports	1	0	0	0	0	7	0	0	8
Wraparound	0	0	0	0	1	0	2	0	3
Employment Supports	0	0	0	4	**3**	**12**	**6**	**11**	**36**

Table 5 (Continued) Participatory Planning Regional Meetings MHSA Program Evaluation Priorities									
Program Type	**Meeting Location**								
	Redding	**Alameda**	**Salinas**	**Sacramento**	**Fresno**	**Santa Barbara**	**Los Angeles**	**Santa Ana**	**Total**
Consumer Advocacy or Empowerment Councils and Programs	0	0	4	**8**	0	2	0	7	21
In Home Services	**6**	0	0	0	0	2	0	0	8
Family Resource Centers	0	**4**	0	0	0	0	0	0	4
Primary Care Supports	0	0	1	0	0	0	0	2	3
Mental Health First Aid	0	3	0	0	0	0	0	0	3
Art Focused Programs	0	0	0	0	0	0	0	2	2
Re-Entry Services	0	0	0	2	0	0	0	0	2
Corrections Focused Programs	0	0	0	0	0	0	0	1	1

Outcome Indicators Recommended by Participants

Rankings of outcome indicators from the regional meetings and statewide webinar/conference call revealed similar preferences for both GSD programs MHSA programs.[26] The rankings are presented in Table 6 and show a clear and strong preference for a set of indicators that are relevant to the programs recommended by participants. Our selection criteria described earlier led to the following seven indicators as priority indicators for the two studies proposed:

[26] The statewide webinar/conference call was an abbreviated opportunity to provide recommendations. The results from this call were similar to those from the regional meetings. The top outcome indicators were satisfaction, continuity of care, and perception of access (four individuals selecting each), followed by wellbeing, employment, and appropriateness of care (three individuals selecting each).

1. Paid and unpaid employment
2. Consumer wellbeing
3. Recovery, wellness, and resilience orientation
4. Consumer/family perception of access to services
5. Housing situation
6. Continuity of care
7. Appropriateness of care

As shown in Table 6, two of the seven indicators (paid and unpaid employment and consumer wellbeing) overlap between the GSD programs and MHSA Program. This overlap is noteworthy for the study approach we propose below (see the study proposals for more detail).

Table 6
Priority Outcome Indicators

Outcome Indicator	GSD Programs	MHSA Programs	Total
Paid and unpaid employment	**27**	**38**	**65**
Consumer wellbeing	**27**	**24**	**51**
Recovery, wellness, and resilience orientation	**22**	**26**	**48**
Consumer/family perception of access to services	**21**	**24**	**45**
Housing situation	**26**	**19**	**45**
Continuity of care	**24**	**15**	**39**
Appropriateness of care	**21**	**11**	**32**
Demographic profile of consumers served	15	15	30
Satisfaction	10	19	29
Cultural appropriateness of services	15	11	26
Evidence-based practice programs and services	8	15	23
Hospitalization for mental health episodes	18	3	21
Access to primary care physician	10	8	18
School attendance	6	10	16
Penetration rates	9	5	14
Arrests	9	4	13
Workforce composition	5	7	12
New consumers by demographic profile	4	7	11
High need consumers served	3	5	8
24-Hour care	6	1	7
Consumers served annually	1	3	4
Involuntary care	1	0	1

Research Methods Recommended by Participants

There was strong agreement across participants from the eight regional meetings concerning research methods. Notably, participants strongly favored the idea of employing a combination of surveys, interviews, and/or focus groups with surveys being a primary recommendation in seven of the eight regional meetings. If a survey was to be used, a number of participants recommended that consumers and family members be directly involved in development of the survey or interview questions.

Some participants expressed concern about how consumers and family members would be recruited to participate in the studies, noting that consumers and family members who may be less engaged in treatment services or are disenfranchised may be overlooked. There was a similar concern expressed about consumers and family members from un-served and underserved communities being overlooked.

Finally, a relatively small number of participants expressed concern about the accuracy of the information in client records and existing information databases. Alternatively, other participants viewed existing data as being useful because it would be objective, quantified, and available; however, they also cautioned against relying on existing data.

Recommendations from County Data Informants

Findings from the evaluation team's previous work with state and County-level data specialists highlight concerns about the availability and integrity of mental health service data that would be relevant for the participatory evaluation studies that have been prioritized. It is noteworthy, in this regard, that data informants from the State Department of Mental Health cautioned that data would be incomplete; in some cases, not all counties contribute to the statewide system. Moreover, data informants from the California Mental Health Directors Association (CMHDA) Indicators, Data, Evaluation Accountability (IDEA) Committee warned that particular types of mental health service data would not be consistent as a result of both counties' use of different data management systems and different data capacities.

Data elements that would be credible and accurate reflections of the prioritized indicators are largely not available in statewide or County databases.[27] This conclusion was confirmed in conversations with County data informants. There was universal agreement across individuals from the seven counties who participated in discussions about the proposed studies that the selected programs are meaningful and relevant. Moreover, there was agreement that data specific to the provision and impact of these services is not available in current databases.

[27] For example, data on the provision of employment or peer counseling services are not available in the Client and Services Information System or Data Collection and Reporting Database.

The vast majority of the County data informants found surveys and follows up interviews to be an appropriate, if not preferred, research approach. One individual noted, in reference to the three programs prioritized in the participatory planning process, "Surveys are the only option for standard data across counties." In addition, they shared the following concerns and recommendations in regards to conducting a survey:

1. Return rates tend to be low
2. Relying on surveys to be distributed through mental health clinics tends to overlook consumers and family members who may not be actively engaged in services
3. Survey length, reading levels, and availability in languages other than English are all important considerations
4. Survey questions need to be developed that lead to actionable results
5. Engaging the assistance of consumer and family partners around distribution and administration of surveys can help insure representative sampling and high return rates
6. Opportunities may exist to build upon similar efforts currently underway in a number of counties.

STUDY PROPOSALS

Participatory Evaluation Approach

The Spectrum of Participatory Approaches to Evaluation

The general purpose for conducting a participatory study can typically be categorized into one of two areas: either for emancipatory/social justice reasons or for the purpose of utilizing socially constructed knowledge that has been systematically collected.[28,29] It is also generally agreed that "participatory evaluation involves a *partnership* between the evaluator and those who participate in the evaluation".[30] However, the spectrum of approaches to research and evaluation that are participatory in nature is wide. The type and nature of participation and the "partnership" in such studies can vary accordingly. In their seminal article on the topic, Bradley J. Cousins and Elizabeth Whitmore[31] identified

[28] Cousins, J.B., & Earl, L.M. (Eds.) (1995). *Participatory evaluation in education: Studies in evaluation use and organizational learning.* London: Falmer.
[29] Upshur, C.C., & Barreto-Cortez, E. (1995). What is Participatory Evaluation (PE)? What Are Its Roots? *The Evaluation Exchange, 1(3&4).* Retrieved November 29, 2011, from http://hfrp.org/evaluation/the-evaluation-exchange/issue-archive/participatory-evaluation
[30] Patton, M.Q. (2008). *Utilization-focused evaluation*, p. 176. Thousand Oaks, CA: Sage.
[31] Cousins, J.B., & Whitmore, E. (1998). Framing participatory evaluation. In E. Whitmore (ed.), Understanding and practicing participatory evaluation. *New Directions for Evaluation, (80), pp. 5-23.*

and categorized 10 forms of "collaborative inquiry"[32] along three distinct dimensions of participation and collaboration including who has control over decision making in a participatory study, who is selected to participate, and the depth of their participation.

In 1998, Cousins and Whitmore acknowledged that the label of participatory evaluation was being applied differently by different people. A decade later, Michael Q. Patton still contended that "since no definitive definitions exist for 'participatory' and 'collaborative' evaluation, these phrases must be defined and given meaning in each setting where they're used".[33] He further suggests that Cousins and Whitmore's dimension classification scheme can be used to help design and negotiate participatory evaluations and that there are no right or wrong places to be on these dimensions; rather, they should be based on the project context (such as evaluation purpose, scope, and resources) and negotiated among the funder, evaluator, and stakeholders.

Given the range of approaches to and within participatory forms of evaluation and research, it is expected that stakeholders of the MHSA Statewide Evaluation may have different views and expectations about how the evaluation deliverables of the participatory research component will be carried out. Therefore, the approach to be taken must be clearly delineated so that interested and involved parties understand the nature of the project, its strengths and limitations, and their individual roles and responsibilities.

Notably, there are certain constraints in the context of the MHSA Statewide Evaluation that impact the evaluation's participatory nature. In particular, certain timelines/deadlines and deliverables have been established by the MHSOAC, and there is a requirement that one of the two evaluation studies must be of a GSD-funded program. In this respect, not all decisions have been left up to participant stakeholders. Still, there is ample opportunity to implement participatory procedures in nearly every aspect of the evaluation process. In the paragraphs below, we define our participatory approach for conducting the two evaluation studies proposed herein.

Participant Selection, Roles, and Responsibilities

We use Cousins and Whitmore's identified dimensions of participation and collaboration in evaluative inquiry to describe who will be the main partners in our participatory approach, the depth of their participation, and where decision making power will reside.

[32] This includes participatory evaluation; other forms of collaborative evaluation, such as empowerment evaluation; and other forms of collaborative inquiry, such as participatory action research.
[33] Patton, M.Q. (2008). *Utilization-focused evaluation,* p. 175. Thousand Oaks, CA: Sage.

Dimension 1: Who Will Have Control Over Decision Making?

Many decisions are made over the course of an evaluation study. One of the first questions that might arise in a participatory evaluation context is: who has control over the decision making? Cousins and Whitmore suggest that there are several possibilities. Control over decision making can rest entirely in the hands of the evaluator, wholly in the hands of stakeholder participants, or some balance between the two. Control over decision making in our participatory studies of GSD and MHSA programs will be balanced between the evaluation team and the participant stakeholders. The evaluation team will guide the process in response to participant priorities, but will need to attend to practical constraints such as timelines, resources, methodological issues, and data credibility/trustworthiness (i.e., validity/reliability). The evaluation team will mediate and help to facilitate the decision making process when there is disagreement or conflict among participant stakeholders.

Dimension 2: Who Will Be Selected to Participate?

According to Cousins and Whitmore, the selection of stakeholders for inclusion in a participatory evaluation can be restricted to primary users of the evaluative data (e.g., program staff and administrators) or can include all groups who might have a legitimate stake (e.g., consumers, community groups, funders). The main group of stakeholders we are inviting to partner with us in conducting these evaluations is, per contractual guidelines for the deliverables, comprised of consumers and their family members or representatives. During our planning process described above, participation was more broad and inclusive, because we wanted input from as many consumers and representatives as possible on the programs of interest, indicators, and methods. For practical reasons, we need to work with a more exclusive group moving forward to manage the process as the work becomes more intense.

Thus, our evaluations of GSD and MHSA programs will be carried out in partnership with a select group of Participatory Evaluation Partners (PEPs). The PEPs will be either consumers and their family members or representatives who are closely affiliated with advocacy or service organizations, or consumers, family members or representatives who currently function as professional staff of such organizations. A total of 10 PEPs will be recruited from the pool of consumers and their family members or representatives who participated in our planning process and expressed interest in being included in future components of the study. These partners will be purposefully selected from across four state regions (southern, Bay Area, central, and superior) to represent consumers of all age groups as well as an array of demographic, un-served, and underserved groups including ethnic minorities, veterans, and LGBTQ community members. This purposeful recruitment strategy will help to ensure that PEPs:

- Are invested and reliable partners in the process
- Will function as important gatekeepers who can successfully access and engage mental health consumers, including those who are typically disenfranchised and unrepresented in studies of the system
- Will improve dissemination efforts and utilization of results due to their access and influence
- Will further apply the evaluation knowledge and skills they acquire through this process in their future work on behalf of mental health consumers.

Dimension 3: What Will Be the Depth of Participation?

In collaborative or participatory inquiry, the depth of participation from stakeholders – as with everything else – can vary widely from participant stakeholders playing a "limited" consultative role at the planning and/or interpretive stages of the study only to having "extensive" depth of participation in all aspects of the research.[34] In our evaluations of GSD and MHSA programs, the PEPs will be asked to participate extensively in all aspects of the research from planning to implementation and dissemination.[35] This process began with our participatory planning process described above and will continue as described in the study proposals.

Training and Compensation of Participant Evaluation Partners (PEPs)

The evaluation team will train the PEPs on all data collection and analysis procedures that will be employed over the course of the studies (described below in the methods sections for each study). Training will involve a combination of in-person meetings, webinars, and conference calls. In addition, the evaluation team will convene regular calls and in-person meetings with the PEPs to make decisions, discuss progress and challenges, and troubleshoot.

The PEPs will each be provided a $500 honorarium for their participation in and contributions to the evaluations. Additional expected benefits for PEPs include professional development and networking opportunities with colleagues, as well as

[34] Ibid 27.

[35] In a presentation to the MHSOAC Evaluation Committee on October 26, 2011 entitled, *Program Evaluation and Evaluating Community Engagement,* Sergio Aguilar-Gaxiola, M.D., Ph.D. defined participatory evaluation as an evaluation approach that "actively engages the community in all stages of the evaluation process." Although there is not an official or shared definition of participatory evaluation – and our proposed evaluation studies are not evaluations of community engagement – it should be noted that our proposed participatory evaluation approach of soliciting an extensive depth of participation from our PEPs is aligned with Dr. Aguilar's definition.

training on evaluation research. Travel for the PEPs will be minimized to the extent possible.

Preview of Study Proposals

Two separate and distinct proposals to evaluate two GSD funded programs and one MHSA funded program are proposed. However, given the programs, outcome indicators, and research methods prioritized in the participatory planning process, the application of a synchronized process between the two studies through a single comprehensive survey and in-depth interviews is ideal.

The target population for both studies is the same – that is, consumers and family members at large. Also, the indicators of interest have high levels of relevance across the program categories. Moreover, this approach overcomes significant limitations around availability and integrity of existing data sets. For example, there is no systematic way (e.g., from claiming data submitted by counties) to identify individuals who received peer counseling services. Having a broader sampling base generates potential subgroups of consumers for comparing service access and outcomes in interesting and valuable ways.

Finally, the use of a statewide survey developed, administered, and interpreted in partnership with PEPs provides an opportunity to gather a new set of data that holds the promise of shedding light on the impacts of MHSA-funded services that has been unavailable to date.

Study #1: General System Development Programs

Combined rankings from the regional meetings and statewide webinar/conference call identified crisis intervention/safety plan programs (herein referred to as "crisis intervention programs") and peer counseling programs as the two primary programs to evaluate under GSD. Additionally, there were seven priority outcomes identified by participants (see the measures section below).

Study Questions

The study questions for evaluating both crisis intervention and peer counseling programs are intended to identify whether there was a need for crisis intervention or peer counseling, whether crisis intervention and/or peer counseling services were accessed and received, the nature or defining features of those services, and what the outcomes of receiving (or not receiving) services were in reference to the priority outcomes identified in the regional meetings and statewide webinar/conference call.

The overarching research questions for evaluating crisis intervention programs are as follows:

1. By whom, why, and when was there a mental health crisis or were crisis intervention services needed?
2. In what timeframe were crisis intervention services received?
3. What key crisis intervention activities were received?
4. Was the level of care received for the crisis appropriate?
5. Did key activities of crisis intervention exemplify recovery, wellness, and resilience orientation?
6. Were inpatient psychiatric services received after the crisis intervention?
7. What were consumers' perceptions of access to crisis intervention and routine mental health services before and after the crisis?
8. Were routine mental health services provided prior to the crisis, after the crisis, and then after crisis intervention?
9. Was there a change in employment and housing before the crisis, after the crisis, and then after crisis intervention?
10. Was there a change in consumer wellbeing before the crisis, after the crisis, and then after crisis intervention?

The overarching research questions for evaluating peer counseling programs are as follows:

1. By whom, why, and when was there a need/desire for peer counseling services?
2. In what timeframe were peer counseling services received?
3. What key peer counseling activities were received?
4. Was the level of care received through peer counseling appropriate?
5. Did key activities of peer counseling exemplify recovery, wellness, and resilience orientation?
6. What were consumers' perceptions of access to peer counseling services?
7. Was there a change in employment and housing before and after receiving peer counseling services?
8. Was there a change in consumer wellbeing before and after receiving peer counseling services?

Methods

Consumers and family members who participated in the participatory planning process agreed that the evaluations should include a mix of quantitative and qualitative methods. Participants specifically recommended a combination of quantitative surveys and qualitative interviews and/or focus groups as the most effective way to collect data. They also recommended that consumers should help develop data collection tools. There was near-consensus that data should be collected directly from consumers rather than relying on service professionals to rate consumers on a measure, for example.

Furthermore, while surveys were recommended, there was concern that conducting a survey could leave out consumers who are not engaged in services or who have been disenfranchised because of severe and persistent mental illness or homelessness, for example.

In light of our participatory evaluation approach, as well as recommendations by participants and County data informants, we propose a statewide survey followed by in-depth interviews of a subset of 40 consumers who complete the survey. The mixed methods evaluation will employ a retrospective cross-sectional design with longitudinal measures built into the retrospective survey. The survey will be quantitative and the in-depth interviews will be qualitative using a grounded theory approach to collect and analyze qualitative data.[36]

The survey will be pen-and-paper with a web-based option. The pen-and-paper survey, as well as the web-based survey, will be available in English, Spanish, and Chinese. The survey will be developed by the Participatory Evaluation Partners (PEPs) and evaluation team. The length of the survey will be determined through the process of developing the survey. Particular attention will be paid to making the survey as brief as possible to reduce respondent burden and missing data, as per the advice of County data informants.

In-depth interviews will be conducted in person using an interview protocol that will be developed by the PEPs and evaluation team. When necessary, interviews may be conducted by telephone. The interview will be conducted in various languages, including sign language for individuals who are deaf and/or hard of hearing. The span of languages will be determined in large part by the capacity of the PEPs, because the PEPs will be leading the interviews with support from an evaluation team member (i.e., each PEP may conduct four in-depth interviews). The interview will take approximately one hour, and each interview participant will receive a $30 gift card to a major store chain in appreciation for his or her time.

Sample

The aim of the evaluation is to have representation from a diverse cross-section of mental health consumers and their family members or representatives. We will seek participation from the population of public mental health consumers and their family members or representatives across the state. For the survey, there will be no sampling criteria per se, although the language limitations of the evaluation will limit participation from consumers who do not read English, Spanish, or Chinese. We will seek

[36] Strauss, A., & Corbin, J. (1998). *Basics of qualitative research techniques and procedures for developing grounded theory*. London: Sage.

representation from consumers of all ages;[37] both genders; all races/ethnicities; various cultural groups (e.g., LGBQT and veterans); and rural, urban, and suburban communities across the state. We anticipate a sample size of 750 consumers to capture the diversity of consumers with respect to these characteristics. From a research perspective, this is a sufficient sample size to conduct statistical analyses of subgroups that are expected (e.g., subgroups by age, gender, race, and consumers who have or have not received crisis intervention or peer counseling services).[38] From a practical perspective, the limited evaluation resources means that recruitment for study participants will rest heavily on organizations that have direct contact with consumers rather than more costly means of recruitment through media campaigns and monetary incentives, for example.

For the in-depth interviews, the PEPs and evaluation team will invite 40 consumers (or family members, caregivers, or parents/guardians of minors) to participate who represent a diverse group by age (i.e., child, transition age youth, adult, and older adult), gender, race/ethnicity, and region (e.g., Superior, Bay Area, Central, and Southern). In response to the concerns raised during the participatory planning phase about surveys not reaching disenfranchised consumers, we will focus recruitment on disenfranchised consumers through the assistance of the PEPs and organizations that target such consumers. This not only addresses specific priorities of our planning participants but it could provide unique insight into a population that has traditionally been difficult to reach. We believe we will be able to reach this population through our PEPs who are trusted gatekeepers in the community and will be able to access this group through their connections. Also, we will seek participation from consumers whose primary language is not English, as well as consumers who are deaf and hard of hearing.

Recruitment Procedures

A similar process used for participatory planning will be used to recruit consumers for the survey. The PEPs will help guide this process by identifying the stakeholder groups for recruitment. At minimum, the four categories of stakeholders that were targeted for the participatory planning process also will be targeted for survey participation:

1. Mental health consumer and family member advocacy organizations
2. Provider organization associations and County mental health agencies
3. Community organizations and committees focusing on the needs of underserved populations
4. State agencies, County associations, and training centers.

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[37] Consumers must be at least 18 years old to participate. Those who are younger than 18 may participate with parent or guardian consent. A parent or guardian may participate in the survey or interview on behalf of a minor.

[38] We would need a minimum of 90 survey participants to conduct a multiple regression analysis with an anticipated effect size of .35, statistical power level of .9, and a probability level of .01 for 10 predictor variables.

The PEPs and evaluation team will correspond via email and telephone with these stakeholder groups to distribute information about the survey. The procedures for identifying survey participants as potential participants of the in-depth interviews will be developed between the PEPs and evaluation team. As an example of a procedure, the PEPs could recruit participants for the in-depth interviews and complete the survey and interviews back-to-back.

Consumer recruitment for the in-depth interviews will be more involved. Again, this process will be developed by the PEPs and evaluation team. This recruitment process is expected to involve a series of correspondence (either via email, telephone, or in person) between the PEPs and prospective interviewees to explain the interview purpose and protocol (including human subjects protection) and to schedule a time to conduct the interview, preferably in person.

Measures

Consistent with our participatory evaluation approach is the joint development of measures between the PEPs and evaluation team. As discussed earlier, the seven priority indicators that were recommended by participants of the regional meetings and statewide webinar/conference call were as follows:

1. Paid and unpaid employment
2. Consumer wellbeing
3. Recovery, wellness, and resilience orientation
4. Consumer/family perception of access to services
5. Housing situation
6. Continuity of care
7. Appropriateness of care.

The PEPs and evaluation team will together develop the survey and interview protocol to measure these seven priority indicators. The survey will be developed to answer the study questions. In addition, survey participants will be asked to provide demographic information such as age, gender, race/ethnicity, zip code, and whether they represent a specific cultural group (e.g., LGBQT, veteran, and deaf and hard of hearing).

Data Analysis

Quantitative data from the survey will be entered into and analyzed with the Statistical Package for the Social Sciences (SPSS) software. Survey data on crisis intervention and peer counseling programs will be combined, but analyses will be conducted both separately and together for all potential subgroups by age, gender, race/ethnicity, region, and service utilization (e.g., consumers who received services and those who did not).

Qualitative data from the in-depth interviews will be entered into and analyzed with the Dedoose software, which is designed for mixed methods studies. Because consumers who participate in the in-depth interviews also will have completed survey data, both sets of quantitative and qualitative data will be available for mixed analysis for approximately 40 consumers. Additional qualitative analyses will be conducted using a grounded theory approach to identify themes, relationships between themes, and dynamics within relationships that infer the degree of impact that crisis intervention and peer counseling services have on consumers' wellbeing, employment, and housing for example.

As with most evaluation activities proposed, data analysis and interpretation will be done in partnership with the PEPs. The PEPs and evaluation team also will consult with County data informants to get input on data analysis, interpretation, and reporting in a way that is useful for quality improvement in data collection and programming.

Human Subjects Protection

The Institutional Review Board (IRB) application that was approved for the MHSA Initial Statewide Evaluation by the University of California Los Angeles will be amended to include these proposed evaluation studies under the MHSA Expanded Statewide Evaluation. Specifically, the survey and in-depth interviews will be included in the amendment. No written or verbal consent process will be involved in the survey; prospective respondents will be made aware that submitting a pen-and-paper survey or accessing the web-based survey constitutes consent to participate in the study. The in-depth interviews will involve either a written or verbal consent/assent process (including consent for minors by a parent or guardian). For both the survey and interview, prospective respondents will be informed of their protections as study subjects. The identity of the subjects will not be revealed and the information shared will be kept confidential. For the in-depth interview, the interview will be tape-recorded for transcription purposes with permission only.

The PEPs will undergo human subjects training through an online course such as the Collaborative Institutional Training Initiative (CITI).

Study #2: MHSA Programs

Combined rankings from the regional meetings and statewide webinar/conference call identified employment supports as the primary program to evaluate under MHSA programs. As described above, the same seven priority outcomes were identified by participants (see the measures section below).

Study Questions

The study questions for evaluating employment supports are intended to identify whether there was a need for employment supports, whether employment supports were accessed and received, the nature or defining features of employment supports, and what the outcomes of receiving (or not receiving) supports were in reference to the priority outcomes identified in the regional meetings and statewide webinar/conference call.

The overarching research questions for evaluating employment supports are as follows:

1. By whom, why, and when was employment supports needed?
2. In what timeframe were employment supports received?
3. What key employment supports were received?
4. Was the level of support received for employment appropriate?
5. Did key employment supports exemplify recovery, wellness, and resilience orientation?
6. What were consumers' perceptions of access to employment supports?
7. Was there a change in employment before and after receiving employment supports?
8. Was there a change in housing before and after receiving employment supports?
9. Was there a change in consumer wellbeing before and after receiving employment supports?

Methods

Consumers and family members who participated in the participatory planning process agreed that the evaluation should include a mix of quantitative and qualitative methods. Participants specifically recommended a combination of quantitative surveys and qualitative interviews and/or focus groups as the most effective way to collect data. They also recommended that consumers should help develop data collection tools. There was near-consensus that data should be collected directly from consumers rather than relying on service professionals to rate consumers on a measure, for example. Furthermore, while surveys were recommended, there was concern that conducting a survey could leave out consumers who are not engaged in services or have been disenfranchised because of severe and persistent mental illness or homelessness, for example.

In light of our participatory evaluation approach, as well as recommendations by participants and County data informants, we propose a statewide survey followed by in-depth interviews of a subset of 40 consumers who complete the survey. The mixed methods evaluation will employ a retrospective cross-sectional design with longitudinal measures built into the retrospective survey. The survey will be quantitative and the in-

depth interviews will be qualitative using a grounded theory approach to collect and analyze qualitative data.[39]

The survey will be pen-and-paper with a web-based option. The pen-and-paper survey, as well as the web-based survey, will be available in English, Spanish, and Chinese. The survey will be developed by the Participatory Evaluation Partners (PEPs) and evaluation team. The length of the survey will be determined through the process of developing the survey. Particular attention will be paid to making the survey as brief as possible to reduce respondent burden and missing data, as per the advice of County data informants.

In-depth interviews will be conducted in person using an interview protocol that will be developed by the PEPs and evaluation team. When necessary, interviews may be conducted by telephone. The interview will be conducted in various languages, including sign language for individuals who are deaf and/or hard of hearing. The span of languages will be determined in large part by the capacity of the PEPs, because the PEPs will be leading the interviews with support from an evaluation team member (i.e., each PEP may conduct four in-depth interviews). The interview will take approximately one hour, and each interview participant will receive a $30 gift card to a major store chain in appreciation for his or her time.

Sample

The aim of the evaluation is to have representation from a diverse cross-section of mental health consumers and their family members or representatives. We will seek participation from the population of public mental health consumers and their family members or representatives across the state. For the survey, there will be no sampling criteria per se, although the language limitations of the evaluation will limit participation from consumers who do not read English, Spanish, or Chinese. We will seek representation from consumers of all ages;[40] both genders; all races/ethnicities; various cultural groups (e.g., LGBQT and veterans); and rural, urban, and suburban communities across the state. We anticipate a sample size of 750 consumers to capture the diversity of consumers with respect to these characteristics. From a research perspective, this is a sufficient sample size to conduct statistical analyses of subgroups that are expected (e.g., subgroups by age, gender, race, and consumers who have or have not received employment supports).[41] From a practical perspective, the limited evaluation resources

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[39] Strauss, A., & Corbin, J. (1998). *Basics of qualitative research techniques and procedures for developing grounded theory*. London: Sage.

[40] Consumers must be at least 18 years old to participate. Those who are younger than 18 may participate with parent or guardian consent. A parent or guardian may participate in the survey or interview on behalf of a minor.

[41] We would need a minimum of 90 survey participants to conduct a multiple regression analysis with an anticipated effect size of .35, statistical power level of .9, and a probability level of .01 for 10 predictor variables.

means that recruitment for study participants will rest heavily on organizations that have direct contact with consumers rather than more costly means of recruitment through media campaigns and monetary incentives, for example.

For the in-depth interviews, the PEPs and evaluation team will invite 40 consumers (or family members, caregivers, or parents/guardians of minors) to participate who represent a diverse group by age (i.e., child, transition age youth, adult, and older adult), gender, race/ethnicity, and region (e.g., Superior, Bay Area, Central, and Southern). In response to the concerns raised during the participatory planning phase about surveys not reaching disenfranchised consumers, we will focus recruitment on disenfranchised consumers through the assistance of the PEPs and organizations that target such consumers. This not only addresses specific priorities of our planning participants but it could provide unique insight into a population that has traditionally been difficult to reach. We believe we will be able to reach this population through our PEPs who are trusted gatekeepers in the community and will be able to access this group through their connections. Also, we will seek participation from consumers whose primary language is not English, as well as consumers who are deaf and hard of hearing.

Recruitment Procedures

A similar process used for participatory planning will be used to recruit consumers for the survey. The PEPs will help guide this process by identifying the stakeholder groups for recruitment. At minimum, the four categories of stakeholders that were targeted for the participatory planning process also will be targeted for survey participation:

1. Mental health consumer and family member advocacy organizations
2. Provider organization associations and County mental health agencies
3. Community organizations and committees focusing on the needs of underserved populations
4. State agencies, County associations, and training centers.

The PEPs and evaluation team will correspond via email and telephone with these stakeholder groups to distribute information about the survey. The procedures for identifying survey participants as potential participants of the in-depth interviews will be developed between the PEPs and evaluation team. As an example of a procedure, the PEPs could recruit participants for the in-depth interviews and complete the survey and interviews back-to-back.

Consumer recruitment for the in-depth interviews will be more involved. Again, this process will be developed by the PEPs and evaluation team. This recruitment process is expected to involve a series of correspondence (either via email, telephone, or in person) between the PEPs and prospective interviewees to explain the interview purpose and protocol (including human subjects protection) and to schedule a time to conduct the interview, preferably in person.

Measures

Consistent with our participatory evaluation approach is the joint development of measures between the PEPs and evaluation team. As discussed earlier, the seven priority indicators that were recommended by participants of the regional meetings and statewide webinar/conference call were as follows:

1. Paid and unpaid employment
2. Consumer wellbeing
3. Recovery, wellness, and resilience orientation
4. Consumer/family perception of access to services
5. Housing situation
6. Continuity of care
7. Appropriateness of care.

The PEPs and evaluation team will together develop the survey and interview protocol to measure these seven priority indicators. The survey will be developed to answer the study questions. In addition, survey participants will be asked to provide demographic information such as age, gender, race/ethnicity, zip code, and whether they represent a specific cultural group (e.g., LGBQT, veteran, and deaf and hard of hearing).

Data Analysis

Quantitative data from the survey will be entered into and analyzed with the Statistical Package for the Social Sciences (SPSS) software. Survey data on employment supports will be analyzed for all potential subgroups by age, gender, race/ethnicity, region, and service utilization (e.g., consumers who received employment supports and those who did not).

Qualitative data from the in-depth interviews will be entered into and analyzed with the Dedoose software, which is designed for mixed methods studies. Because consumers who participate in the in-depth interviews also will have completed survey data, both sets of quantitative and qualitative data will be available for mixed analysis for approximately 40 consumers. Additional qualitative analyses will be conducted using a grounded theory approach to identify themes, relationships between themes, and dynamics within relationships that infer the degree of impact that employment services have on consumers' wellbeing and housing for example.

As with most evaluation activities proposed, data analysis and interpretation will be done in partnership with the PEPs. The PEPs and evaluation team also will consult with County data informants to get input on data analysis, interpretation, and reporting in a way that is useful for quality improvement in data collection and programming.

Human Subjects Protection

The Institutional Review Board (IRB) application that was approved for the MHSA Initial Statewide Evaluation by the University of California Los Angeles will be amended to include these proposed evaluation studies under the MHSA Expanded Statewide Evaluation. Specifically, the survey and in-depth interviews will be included in the amendment. No written or verbal consent process will be involved in the survey; prospective respondents will be made aware that submitting a pen-and-paper survey or accessing the web-based survey constitutes consent to participate in the study. The in-depth interviews will involve either a written or verbal consent/assent process (including consent for minors by a parent or guardian). For both the survey and interview, prospective respondents will be informed of their protections as study subjects. The identity of the subjects will not be revealed and the information shared will be kept confidential. For the in-depth interview, the interview will be tape-recorded for transcription purposes with permission only.

The PEPs will undergo human subjects training through an online course such as the Collaborative Institutional Training Initiative (CITI).

APPENDIX A

MHSOAC RFP 1-70134-000

DELIVERABLE 2 SCOPE OF WORK

Deliverable 2: Impact of MHSA on Client Outcomes using Participatory Research[42]

a) General System Development Programs under the CSS component of the MHSA
   1. Written report submitted electronically and hard copy by 11/30/2011[43] that specifies at least one selected General System Development-funded service/strategy, at least one client outcome prioritized from the MHSA and/or system of care statutes, and a description of the methodology to be used, including any new data collection.
   2. Initial written report submitted electronically and hard copy by 9/30/2012 that analyzes impact of the selected General System Development service(s)/strategy(ies) on the selected client outcome(s).
   3. Final written report submitted electronically and hard copy by 12/31/2012 that analyzes impact of the selected General System Development service(s)/strategy(ies) on the selected client outcome(s).

b) Involvement of individuals living with mental illness, their families and personal caregivers in the public mental health system.
   1. Written report submitted electronically and hard copy by 11/30/2011 that specifies the type(s) and definition of involvement, client outcome(s) prioritized from the MHSA and/or system of care statutes, and a description of the methodology to be used, including any new data collection.
   2. Initial written report submitted electronically and hard copy by 9/30/2012 that analyzes impact of the selected client/family member/personal caregiver involvement on the selected client outcome(s).
   3. Final written report submitted electronically and hard copy by 12/31/2012 that analyzes impact of the selected client/family member/personal caregiver involvement on the selected client outcome(s).

[42] *MHSOAC RFP 1-70134-000* pages 7-8.
[43] Deliverable due dates reflect adjustments from the original scope of work, as approved by MHSOAC.

APPENDIX B

PARTICIPATORY PLANNING INVITATIONS DISTRIBUTION LIST

Mental Health Consumer and Family Member Advocacy Organizations

- California Network of Mental Health Clients
- California Youth Connection
- California Youth Empowerment Network
- Client and Family Leadership Committee (care of Mental Health Association of San Francisco)
- Family and Youth Roundtable
- Mental Health America (AKA, Mental Health Association) in California
- NAMI California
- United Advocates for Children and Families
- United Parents

County Mental Health Agencies and Provider Organization Associations

- The Association of Community Human Service Agencies, Los Angeles County
- California Alliance of Child and Family Services
- California Association of Social Rehabilitation Agencies
- California Community Colleges: Student Services and Special Programs
- California Council of Community Mental Health Agencies
- California Family Resource Association
- Sacramento Association of Mental Health Contractors
- Santa Clara Mental Health Providers Association

Community Organizations and Committees Focusing on the Needs of Underserved Populations

- African American Health Institute of San Bernardino County
- California Rural Indian Health Board
- Cultural and Linguistic Competence Committee
- Racial and Ethnic Mental Health Disparities Coalition (REMHDCO)
- Greater Options and Assistance for Lifelong Success (GOALS) for Women, Inc.
- LBGTQQI2-S Inclusion Initiative of Contra County Health Services
- Office of Multicultural Services: California Reducing Disparities Project, California Department of Mental Health
- Los Angeles Gay and Lesbian Center
- Native American Health Center

State Agencies, County Associations, and Training Centers

- California Department of Aging
- California Department of Alcohol and Drug Programs
- California Institute for Mental Health
- California Mental Health Directors Association
- California Mental Health Planning Council

APPENDIX C

SAMPLE EMAIL INVITATION

PROJECT DESCRIPTION LETTERS

Sample Invitation Email

Hi All,

We are writing to you from the UCLA Center for Healthier Children, Families & Communities, Evaluation Team, to ask for your help.

UCLA, through a contract with the Mental Health Services Oversight and Accountability Commission, is conducting an evaluation of the Mental Health Services Act. This evaluation effort includes a participatory research component in which consumers and family members of consumers will help to identify service or program strategies, outcomes and the evaluation methods to be used.

We are inviting consumers and family members to join this evaluation effort by attending a regional planning meeting or a statewide conference call.

We will be convening 7 meetings across the state, 3 to be conducted in Spanish (Salinas, Fresno, Los Angeles), and 4 to be conducted in English (Redding, Sacramento, Santa Barbara, Santa Ana). We have the capacity to invite up to 10 participants for each meeting.

We are seeking participation from consumers and family members representing all four of the MHSA age groups (child, TAY, adult, older adult), and diverse ethnic and cultural groups, in particular historically un- and under-served communities. Consumers and family members will receive a $75 gift card as compensation for their time and expenses.

In addition, we will be convening a single statewide conference call for consumers and family members who are interested in participating in this effort, but who are not able to attend one of the regional meetings.

All of the details about the regional meetings and conference call are described in the attached letter. Please note that there is a Spanish version of the letter attached as well.

To register for a meeting or the conference call, please send an email to or call:

--Laura Valles at lvallesassoc@aol.com or (323) 899-2735 for meetings in Spanish
--Todd Sosna at todd.sosna@gmail.com or (805) 452-1010 for meetings in English

Thank you in advance for your help with this important and exciting work,

Todd and Laura
Evaluation Team
UCLA Center for Healthier Children, Families & Communities

Project Description (English)

UCLA Center for Healthier Children, Families & Communities

The University of California Los Angeles (UCLA), through a contract with the Mental Health Services Oversight and Accountability Commission, is conducting an evaluation of the Mental Health Services Act. This evaluation effort includes a participatory research component in which consumers and family members of consumers will help us identify service or program strategies, outcomes and the evaluation methods to be used.

We are inviting **consumers and family members** to join in this evaluation effort by attending a regional planning meeting or a statewide conference call (as described below).

Consumer and family members who would like to participate in one of the regional meetings or the statewide conference call, can simply send an email to or call

- **Laura Valles at lvallesassoc@aol.com or (323) 899-2735 for meetings in Spanish**
- **Todd Sosna at todd.sosna@gmail.com or (805) 452-1010 for meetings in English**

In addition, we are interested in input from **other stakeholder groups**, as described in the final section of this letter.

If you represent a county, private provider, community organization, or other stakeholder, and would like to join one of the statewide conference calls, please send an email to Todd Sosna at todd.sosna@gmail.com and you will be registered.

Thank you in advance for taking the time to consider this invitation.

If you have questions about participating in any aspect of this project please contact Todd Sosna, Ph.D., at todd.sosna@gmail.com or (805) 452-1010, or Laura Valles at lvallesassoc@aol.com or (323) 899-2735.

Sincerely,

Todd Sosna and Laura Valles
Evaluation Team
UCLA Center for Healthier Children, Families & Communities
10990 Wilshire Blvd. Ste. 900, Los Angeles, CA 90024

Regional Meeting for Consumers and Family Members

Audience: Consistent with the focus of the Mental Health Services Act (MHSA), we are seeking participation from consumers and family members representing all four age groups (children, transition age youth, adults, and older adults), all regions of the state, and diverse ethnic and cultural groups, in particular historically un- and under-served communities.

Logistics: We will convene seven regional meetings across the state, each lasting 3-hours (as noted below). Three meetings will be conducted in Spanish and four in English. We have the capacity to invite up to 10 participants for each regional meeting. This number is meant to allow for everyone's full participation and opportunity to provide detailed and concrete suggestions.

We will provide refreshments and a $75 Mastercard or Visa gift card for each consumer/family member as compensation for their time and travel.

Because these meetings will be used to guide the way in which future evaluation is conducted, all of the meetings will be audio recorded to insure that comments from participants are accurately described. In addition, basic demographic information about each participant and whom they represent (for example, children, TAY, adults, or older adults) will be gathered so that the breadth of input and representation can be accurately reported. The UCLA evaluation team will maintain the confidentiality of individual participants.

Meeting Goals

GOAL 1: Select programs or services to be the focus of evaluation. Participants will help to identify at least one program intended to increase consumer and family member involvement, and at least one program supported with *General Systems Development* funds.

General Systems Development funds, as part of the MHSA, are available to help counties improve programs, services and supports, and to change their service delivery systems and build transformational programs and services. These funds have been used to support a variety of important programs and services including: crisis interventions/supports, peer counseling, outreach activities, recovery centers, engagement activities, wellness centers, housing supports, education supports, safety plan supports, and wraparound programs.

GOAL 2: Select outcomes to be the focus of evaluation. Outcomes may be at the consumer or system level, as follows:

Consumer Level Outcomes	**System Level Outcomes**
○ Education/Employment – e.g., an increase in school attendance or paid employment ○ Homelessness/Housing – e.g., a decrease in homelessness or increase in stable housing ○ Legal Problems – e.g., a decrease in arrests ○ Emergency Care – e.g., a decrease in psychiatric hospitalizations	○ Access to Services – e.g., more individuals from underserved populations accessing care ○ Program Performance – e.g., improvements in consumer well-being or satisfaction with services ○ Service System Structure – e.g., use of recovery practices or availability of evidence-based practice

GOAL 3: Select strategies for carrying out the evaluation. This could involve a variety of different evaluation activities such as looking at changes over time in important outcomes like the number of days of stable housing or the number of days of psychiatric hospitalization.

Alternatively, the study could involve qualitative approaches, for example, focus groups that ask consumers and family members about their experiences receiving services and the use of recovery and resiliency approaches.

Meeting Schedule

Meetings will be held in various locations across the state. Each meeting will have the same content and format, so consumers and family members would only attend a single meeting, at the location and time most convenient for them.

	SANTA BARBARA	REDDING	SACRAMENTO	SANTA ANA
ENGLISH	**Tuesday October 11th 9:00-12:00 CARES 2034 De La Vina St. Santa Barbara, CA 93101**	**Wednesday October 12th 1:00-4:00 Redding Library 1100 Parkview Ave., Redding, CA 96001**	**Thursday October 13th 9:00-12:00 United Advocates for Children and Families 2035 Hurley Way, Suite 290 Sacramento, CA 95825**	**Friday October 14th 9:00-12:00 Orange County Office of Education 600 W. Santa Ana Blvd. Rm. #525 Santa Ana, CA 92701**
SPANISH	**Salinas October 12th 1:30-4:30 Monterey County Health Dept. Shasta Room 1270 Natividad Rd. Salinas, CA 93906**	**Fresno October 13th 1:00-4:00 EMQ Families First 5168 North Blythe Ave. Suite 101 Fresno, CA 93722**	**Los Angeles October 17th 1:00-4:00 Human Services Association 6423 Florence Place, 2nd Floor Bell Gardens, CA 90201**	

Consumer and family members who would like to participate in one of these regional meetings, or for more information, please send an email to or call

- **Laura Valles at lvallesassoc@aol.com or (323) 899-2735 for meetings in Spanish**
- **Todd Sosna at todd.sosna@gmail.com or (805) 452-1010 for meetings in English**

CONFERENCE CALL/WEBINAR FOR CONSUMERS AND FAMILY MEMBERS

In addition to the regional meetings, we will be convening a statewide conference call/webinar for consumers and family members who would like to participate but are not able to attend one of the regional meetings.

The focus and content of the conference call will be a shorter version of the in-person regional meetings. A consumer or family member would only join the conference call if they were not able to attend a meeting. Please note that, unlike for the meetings, no compensation will be available for attendance on a conference call.

Again, these conference calls will be audio recorded to insure that comments from participants are accurately described. In addition, basic information about each participant and whom they are representing (for example, children, TAY, adults, or older adults) will be gathered so that the breadth of input and representation can be accurately reported. The UCLA evaluation team will maintain the confidentiality of individual participants.

Participants who have computers are encouraged to join as a webinar. However, if it is not possible to access the webinar, it is fine to join just the conference call.

If you are a consumer or family member and would like to join the statewide webinar conference call, please send an email to or call Todd Sosna at todd.sosna@gmail.com or (805) 452-1010 and a webinar link will be sent to you.

The conference call number and access code are noted below.

Consumer and Family Members Conference Call/Webinar

Wednesday, October 26th
9:00 – 10:30

Conference Call Phone Number

Toll Free 1-888-921-8686
Passcode is 1031202437

CONFERENCE CALLS FOR COUNTIES, PRIVATE PROVIDERS, COMMUNITY ORGANIZATIONS

Conference calls will be scheduled to gather input from other important stakeholders, in addition to consumers and family members.

The focus and content of the conference call/webinar will be a shorter version of the regional meetings held with consumers and family members.

These conference calls will be audio recorded to insure that comments from participants are accurately described. In addition, basic information about each participant and whom they are representing (for example, children, TAY, adults, or older adults) will be gathered so that the breadth of input and representation can be accurately reported. The UCLA evaluation team will maintain the confidentiality of individual participants.

Participants who have computers are encouraged to join as a webinar. However, if it is not possible to access the webinar, it is fine to join just the conference call.

If you represent a county, private provider, community organization, or other stakeholder, and would like to join one of the statewide conference calls, please send an email to Todd Sosna at todd.sosna@gmail.com and a webinar link will be sent to you.

The conference call number and access code are noted below.

Community Organizations Conference Call

Thursday, October 20th
9:00 – 10:30

Conference Call Phone Number
Toll Free 1-888-921-8686
Passcode is 1031202437

State Agencies, Counties, and Training Centers Conference Call

Thursday, October 20th
1:30 – 3:00

Conference Call Phone Number
Toll Free 1-888-921-8686
Passcode is 1031202437

Mental Health Providers Conference Call

Wednesday, October 26th
1:30 – 3:00

Conference Call Phone Number
Toll Free 1-888-921-8686
Passcode is 1031202437

Project Description (Spanish)

UCLA Center for Healthier Children, Families & Communities

La Universidad de California Los Angeles (UCLA), atraves de un contracto con la Comisión de Rendición de Cuentas y Supervisión de Servicios de Salud, llevara a cabo una evaluación de la ley de Servicios de Salud Mental. Esta evaluación incluye un componente de grupos de enfoque donde buscamos la opinión de consumidores y de miembros de familia de consumidores para que nos ayuden a identificar servicios o estrategias programaticas, resultados, y los metodos de la evaluación.

Si ud. es un consumidor de servicios de salud mental o miembro de familia, lo invitamos a participar en una de las reuniones regionales o llamadas de conferencia.

Personas interesadas en las reuniones regionales o llamadas pueden comunicarse con:

- **Laura Valles al lvallesassoc@aol.com o (323) 899-2735 (Español)**

- **Todd Sosna al todd.sosna@gmail.com o (805) 452-1010 (Ingles)**

Gracias por su consideración de esta invitación.

Para más información, póngase en contacto con Todd Sosna, Ph.D., al todd.sosna@gmail.com o (805) 452-1010, o Laura Valles at lvallesassoc@aol.com o (323) 899-2735.

Sinceramente,

Todd Sosna y Laura Valles
Equipo de Evaluación
UCLA Center for Healthier Children, Families & Communities
10990 Wilshire Blvd. Ste. 900, Los Angeles, CA 90024

Logística y Metas de Reuniones Regionales

Reuniones Regionales

Audiencia: Consistente con el enfoque de la Ley de Servicios de Salud Mental (MHSA), buscamos participación de consumidores y miembros de familia de consumidores representando los cuatro grupos de edad (niños, jóvenes de edad de transición, adultos, y adultos mayores), cada region del estado, y diversos grupos étnicos y culturales, en particular comunidades carentes de servicios.

Logística: Convocaremos siete reuniones regionales (como se indica a continuación) atraves del estado. Cada reunion durará 3-horas. Tres reuniones seran en Español y cuatro en Ingles. Para permitir la maxima participación de cada participante tenemos espacio para 10 participantes en cada reunion regional.

Proporcionaremos refrescos y tarjetas de regalo Mastercard or Visa valoradas en $75 para cada consumidor o miembro de familia (una por familia).

Todas las reuniones seran grabadas para asegur que todos los comentarios esten captados correctamente. Tambien captaremos información demográfica de cada participante y los grupos que representan. El equiip de UCLA mantendra la confidencialidad de cada participante.

Metas de las Reuniones

Meta #1: Seleccionar programas o servicios como enfoque de la evaluación. Participantes nos ayudaran a identificar por lo menos un programa con la intencion de aumentar el involucramiento de consumidores or miembros de familia, y por lo menos un programa relacionado con los fondos de desarrollo de sistemas generales.

Fondos de desarrollo de sistemas generales, como parte del MHSA, estan disponibles para mejorar programas y servicios, y para cambiar el sistema de servicios. Ejemplos de estos programas y servicios incluyen: intervención en crisis, centros de recuperación y bienestar, consejería de pares, y apoyos educacionales.

Meta #2: Seleccionar resultados como enfoque de la evaluación. Ejemplos de resultados incluyen:

Resultados al Nivel del Consumidor	Resultados al Nivel del Sistema
○ Educación/Empleo	○ Acceso a Servicios
○ Viviendas/Personas sin hogar	○ Ejecución de Programas
○ Problemas Legales	○ Estructura del Sistema de Servicios
○ Atención de Emergencia	

Meta #3: Seleccionar estrategias para implementar las actividades relacionadas con la evaluación.

Evaluación de la Ley de Servicios de Salud Mental
Reunión Regional

Son necesarias sus sugerencias y opiniones!

Reuniones estan citadas a través del estado. Cada reunión cubrira el mismo contenido para que cada consumidor o miembro de familia solo tenga que asistir la reunion en la ubicación y tiempo mas conviniente.

Sus sugerencias y opiniones nos ayudaran a identificar servicios o estrategias programaticas, resultados, y los metodos de la evaluación

ENGLISH	SANTA BARBARA **Tuesday** **October 11th** **9:00-12:00** **CARES** **2034 De La Vina St.** **Santa Barbara, CA 93101**	REDDING **Wednesday** **October 12th** **1:00-4:00** **Redding Library** **1100 Parkview Ave. Redding, CA 96001**	SACRAMENTO **Thursday** **October 13th** **9:00-12:00** **United Advocates for Children and Families** **2035 Hurley Way, Suite 290** **Sacramento, CA 95825**	SANTA ANA **Friday** **October 14th** **9:00-12:00** **Orange County Office of Education** **600 W. Santa Ana Blvd. Rm. #525** **Santa Ana, CA 92701**
SPANISH	**SALINAS** **12 de Octubre** **1:30-4:30** **Monterey County Health Dept.** **Shasta Room** **1270 Natividad Rd.** **Salinas, CA 93906**	**FRESNO** **13 de Octubre** **1:00-4:00** **EMQ Families First** **5168 North Blythe Ave.** **Suite 101** **Fresno, CA 93722**	**LOS ANGELES** **17 de Octubre** **1:00-4:00** **Human Services Association** **6423 Florence Place, 2nd Floor** **Bell Gardens, CA 90201**	

** Proporcionaremos refrescos y tarjetas de regalo Mastercard or Visa valoradas en $75 para cada consumidor o miembro de familia (una por familia).**

Espacio es limitado. Para reservar su espacio, póngase en contacto con:
Laura Valles al lvallesassoc@aol.com o (323) 899-2735 para reuniones en Español

Todd Sosna al todd.sosna@gmail.com o (805) 452-1010 para reuniones en Ingles

LLAMADA DE CONFERENCIA PARA CONSUMIDORES DE SERVICIOS O MIEMBROS DE FAMILIA

Además de reuniones regionales, convocaremos llamadas para personas que no pueden asistir unas de las reuniones regionales. El enfoque y contenido de las llamadas sera una version breve de las reuniones regionales. Participantes en estas llamadas no recibiran compensación por su participación.

Estas llamadas seran grabadas para asegurar que los comentarios estan captados correctamente. Tambien recopilaremos informacion demográfica de cada participante. El equipo de UCLA mantendra la confidencialidad de cada participante.

Participantes con computadoras podran conectarse atraves del internet.

Si ud. Es un consumidor de servicios de salud mental o miembro de familia y quiere participar en la llamada, reserve su espacio conTodd Sosna al todd.sosna@gmail.com o (805) 452-1010 y le enviaremos los detalles de la llamada. El número de conferencia para la llamada es:

26 de Octubre
9:00 – 10:30

Número de Llamada

Numero: 1-888-921-8686
Codigo: es 1031202437

APPENDIX D

REGIONAL MEETINGS MATERIALS

UCLA MHSA Evaluation

Consumers and Family Members
Planning Meeting

First Name	
Last Name	
Agency Affiliation (if any)	
City Where You are From	
Consumer or Family Member	
Representing **Children (0-15), TAY (16-25)** **Adult (26-59), Older Adults (60+)**	
Gender	
Age	
Ethnicity	
Your Primary Language	
Representing any Underserved Communities? **LBGTQ?** **Veterans?** **Deaf or Hard of Hearing?** **Other?**	
Phone Number	
Email Address	
Received $75 Gift Card	

UCLA MHSA Evaluation

Consumers and Family Members Planning Meeting

Welcome and Introductions – 20 minutes
- Voluntary participation and audio taping announcement
- Meeting goals
- Review of agenda
- Introduction of facilitators and participants

Project Overview – 30 minutes
- Mental Health Services Act
- Community Supports and Services
- Selecting programs, outcomes, and research strategies
- Decision making process
- Ground rules
- Questions

Selecting Programs to Evaluate – 35 minutes
- General Systems Development funded programs
- Questions
- Experiences with General Systems Development programs
- Discussion
- Program choices

- Consumer and family involvement programs
- Experiences and discussion
- Program choices

Selecting Outcomes – 35 minutes
- Statewide priority indicators
- Questions and discussion
- Outcome domain choices
- Outcome indicator choices

Study Methods – 35 minutes
- Research strategies
- Questions and discussion
- Study method choices

Conclusion—10 minutes
- Summary of decisions
- Meeting survey
- Gift cards

Thank you!

Ground Rules

Everyone has an opportunity to share their thoughts and opinions.

All ideas are welcome.

We are respectful of each other.

One person talks at a time.

It is okay to disagree.

Relax, participate and have fun.

Mental Health Services Act (MHSA)

The Mental Health Services Act (MHSA) resulted from a voter initiative and became law in January 2005. It provides funding to expand access to public mental health services and restructure the system to be more consumer-oriented and to support a broad continuum of prevention, early intervention and service needs.

MHSA supports a continuum of care, which includes services for treatment and recovery and all of the things that can be done to help people stay mentally healthy and stable so they do not need intensive services or treatment.

MHSA programs are required to emphasize strategies that reduce seven negative outcomes: suicide, incarcerations, school failure or dropout, unemployment, prolonged suffering, homelessness, and removal of children from their homes.

Community Services and Supports (CSS)

Community Services and Supports (CSS) is one component of the MHSA and provides funding for direct services to people with serious mental health disorders. These services and supports include consumer and family member involvement, and recovery and resiliency principles and practices.

Community Services and Supports are the programs and services identified by each County Mental Health Department through its stakeholder process to serve unserved and underserved populations, with an emphasis on eliminating disparity in access and improving mental health outcomes for racial/ethnic populations and other unserved and underserved populations.

General System Development

General System Development funds are one component of Community Services and Supports to improve programs, services and supports, change service delivery systems and build transformational programs and services, including strategies for reducing disparities in access and quality of care.

General System Development Programs and Strategies

Crisis Intervention/Supports

- Strategies for addressing and avoiding mental health crises, for example, mobile crisis teams, or developing support systems and safety plans.

Peer Counseling

- Services provided by consumer and family member partners to support recovery, resilience and wellness.

Outreach Activities

- Strategies, often directed toward underserved communities, to increase information about mental health services, reduce stigma around mental health disorders, and increase access to services and supports.

Recovery Centers

- Consumer and family service centers, often including a variety of consumer and family led and self-help supports, and housing, employment and school assistance, and recovery focused programs.

Engagement Activities

- Strategies, often directed toward underserved communities, to increase hope and positive expectations for change, and support enrollment into services and supports.

Wellness Centers

- Centers that provide a wide range of formal and informal services and supports, to enhance health, wellness and recovery, and may include the types of supports available in recovery centers.

Housing Supports

- Housing supports and assistance including housing units and subsidies, and assistance obtaining and maintaining independent living.

Educational Supports

- Educational supports and assistance including guidance and support to enroll and succeed in school.

Safety Plan

- Intervention strategies, incorporating formal and informal supports, to anticipate, prevent, prepare for and address safety concerns.

Wraparound

- Intensive, individualized care planning and management for children and youth with complex mental health needs, in partnership with each youth and their families, including access to a full continuum of formal and informal services and supports.

Priority Outcome Indicators

The *California Mental Health Planning Council* proposed a set of performance outcomes for the CSS programs. The priority indicators are broadly defined as key measures of MHSA impact.

The set of priority indicators came from discussions involving the Planning Council and mental health service stakeholders with the goal of streamlining the MHSA's monitoring and planning activities.

Consumer Level Outcomes

- **Domain: Education/Employment**
  - Indicator: Average attendance
  - Indicator: Paid and unpaid employment

- **Domain: Homelessness/Housing**
  - Indicator: Housing situation

- **Domain: Justice Involvement**
  - Indicator: Arrests

- **Domain: Emergency Care**
  - Indicator: Hospitalization for mental health episodes

System Level Outcomes

- **Domain: Access**
  - Indicator: Demographic profile of consumers served
    - *Description of who is accessing services, for example, age, gender and ethnicity*

  - Indicator: New consumers by demographic profile
    - *Description of changes in who is accessing services, reflecting the impact of outreach and engagement activities*

  - Indicator: High need consumers served
    - *Looking at the subset of consumers with high needs, for example, individuals who are homeless*

  - Indicator: Access to primary care physician
    - *Looking at the number of consumers who have a primary care physician*

  - Indicator: Consumer/family perception of access to services
    - *Consumer impressions of access to and satisfaction with services*

- **Domain: Performance**
    - Indicator: Consumers served annually

    - Indicator: Involuntary care

    - Indicator: 24-Hour care
        - *Long term hospitalization or nursing home care*
    -
    - Indicator: Appropriateness of care
        - *A variety of quantitative and qualitative indications that services are appropriate, for example, use of protocols for treating dual disorders, hospitalization readmission rates, or consumer perception of the appropriateness of care*

    - Indicator: Continuity of care
        - *Indications of uninterrupted and coordinated care, for example, reintroduction into the community, singe care/service point, or discharge plans*

    - Indicator: Penetration rates
        - *Number of consumers served in relation to those eligible or in need of services among various groups*

    - Indicator: Consumer wellbeing

    - Indicator: Satisfaction

- **Domain: Structure**
    - Indicator: Workforce composition
        - *The extent to which the mental health system workforce is appropriate to serve diverse populations, for example, demographic profile of staff, staff to consumer ratio, or numbers of consumer and family partner-staff*

    - Indicator: Evidence-based practice programs and services

    - Indicator: Cultural appropriateness of services

    - Indicator: Recovery, wellness and resilience orientation
        - *The extent to which recovery, wellness and resiliency values and practices have been incorporated into services*

Research Strategies

Types of Information that could be Used in a Study

- Occurrence of various events, for example, the number of hospital admissions, the number of arrests, the number of days of employment

- Information reported by consumers and family members, for example, their views on the services received or achievement of their goals

- Information reported by staff, for example, about the services they provide

Ways of Gathering the Information

- Review of mental health records

- Questionnaires completed by consumers, family members or providers

- Focus groups conducted with consumers, family members or providers

- Individual interviews with consumers, family members or providers

Ways of Comparing the Information

- Compare across two (or more) groups of consumers, for example those who received services from a Recovery Center and those who did not

- Compare changes from before and after an intervention or program or systems change occurs, for example, change in hospitalization, or arrests or employment, before and after participation in Recovery Center services

- Describing areas of need, services received and outcomes achieved based on a series of focus groups or interviews or case studies

APPENDIX E

STATEWIDE WEBINAR/CONFERENCE CALL MATERIALS

(See attached for the PowerPoint presentation)

APPENDIX F

PLANNING MEETING SURVEY

UCLA MHSA Evaluation

Consumers and Family Members
Meeting Survey

For each question below, please circle the number that most closely describes your experience in today's planning meeting. We appreciate your honest feedback.

1. The meeting goals were clear?

Not at All				Definitely
1	2	3	4	5

2. I was provided the information and opportunity to make informed recommendations about which **General System Development and consumer involvement programs** should be the focus of evaluation?

Not at All				Definitely
1	2	3	4	5

3. I was provided the information and opportunity to make informed recommendations about which **outcomes and indicators** should be the focus of evaluation?

Not at All				Definitely
1	2	3	4	5

4. I was provided the information and opportunity to make informed recommendations about which **study methods** should be used for an evaluation?

Not at All				Definitely
1	2	3	4	5

5. I was advised that participation in the meeting was voluntary and that it would be audio-taped?

Yes No

In the space below, please add any other comments about this meeting that you think would be important for us to know.

THANK YOU for your help today!

APPENDIX G

POST-SURVEY PARTICIPANT COMMENTS

- Thanks for the opportunity to participate and the opportunity to share my needs.
- For educational workshops for the police department who is not aware of all services. I ask for a workshop for this department.
- It is very important to focus on strategies for helping the community that suffers from mental health issues.
- It was informative to learn about the evaluation underway.
- More informational groups because not everyone has services because they don't know how to access services.
- Thank you for the support group that helps us.
- Very instructive, for me it was all good.
- This was very helpful for me.
- More access for Hispanics.
- I would like to see focus group based on age groups/ex: 0-5, children, TAY, Adults) due to age groups having different perspectives and opinions.
- I like focus groups.
- I liked the group.
- Have meeting like this one more often.
- I was pleased with the presentation and the chance to participate in this subject of which I am a consumer. Thank you to Todd Sosna for providing a very thorough and informative presentation.
- I enjoyed participating and the interactions that happened and making a contribution.
- Have 2 types. 1st children and 2nd adult.
- Todd did a great job including everyone in the discussion. I felt like I was heard.
- Very well organized. Very pleasant facilitators and well-informed. Made me feel like our input was important. Good group interaction. Todd's very congenial. Laura has beautiful smile. Good overall. Expensive, but let's hope our suggestions and comments are used accordingly. Interesting and hopeful.
- We are all here representing others, but you really need to hear the voice of the ones who have experienced and lived through this as well, for accurate information.
- Todd, you are an excellent facilitator for this purpose!
- I hope our input helps for positive outcomes.
- Good meeting. ☺
- Glad to see that consumers were in attendance. Kept on track in dealing with lots of info to make decisions on!!
- I would like to be kept involved via email.
- The meeting was very informative and interesting, facilitators are very warm, engaging and welcoming. Enjoyed this focus group very much.
- This meeting gives me hope that something is being done to improve mental health services in our state and therefore in our country.

- This was my first focus group and my mind and ideas were expanded about mental health and research.
- Thank you for the opportunity to participate. ☺
- I enjoy focus groups, I would recommend that a wider berth of participants be recruited.
- I really think I've made a contribution and a difference.
- Pretty big difference in expected versus actual. ☺
- One of the best run meetings I've attended. Great timing, organization and manners!
- Well run, well facilitated meeting –
- I hope that the research results will be available to participants!
- Prefer more of a systematic paperwork/outline approach, more of a summary!
- A bit of over talking.
- Very good facilitator. He kept us on task and focused. Thanks.
- Very interesting and informative.
- Keep doing this evaluation, to get more of the community Input! ☺
- Might be good to allow participants the opportunity to review information before the actual meeting. It's a lot to absorb at the spur of the moment. Thanks!
- Nice to be in a highly organized and thoughtfully run meeting where I was actively listened to!

UCLA MHSA Evaluation

Participatory Evaluation Consumers & Family Members Webinar

October 26th, 2011

9:00-10:30

UCLA Center for Healthier Children, Families & Communities

Mental Health Services Act (MHSA)

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- Provides funding to expand access to public mental health services and restructure the system to be more consumer/family-oriented and recovery focused

Community Services and Supports (CSS)

- Community Services and Supports (CSS) is one component of the MHSA and provides funding for direct services to people with serious mental health disorders
- These services and supports include consumer and family member involvement, and recovery and resiliency principles and practices
- The programs and services identified by each County Mental Health Department through its stakeholder process to serve unserved and underserved populations

General System Development

- General System Development funds are one component of Community Services and Supports to improve programs, services and supports, change service delivery systems and build transformational programs and services, including strategies for reducing disparities in access and quality of care.

General System Development Programs and Strategies

- **Crisis Intervention/Supports**
  - Strategies for addressing and avoiding mental health crises, for example, mobile crisis teams, or developing support systems and safety plans.
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- **Recovery Centers**
  - Consumer and family service centers, often including a variety of consumer and family led and self-help supports, and housing, employment and school assistance, and recovery focused programs.
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  - Centers that provide a wide range of formal and informal services and supports, to enhance health, wellness and recovery, and may include the types of supports available in recovery centers.

General System Development Programs and Strategies

- **Housing Supports**
  - Housing supports and assistance including housing units and subsidies, and assistance obtaining and maintaining independent living.
- **Educational Supports**
  - Educational supports and assistance including guidance and support to enroll and succeed in school.
- **Safety Plan**
  - Intervention strategies, incorporating formal and informal supports, to anticipate, prevent, prepare for and address safety concerns.
- **Wraparound**
  - Intensive, individualized care planning and management for children and youth with complex mental health needs.

Which General System Development program(s) or strategies do you think should be the focus of a statewide study?

Are there other MHSA funded programs or strategies that include or promote consumer and family involvement, not on the General System Development list, that you think should be the focus of a statewide study?

Priority Indicators

- The *California Mental Health Planning Council* proposed a set of performance outcomes for the CSS programs. The priority indicators are broadly defined as key measures of MHSA impact.
- The set of priority indicators came from discussions involving the Planning Council and mental health service stakeholders with the goal of streamlining the MHSA's monitoring and planning activities.

Consumer Level

- Education/Employment
  - **Indicator: Average attendance**
  - **Indicator: Paid and unpaid employment**
- Homelessness/Housing
  - **Indicator: Housing situation**
- Justice Involvement
  - **Indicator: Arrests**
- Emergency Care
  - **Indicator: Hospitalization for mental health episodes**

Access

- **Indicator: Demographic profile of consumers served**
  - *Description of who is accessing services, for example, age, gender and ethnicity*
- **Indicator: New consumers by demographic profile**
  - *Description of changes in who is accessing services, reflecting the impact of outreach and engagement activities*
- **Indicator: High need consumers served**
  - *Looking at the subset of consumers with high needs, for example, individuals who are homeless*

Access

- **Indicator: Access to primary care physician**
  - *Looking at the number of consumers who have a primary care physician*
- **Indicator: Consumer/family perception of access to services**
  - *Consumer impressions of access to and satisfaction with services*

Performance

- **Indicator: Consumers served annually**
- **Indicator: Involuntary care**
- **Indicator: 24-Hour care**
  - *Long term hospitalization or nursing home care*
- **Indicator: Appropriateness of care**
  - *A variety of quantitative and qualitative indications that services are appropriate, for example, use of protocols for treating dual disorders, hospitalization readmission rates, or consumer perception of the appropriateness of care*

Performance

- **Indicator: Continuity of care**
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- **Indicator: Consumer wellbeing**
- **Indicator: Satisfaction**

Structure

- **Indicator: Workforce composition**
  - *The extent to which the mental health system workforce is appropriate to serve diverse populations, for example, demographic profile of staff, staff to consumer ratio, or numbers of consumer and family partner-staff*
- **Indicator: Evidence-based practice programs and services**
- **Indicator: Cultural appropriateness of services**
- **Indicator: Recovery, wellness and resilience orientation**
  - *The extent to which recovery, wellness and resiliency values and practices have been incorporated into services*

Which indicator(s) do you think should be evaluated in a statewide study?

Research Strategies

- **Types of Information that could be Used in a Study**
  - Occurrence of various events, for example, the number of hospital admissions, the number of arrests, the number of days of employment
  - Information reported by consumers and family members, for example, their views on the services received or achievement of their goals
  - Information reported by staff, for example, about the services they provide

Research Strategies

- **Ways of Gathering the Information**
  - Review of mental health records
  - Questionnaires completed by consumers, family members or providers
  - Focus groups conducted with consumers, family members or providers
  - Individual interviews with consumers, family members or providers

Research Strategies

- **Ways of Comparing the Information**
  - Compare across two (or more) groups of consumers, for example those who received services from a Recovery Center and those who did not
  - Compare changes from before and after an intervention or program or systems change occurs, for example, change in hospitalization, or arrests or employment, before and after participation in Recovery Center services
  - Describing areas of need, services received and outcomes achieved based on a series of focus groups or interviews or case studies

What types of information--
What ways of gathering information--
What ways of comparing information--

do you think should be used in a statewide study?

Thank You for Your Help!