

Article

Transformation of the California Mental Health System: Stakeholder-Driven Planning as a Transformational Activity

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Abstract

OBJECTIVE: This study describes strategies developed by California counties to transform their mental health systems under the 2004 Mental Health Services Act (MHSA). This voter initiative places a 1% tax on annual incomes over \$1 million; tax monies are earmarked to transform county-operated mental health services into systems that are oriented more toward recovery. MHSA implementation itself can be considered "transformational" by balancing greater standardization of mental health service delivery in the state with a locally driven planning process. **METHODS:** A qualitative content analysis of the three-year plans submitted by 12 counties to receive funds under MHSA was conducted to identify common themes, as well as innovative approaches. These 12 (out of 58) counties were chosen to represent both small and large counties, as well as geographic diversity, and they represent 62.3% of the state population. **RESULTS:** This analysis showed that the state guidelines and local planning process generated consistency across counties in establishing full-service partnerships with a "whatever it takes" approach to providing goal-directed services and supports to consumers and their families. There was, however, little convergence around the specific strategies to achieve this vision, reflecting both the local planning process and a relative lack of clear policy

and guidance on evidence-based practices. **CONCLUSIONS:** There are many obstacles to the successful implementation of these ambitious plans. However, the state-guided, but stakeholder-driven, transformation in California appears to generate innovative approaches to recovery-oriented services, involve consumers and family members in service planning and delivery, and build community partnerships that create new opportunities for consumers to meet their recovery goals.

Introduction

California is the nation's largest state with the socioeconomic, demographic, and ethnic diversity of a large country. Efforts to undertake and succeed in a major transformation of its mental health system—as called for in the President's New Freedom Commission report (1) and the Institute of Medicine's report on *Improving the Quality of Care for Mental and Substance-Use Conditions* (2)—face numerous challenges. However, recent events have created a stimulus, if not a mandate, for change. In November 2004, California voters passed Proposition 63, which became the Mental Health Services Act (MHSA) (3,4). This historic legislation places a 1% tax on adjusted gross annual incomes over \$1 million and earmarks the tax monies to transform the state's 58 county- and city-operated mental health authorities into more consumer- and family-driven, culturally competent, recovery-oriented systems. Addressing the needs of previously unserved or underserved populations is also a clear priority of the legislation. The MHSA was projected to generate nearly \$700 million by fiscal year (FY) 2007, increasing thereafter, but actual funding levels have exceeded projections by more than 30% (5,6). In addition to substantial systemwide investment, the new funds represent about a 10% increase in county mental health budgets (7,8,9,10,11,12,13,14,15,16,17,18,19).

Editor's Note: This article is the 11th in a series of reports addressing the goals that were established by the President's New Freedom Commission on Mental Health. The series is supported by a contract with the Substance Abuse and Mental Health Services Administration (SAMHSA). Jeffrey A. Buck, Ph.D., and Anita Everett, M.D., developed the project, and Dr. Buck and Kenneth S. Thompson, M.D., are overseeing it for SAMHSA. The series features articles on topics such as employment, housing, and Medicaid policy as well as reports from states that received a SAMHSA-funded State Incentive Mental Health Transformation Grant.

MHSA implementation itself can be considered "transformational" by balancing greater standardization of mental health service delivery in the state with extensive community involvement and stakeholder input. The state issued guidelines to ensure that this major transformation is consistent with the recovery-oriented spirit of the legislation, but the specific approach in each county was defined by a locally driven planning process (20,21).

This article analyzes the content of the plans submitted by 12 counties to transform their child and adult systems of care. The objectives of this descriptive study were to identify the most common and innovative strategies that counties developed to transform their mental health systems and to examine whether MHSA implementation is moving the entire system toward recovery- and resiliency-oriented services, while preserving the flexibility of counties to respond to local needs and priorities.

Context and values of MHSA

MHSA grew out of successful experience with innovative models implemented in California, including a recovery-oriented program targeted to homeless consumers with mental illness, known as "AB2034," which was recognized as a model program by the President's New Freedom Commission (3). The experience with these models created the expectation that the state's mental health system can and should promote recovery for adults with serious mental illness and resilience for children and adolescents with serious emotional disturbances. Services funded by MHSA are required to promote the concepts of recovery and resilience, as well as support consumer-operated services, reflect the diversity of mental health consumers, and plan for each consumer's individual needs (3,22).

The first funding was made available in FY 2006 for the community services and supports (CSS) component of MHSA (other components include workforce education and training, capital facilities and technology investment, prevention and early intervention, housing, and innovative programs). Each county was required to submit a three-year plan to transform child and adult systems of care, subject to guidelines of and approval by the Department of Mental Health (DMH) (5,20,22,23). DMH also provided guidelines and a small amount of funding for the county-level planning processes. The planning guidelines specified that consumers and family members must be included in the process, particularly those from groups that were previously unserved or underserved. The counties also were required to include representatives from relevant agencies, including law enforcement, education, and social services (23). The stakeholder process involved topic-specific workgroups, the development of publicly available discussion documents, and general stakeholder meetings. It is estimated that over 100,000 stakeholders participated across the state (24). As of May 2008 all 58 California counties had submitted plans, and 57 of those had been approved by DMH (20).

DMH guidelines mandated that new and expanded services be provided through full-service partnerships (FSPs). FSPs, which are rooted in the assertive community treatment and wraparound services models (25), use a team approach to provide comprehensive, community-based psychiatric treatment, rehabilitation, and support for "whatever it takes" to move toward recovery and resilience for target populations. FSPs may provide housing, employment, and other services necessary to meet individual recovery goals (5). Each county's CSS allocation could be applied to a combination of FSP, system development to improve core services, and outreach and engagement to identify and

reach populations currently unserved or underserved. The DMH specified that at least 51% of CSS funds must be used for FSP programs.

Methods

A qualitative content analysis was conducted of the three-year CSS plans submitted by 12 of California's counties. The study was conducted from November 2006 to November 2007. Although the information used was publicly available, and therefore informed consent was not required, approval by the University of California, Berkeley, Institutional Review Board for a broader study of MHSA implementation also covered this study.

The sample of counties was selected to represent both small and large counties and geographic diversity (for example, north or south and interior or coastal). The willingness of local leadership to participate was also a factor. No county that was asked to participate refused, and the sample counties represent 62.3% of the state population.

The unit of analysis is an individual program within the county plans (N=141 programs in 12 county plans). The plans were structured around programs, which we define as an integrated set of services, providers, outreach strategies, and treatment approaches designed to meet the specific needs and recovery and resilience goals of a target population. Counties could propose to initiate or expand multiple programs within their plans in the three categories (FSP, system development, and outreach and engagement), and the number of programs per county ranged from four to 31, with an average of 12.

We analyzed the CSS plans by using established qualitative content analysis methods. We used directed content analysis to examine the array of services planned as part of FSP programs based on the American Association of Community Psychiatrists (AACCP) guidelines for recovery-oriented services (26,27). Directed content analysis involves coding the content into predefined categories based on existing theory, research, or well-accepted criteria (28). A set of eight service categories was defined before analysis through an iterative process reflecting the AACCP guidelines, DMH guidelines, and the actual description of services given in the plans. The defined service categories include therapeutic and rehabilitative services, services for co-occurring disorders or substance abuse, case management, peer support, outreach, employment and education services, housing, and other supports.

Categories could not be identified before analysis of the strategies that counties developed for client- and family-driven systems, cultural competence, and community collaboration. Therefore, we conducted conventional content analysis; in this type of analysis, coding categories are derived inductively from the content (28). The content of the programs was coded into the categories and compiled to analyze the range of strategies and whether there was concentration in any of the categories.

Results

Array of planned FSP services

Of the 86 programs that were identified as FSPs, 63% (N=54) planned to provide services in six of the eight categories. Thirty percent (N=26) planned services in all eight categories. The most frequent services were in the therapeutic and rehabilitative category, with 94% of FSP programs specifying these services (Table 1). In the housing category, 85% of programs planned to directly provide, contract for, or facilitate linkages to housing services. The emphasis on housing is an important aspect of recovery-oriented services, but it may also reflect the concern of California voters about the local consequences of unserved homeless residents with mental illness (29).

<p>View this table: [in this window] [in a new window]</p>	<p>Table 1. Array of services planned within 86 full-service partnership programs under the Mental Health Services Act in 12 California counties</p>
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Employment and education were included in 77% of the programs and peer support in 72%. Only 76% of the programs specifically identified case management services. Because case management is a core element of the FSP model, it may be that counties assumed that this feature of the program did not need to be stated explicitly. If this is not the case, programs without case management could not be expected to achieve the objectives of FSP. Efforts to better integrate mental health and substance abuse services were explicitly planned in 66% of the programs across all age groups, in 65% of programs targeted to adults (26 of 40 programs), and in 61% of programs targeted to transition-aged youths (20 of 33 programs).

In addition to the evidence-based assertive community treatment model that formed the basis for FSP, DMH encouraged counties to use more evidence-based and emerging best practices. This was a challenge for counties, because DMH did not provide criteria for levels of evidence or fidelity scales, and disagreement remains about defining evidence-based mental health practices (30). The counties responded by identifying 24 models that can be considered evidence-based or emerging best practices (Table 2) (27). The most common practices included integrated systems of care for co-occurring disorders and mobile service teams providing outreach, crisis response, assessment, and short-term treatment. There was a particular focus on expanding evidence-based interventions for children, including multidimensional family therapy and therapeutic foster care.

<p>View this table: [in this window] [in a new window]</p>	<p>Table 2. Number of programs (N=141) in 12 California counties planning on providing services based on evidence-based or emerging best practices under the Mental Health Services Act</p>
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Planned housing services included residential treatment, supportive housing, permanent and transitional housing subsidies and support, master leases, and emergency housing. Employment services focused on vocational training and support, skills development, and job readiness training. The range of supportive services varied, and the most frequent was assistance with benefits and entitlements, provided by 17% of FSP programs (15 of 86 programs). Several FSP programs (six of 86 programs, or 7%) planned to complement their service arrays with a "recovery curriculum" developed and run by community-based organizations.

Strategies for system transformation

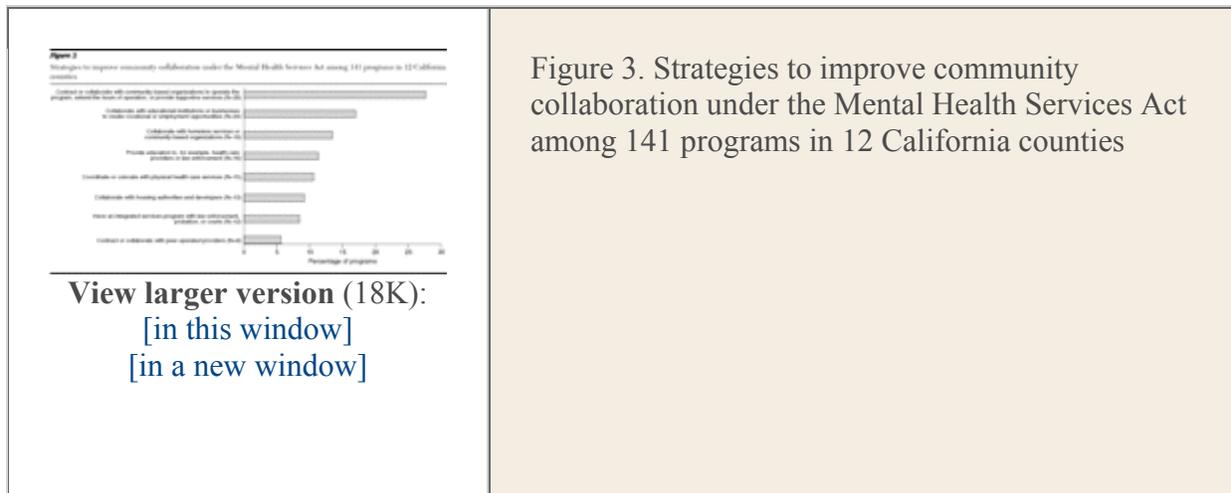
To analyze the strategies for transformation and changing the culture of the system to be more client and family centered, improve cultural competency, and increase community collaboration, we examined all 141 programs in the three program categories. The most common and innovative approaches are summarized below.

Client- and family-driven mental health system. DMH program requirements emphasize that the needs and preferences of consumers and family members must drive the policies, programs, and services in the system. To achieve this goal, a significant share of the new positions created in the programs was allocated to consumers and family members. Several programs also specified a role for consumers and family members on policy boards and cultural competency committees and provided opportunities for them to be part of program planning and management.

Peer support services are a key element of recovery-oriented programs and an important way to involve consumers and family members in service planning, outreach, and delivery. The range of peer support services planned is presented in [Figure 1](#). Peer recovery support and peer recovery advocates (in 41% of programs) and peer-run and family-run support groups (22%) were the most common strategies. Including peer specialists on multidisciplinary teams is planned in 11% of programs. Wellness centers are being developed or expanded to create a supportive, peer-run environment for

The ability to recruit, hire, and retain bilingual and bicultural staff has been a challenge for many of California's counties. Several programs included strategies for increasing their capacity to integrate bilingual and bicultural service providers, such as collaborating or contracting with ethnic-specific community-based organizations, co-locating services in ethnically based health clinics, or engaging consumers, family members, or community workers from different ethnic communities to provide outreach or supportive services. Other strategies included training for staff and collaborating organizations, developing culturally and linguistically appropriate policies and procedures, and using interventions that have demonstrated efficacy in the populations and communities being served.

Community collaboration. All counties expressed the need to better collaborate with other government agencies, community-based organizations, primary care providers, and other stakeholders to provide mental health services that are holistic and integrated with other services that consumers may be receiving. Specific strategies for working more closely with community stakeholders are shown in [Figure 3](#).



The most common strategies included contracting or collaborating with community-based organizations to operate the program, extending the hours of operation, or providing supportive services (28% of programs), as well as collaborating with educational institutions and businesses to create vocational and employment opportunities (17% of programs). Several programs identified contracting with community-based organizations as a way to achieve other goals, such as reaching underserved ethnic communities, increasing the number of bilingual and bicultural service providers, or hiring consumers and family members when county policies and procedures pose excessive barriers. Several programs, particularly for older adults, planned to educate and collaborate with primary health care providers, and others planned to colocate services in primary health care clinics.

All counties identified improved collaboration with law enforcement and the criminal justice system as a priority, and 30% of all programs are specifically targeted to offenders with mental illness. Strategies included placing clinicians in courts, probation offices, and juvenile halls, as well as including probation officers on the multidisciplinary FSP teams. Several programs planned to strengthen relationships and understanding within the criminal justice system about mental illness through education programs for law enforcement professionals, including evidence-based crisis intervention training.

Discussion

This study used qualitative content analysis to describe the plans of 12 diverse California counties for transforming the state's mental health system. Identifying categories of services and strategies to describe such a large transformation initiative was a challenge. The AACP guidelines for recovery-oriented services were a useful framework, but they failed to capture the subtlety of different strategies the counties are using to reach out to unserved and underserved mental health consumers and to serve them in a different way. An important outcome of MHSA implementation may be a deeper understanding of not only the types of services needed to promote recovery and resilience but also attributes of the services and how they are delivered, which would facilitate future attempts to characterize and describe such a transformation.

Within the constraints of the analytical framework, this study showed that California's approach to implementing MHSA, blending broad principles with specific local strategies, is clearly reflected in the county plans. The analysis demonstrated that there is considerable consistency across counties in planning FSP programs that provide a full range of services to do "whatever it takes" to partner with consumers and support their individual recovery goals.

The strategies and approaches for transforming the culture of their systems into more consumer- and family-driven, culturally competent systems with strong community collaboration are as varied and diverse as the counties themselves. New approaches to involving consumers and family members in service planning and delivery are evident throughout the plans. Creative partnerships have been proposed with other government agencies and institutions, such as law enforcement and the criminal justice system, physical health care providers, educational institutions, and the private sector. The diversity in strategies also may reflect different starting points of system development and a lack of evidence about "what it takes" to achieve recovery and resilience.

Several weaknesses in the plans also were identified, and some of these are indicative of gaps in the state-level guidelines. For example, an important weakness is the lack of guidance on evidence-based practices. The result is that other than the FSP model based on assertive community treatment, evidence-based practices are infrequently specified in the plans. The plans are also relatively limited regarding concrete strategies for improving cultural competency and strengthening community collaboration.

Conclusions

Driven by a new funding initiative, California has approached a major transformation of its mental health system by creating a synergy between a state-level framework of overarching principles and goals and community-based stakeholder planning for local implementation. This process itself may be transformational, generating county plans that reflect a consensus on local concerns and values that should drive the state mental health system while responding to the tremendous diversity in needs, priorities, and cultural values among California's mental health consumers, family members, and communities.

This analysis focused on the planning process, so it is not possible to draw conclusions about the quality or fidelity of the programs, their effectiveness, or whether they will spark the intended mental health system transformation. The challenge will be to ensure that implementation achieves the stated goals of the legislation to promote recovery and reduce the negative consequences of untreated mental illness, including suicide, incarcerations, school failure or dropout, unemployment, prolonged suffering, homelessness, and removal of children from their homes. The legislation calls for the establishment of the Mental Health Services Oversight and Accountability Commission to guide and monitor MHSA implementation. A basic statewide data system is now in place to track the progress of individual FSPs toward reducing adverse events among enrolled individuals. Evaluating the implementation of the county plans and holding counties accountable for outcomes will be a future step. However, the state and counties need time to gain experience and set realistic expectations for this monumental effort at transformation.

There are many obstacles to the successful implementation of these ambitious county plans. Maintaining the participatory approach and open dialogue of the planning process through program implementation could prove to be a challenge. Program success also will depend on the counties' ability to recruit, hire, train, and retain qualified staff, consumers, and family members who reflect the cultural and linguistic diversity of the consumers and are committed to integrating recovery principles into all aspects of program implementation. Although the counties are clear in their intention to improve the cultural competency of their systems and strengthen community collaboration, the concrete steps required are not fully developed in the plans. Counties may have been waiting for the workforce education and training portion of MHSA funds to become available to strengthen cultural competency, which raises the issue of the appropriate sequencing of implementation of the legislation.

In addition, the relative lack of clear policy and guidance on evidence-based practices leaves much uncertainty about the potential effectiveness of the strategies adopted by the counties. These weaknesses may have been overcome if the state had been more structured and directive in its policy, but the approach that was taken needs to be considered in light of California's diversity and history. There is a long-standing tradition in California of decentralization in the mental health system, and the state works to find the most constructive balance between defining system-level principles and facilitating locally driven policies and practices.

Despite these challenges, the vision of the legislation and the DMH, together with the comprehensive, broad-based county planning processes, gives the counties clear roadmaps to proceed with implementation and make adjustments in programs and strategies to achieve the goal of promoting recovery and resiliency for the state's residents served by the county mental health systems.

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The authors report no competing interests.

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