MHSA Community Program Planning Processes – Technical Evaluation Report

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

Project/Agreement #12MHSOAC009

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Executive Summary

Introduction

California's Mental Health Services Accountability and Oversight Commission (MHSOAC) contracted with Resource Development Associates (RDA) to conduct a participatory evaluation of the CPP processes implemented throughout the state. The Mental Health Services Act (MHSA) Community Program Planning (CPP) Descriptive Evaluation (herein "evaluation") is a participatory research project to measure the impact and effectiveness of CPP processes in California's 58 counties and two municipalities (herein "California counties" or "counties") that provide public mental health services. Community Program Planning (CPP) refers to the structured process implemented by Counties in partnership with stakeholders to determine appropriate uses for available MHSA funds. In the spirit of MHSA's commitment to involving stakeholders in its efforts, this Evaluation includes a collaborative partnership between Resource Development Associates (RDA) and the Client Stakeholder Project (CSP), each under separate contract with the MHSOAC.

The purpose of the evaluation is to identify the most promising CPP processes and practices by assessing the content and quality of CPP processes; MHSA outcomes that result from CPP processes such as the number and diversity of participants; the quality of CPP processes for quality improvement purposes; and the perceived impact these processes have on CPP participants, the public mental health system, and the broader community. This evaluation aims to provide a picture of CPP processes used across the state and strategies to which stakeholders react most positively as well as identify promising CPP practices that could be replicated in future CPP processes. These promising CPP practices may be incorporated into the training and technical assistance to be made available upon request to a county entity and/or stakeholder to ensure meaningful stakeholder involvement and participation in local CPP processes throughout the State.

Methodology

The evaluation team used a mixed-methods approach to evaluate CPP processes across the state and their effectiveness in promoting meaningful participation by stakeholders. The evaluation's findings were developed from a combined review and analysis of information from five data collection instruments completed for each county: 1) County Web-Based Data Request, 2) MHSA Annual Update Document Review, 3) Key Informant Interviews with county MHSA/CPP Coordinators, 4) Focus Groups with stakeholders, and 5) Stakeholder Surveys. The quantitative and qualitative information gathered from these instruments provided a vast quantity of data that allowed the evaluation team to apply triangulation to strengthen the validity of findings and provide different perspectives on complex and multi-dimensional phenomena. Findings from this evaluation are discussed from three perspectives: 1) statewide, 2) regionally, and 3) county size. The analytic methods of this evaluation changed following the data collection phase because the data requested was different from the data that counties had available

to provide, and the data that counties did have available was inconsistent across the state. Standardizing the types, format and reporting mechanisms of data collected would strengthen future evaluation of CPP processes.

Key Findings

Over the course of this project, the evaluation team discovered many key findings. These key findings stemmed from the evaluation team's critical review and interpretation of the data collected. The evaluation findings support the application of MHSA principles in CPP processes, which may be unsurprising, but offer evidence to support the application of and suggest a need to reinvigorate CPP processes across the state with MHSA principles. Evaluation findings also suggest that CPP activities vary regionally and in terms of county size, and that the resources required for and allocated to CPP activities are a critical aspect of implementing CPP processes.

Evaluation findings are organized by categories or domains from the evaluation logic model (i.e. inputs, outreach, participant input, training, and impacts on stakeholders, the public mental health system, and the broader community).

Inputs

In this domain, the evaluation team looked to answer the question: What resources do counties have to conduct CPP processes? This involved looking at the number of full-time equivalents (FTEs) specifically allocated to the CPP process and whether training was provided to people who filled these positions.

Key Findings for CPP Inputs

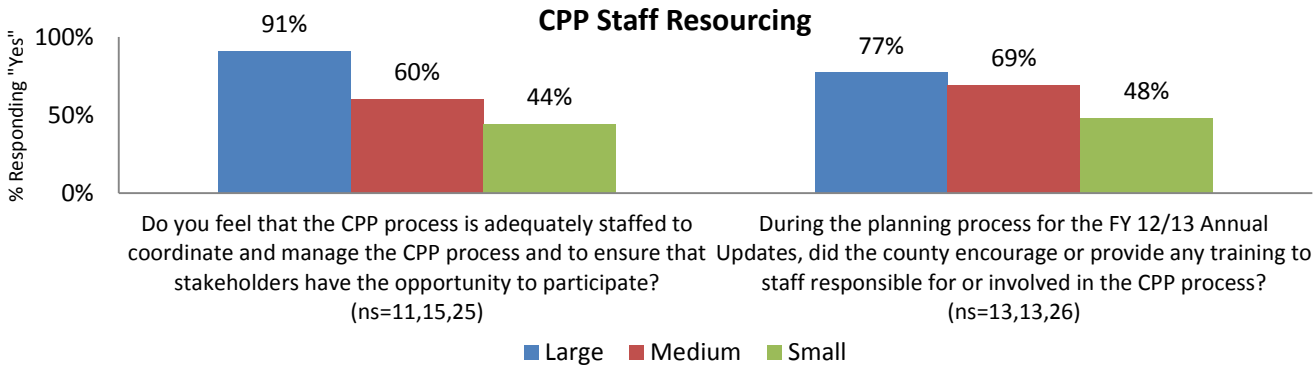
1. On average, counties designated 1.84 full-time equivalents (FTE) to conduct and/or monitor CPP activities. FTE was directly related to county size: the larger the county, the more FTEs were created.
    - **Large counties** designated the most FTEs with an average of 3.58 FTEs.
    - **Small counties** designated the least FTEs with an average of 0.96 FTEs.

> *During large CPP processes I think the City could utilize at the minimum one additional staff member (a half time person at least), to more adequately support the work in this area.*
>
> Medium Central County MHSA/CPP Coordinator

2. Only 60% of counties said they were able to assign adequate FTEs to CPP activities. This rating differed by county size.
    - About 90% of the **large counties** felt they had enough FTEs for the CPP process.
    - Only 44% of **small counties** felt they had enough FTEs for the CPP process.

3. Whether or not counties provided or encouraged staff training in CPP processes also varied by county size.

- About 75% of **large counties** reported that they encouraged or provided training to staff conducting the CPP process.
- Only 50% of **small counties** reported that they encouraged or provided training to staff conducting the CPP process.



4. Counties reported that it was important to have staff with multilingual fluency to increase outreach and engagement to more stakeholders, especially those who have limited English proficiency (LEP).

Outreach

To gain a better understanding of counties' outreach activities during CPP processes, the evaluation team considered the following questions: What kinds of outreach do counties conduct and how much? How do counties reach out to specific stakeholder groups? What kinds of incentives do counties provide to encourage CPP participation? What are the barriers to CPP participation?

Key Findings for Outreach Processes

1. Most counties used a variety of concurrent outreach methods to encourage stakeholder participation in CPP activities. However, the outreach method varied, depending on the CPP activity. For example:

   - ***For CPP activities such as needs assessments and program strategizing efforts, counties relied more on direct outreach.*** Examples include making a personal phone call or going out into the community.

   - ***For CPP activities that sought public comments or participation at public hearings, outreach was more widespread.*** For example, counties were more likely to post the draft plan on the county website to receive public comment.
   - ***Counties' outreach approaches were related to county size.*** **Medium** and **small counties** often used a variety of outreach activities concurrently to allow for more targeted outreach, while **large counties** relied more on mass communication efforts, such as radio and television announcements.

2. ***A key engagement method that emerged was word-of-mouth efforts that included a "personal touch."*** This was particularly reflective of the **Central** and **Southern regions** where most of the state's small counties are located and there is the most geographic variation.
    - County informants and stakeholders reported some of the most effective outreach activities involve the more informal social gatherings that do not specifically focus on MHSA or CPP activities, such as a BBQ or dinner and movie night.
    - Using existing community activities to recruit CPP participants seems to be effective because these less-formal activities support ongoing community building and networking.
    - Data seems to indicate that, by going out to the stakeholder communities to encourage CPP participation in settings that were already familiar and comfortable for stakeholders, counties were able to increase their CPP participation and collect more meaningful feedback.

3. ***Both stakeholders who participated and those who did not participate in FY 2012-13 CPP activities reported having meals at meetings was a top incentive.*** Financial incentives and offering childcare services during CPP activities also seem to be potential ways of encouraging stakeholder participation in CPP activities.

4. ***However, counties often identified transportation to meetings as a key challenge to stakeholder participation***, even though many counties reported providing transportation to CPP activities.
    - **Large counties** and counties in the **Bay Area**, **Los Angeles**, and **Southern** regions reported the wide county geography made it difficult to travel to a centralized location for a CPP meeting.
    - **Small counties** and counties in the **Central** and **Superior** regions mentioned the transportation challenges related to a lack of reliable public transportation.

5. ***Counties and stakeholders reported different barriers to participation, indicating that counties and stakeholders may not agree about what encourages or facilitates participation in CPP activities.***
    - Counties reported that stakeholders needed more training in order to feel comfortable and meaningfully participate in CPP activities. Counties also identified barriers related to language, stigma, and childcare.
    - Stakeholders identified different barriers. Their primary barriers to CPP participation related to inaccessibility issues around the following: 1) inconvenient meeting times and locations, and 2) CPP meetings that relied heavily on statistics and technical jargon.

Key Findings for Outreach Outcomes

Outreach Activities

1. Using social media to reach stakeholders was linked with stakeholders feeling as though they contributed more, felt safer to participate, had more trust in the public mental health system, and

had an increased sense of wellness as a result of participating in the CPP process. Not using social media to reach stakeholders was linked with a decrease in stakeholder perceptions of contribution, safety, trust, and wellness as a result of participating.

Social Media

Perception of Contribution
Participation Safety
Participant Trust
Perception of Wellness

2. Using announcements at meetings to outreach to stakeholders was linked with an increase in stakeholder's perceptions of contribution and trust. Not using announcements at meetings to outreach to stakeholders was correlated with a decrease in stakeholder's perceptions of contribution and trust.

Announcements at Meetings

Perception of Contribution
Participant Trust

Incentives to Encourage Stakeholder Participation

3. Providing stipends/other financial incentives to encourage stakeholder participation was correlated with stakeholders feeling more satisfied and that the process was more recovery oriented as well as a perception of an increased sense of wellness as a result of CPP participation. Not providing stipends/other financial incentives to encourage stakeholder participation was associated with a decrease in stakeholder's perceptions of satisfaction, recovery orientation of the process, and sense of wellness as a result of CPP participation.

Stipends/Other Financial Incentives

Participant Satisfaction
Recovery Orientation
Perception of Wellness

4. Providing childcare to encourage stakeholder participation was correlated stakeholders feeling that CPP meetings were more effective and safe and that their opinions and culture were respected as well as increased their trust in the public mental health system. Not providing childcare was linked with a decrease in stakeholder's perception of CPP meeting effectiveness, respect of participant opinions and culture, safety, and trust.

Childcare

CPP Meeting Effectiveness
Respect of Participant Opinions & Culture
Participant Safety
Participant Trust

Participant Input

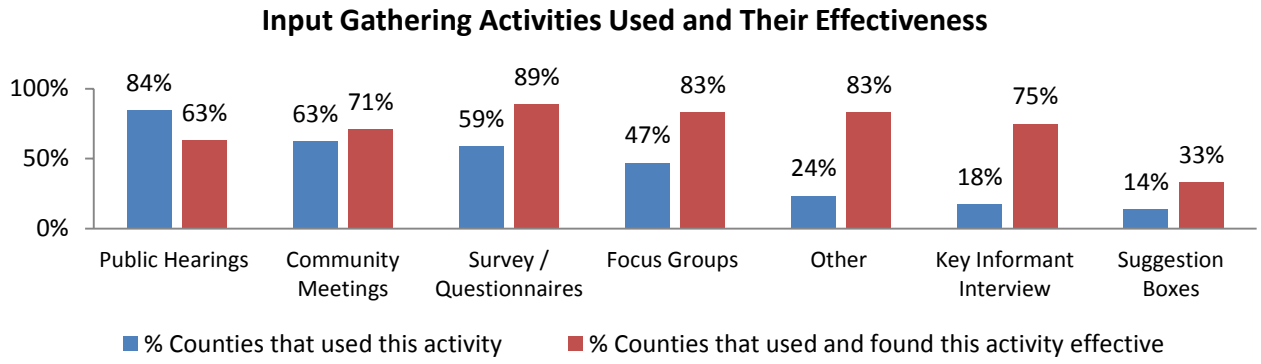
To better understand what constitutes meaningful stakeholder involvement throughout the CPP process, the evaluation team reviewed which stakeholder groups and how many stakeholders participated in FY 2012-13 CPP processes, how counties made CPP processes accessible and inviting to stakeholders to promote participation, and how counties collected and used stakeholder input.

Key Findings for Participant Input Processes

1. ***Building stakeholders' trust in the public mental health system was crucial to making participants feel safe during CPP activities.*** Most of the counties said it was important to be open, responsive, and respectful at CPP activities. How counties built trust differed by MHSA region:
    - **Bay Area counties** said it was important to create meeting goals with participants and reach out to stakeholder groups that had not previously participated.
    - **Central counties** said using peer-led activities helped build stakeholder trust.
    - **Los Angeles County** did not identify any processes because they believed that trust and open dialogue already existed.
    - **Southern counties** credited their community events and retreats for successful trust building.
    - **Superior counties** had mixed experiences in building stakeholder trust. Many of the **smaller counties** reported struggling with the stigma of mental health and accessing mental health services.

2. The largest stakeholder groups participating in the CPP process were consumers and family members, followed by county mental health department staff. The least represented stakeholder group was providers of veteran services.

3. The most frequent CPP activities used to gather stakeholder input were perceived to be less effective as some of the activities used less often.



4. Counties engaged in a number of CPP activities to gather participant input. ***More specifically, counties invested more effort in gathering participant input for needs assessments and program development than they did to finalize drafted plans.***
   - Counties and stakeholders reported town hall/community meetings and focus groups as the most popular needs assessment activities.
   - Surveys/questionnaires were significantly associated with positive perceptions by stakeholders.
   - While counties were less thorough in their outreach and engagement with stakeholders to seek input during the plan finalization, counties also indicated that public hearings were the least effective activity in gathering participant input.

5. ***Participant input in finalizing drafted plans varied by county size.*** Medium and small counties were more likely than large counties to implement a wider variety of methods to share their MHSA plans with stakeholders.

Key Findings for Participant Input Outcomes

1. Using surveys/questionnaires was linked with stakeholders feeling that CPP meetings were more effective and safe and that they contributed more. Not using surveys/questionnaires was linked with a decrease in stakeholder's perception of CPP meeting effectiveness, contribution, and safety.

Surveys/Questionnaires

CPP Meeting Effectiveness
Perception of Contribution
Participant Safety

Training

While training is not required for the CPP process, it was apparent through county and stakeholder feedback that some participant training was necessary to help stakeholders meaningfully participate. Therefore, the evaluation team examined whether or not counties provided training to participants in CPP processes, how many times, and which specific trainings.

Key Findings for Training Processes

1. Only 56% of counties said they provided some kind of training for CPP participation, but 70% of CPP participants said that they felt trained enough to be able to participate.
    - **Small and large counties, and the Central and Superior regions** tended to provide more trainings.
    - **Medium counties** provided trainings to fewer participants. However, CPP participants from **medium counties** reported feeling most well trained to participate.
    - **Bay Area and Southern counties** also reported providing training to fewer participants. They also reported having more participants who have participated in multiple activities over more time. However:
        - 73% of **Southern county** participants said they felt well trained to participate, but
        - Only 59% of **Bay Area county** participants said they felt well trained to participate

2. Even though stakeholders reported that they felt trained enough to be able to participate, counties reported that their participants needed to be better trained.

3. Some suggestions that stakeholders and counties made for improved participant training were:
    - Use less jargon and provide activities in languages other than English.
    - Provide participant training materials, expectations, and background information before the CPP activities.

Key Findings for Training Outcomes

Providing support for external trainings was associated with stakeholders feeling that CPP meetings were more effective. *Not* providing support for external trainings to encourage stakeholder participation was correlated with a decreased stakeholder perception of CPP meeting effectiveness.

Support for External Trainings

"[A] lack of community understanding in how to provide the information needed [is a barrier to participation]."

MHSA/CPP Coordinator, Medium Superior County

CPP's Impact on Stakeholder Empowerment, Wellness and Recovery

In this domain, the evaluation team answered the question: How does participation in the CPP process affect individual participant's overall sense of empowerment, hope, self-determination, social connection, wellness, and recovery as well as personal trust in and collaboration with the public mental health system?

Key Findings

1. Stakeholders felt that participating in the CPP process slightly improved their sense of wellness.
    - **Los Angeles** and **Southern** county stakeholders reported the greatest levels of improved wellness.
    - **Bay Area** county stakeholders reported the lowest levels of improved wellness.

> *"The CPP gives me a goal when I participate and helps in my recovery."*
>
> *Stakeholder*, Small Superior County

2. Further analysis indicates that the more CPP activities are recovery-oriented, the more positive participants rate their perception of wellness as a result of participating in CPP activities.
    - The majority of stakeholder survey respondents believed their CPP meetings were safe (79%), culturally-competent (76%), stakeholder-driven (72%), and recovery-oriented (71%).

3. It is encouraging to note that California's CPP participants also recognized their counties incorporating MHSA principles into CPP processes.

4. Stakeholders reported a small increase of trust in the public mental health system as a result of participating in CPP activities. More specifically, the more stakeholders felt they were contributing to the design of programs and service delivery, the more their trust in the public mental health system grew.
    - **Los Angeles** and **Southern** county stakeholders reported the highest levels of increased trust in the public mental health system.
    - **Bay Area** county stakeholders reported the lowest levels of increased trust in the public mental health system.

5. Stakeholders across the state agreed that their counties' CPP processes were recovery-oriented.
    - **Large counties** and counties in the **Los Angeles** and **Southern regions** tended to have more agreement that their CPP processes were recovery-oriented.
    - Counties in the **Bay Area region** expressed the lowest level of agreement.

CPP's Impact on the Public Mental Health System

*For this domain, the evaluation team looked at stakeholders' perceptions of counties' CPP processes and how the CPP process impacts **system-wide** changes such as mental health policy, program planning, and implementation as well as how the CPP process influences further trust and partnership among mental health service providers and between health and human service providers.*

Key Findings

1. The more stakeholders felt they were contributing to the design of programs and service delivery, the more their trust grew in the public mental health system.
   - **Los Angeles** and **Southern** stakeholders had the highest levels of agreement that participation in higher-level planning increased trust in the public mental health system.

2. MHSA/CPP Coordinators and stakeholders reported the CPP process strengthened the promotion of MHSA principles in the public mental health system. They felt that the CPP process enhanced cultural competency, community collaboration, integrated service experience, family- and client-driven services, and a recovery-oriented approach to public mental health services and delivery. Some examples are:
   - Counties noted a deeper understanding of the cultural dynamics and mental health needs of various ethnic minority groups. At the same time, stakeholders noted counties enhanced outreach and engagement with the cultural communities they serve.
   - Some counties and stakeholders reported new partnerships between primary care and mental health services.
   - Stakeholders reported that CPP processes led to greater support networks for family members by providing them with greater awareness of current services and supports.
   - Counties and stakeholders noted how participation in the CPP process by stakeholders and community members created improved public awareness of mental health issues, hope, and recovery.

3. Counties and stakeholders described how collaborative planning between stakeholders from different backgrounds and organizations improved integration of mental health services with other disciplines.

> *"We have seen a lot of transformation: a huge impact that has improved the whole system in terms of communication, collaboration and better and more services. The 'no wrong door' approach has helped build deeper relationships and partnerships."*
>
> Los Angeles County Stakeholder

CPP's Impact on the Broader Community

For this domain, the evaluation team examined how CPP processes impact community views of the public mental health system and issues of stigma. County informants and stakeholders were asked to describe how CPP processes influenced community awareness of mental health and seeking public mental health services.

Key Findings

1. Overall, stakeholders reported that they had noticed a broader county shift towards a community-driven mental health services approach that emphasizes wellness and recovery as a result of their counties' CPP processes, instead of focusing on mental illness.
    - Stakeholders in **small counties** particularly stressed that their counties' CPP processes had increased public awareness around mental health-related issues as well as stakeholders' knowledge of mental health services.
    - The **Bay Area** region had the fewest counties who said that their CPP process had a positive impact on community awareness of mental health.

> *It is my hope that through the CPP processes and through making myself available at all times to listen, take input, and answer questions from community members and stakeholders, that the public's perception of Mental Health and MHSA funded services is one that shows transparency, openness, collaboration, inclusiveness, and reduces stigma and discrimination for people with mental illness.*
>
> MHSA/CPP Coordinator, Small Bay Area County

2. About 75% of counties and 50% of stakeholders felt the CPP process improved the community's perceptions of receiving a mental health diagnosis and seeking public mental health services.
    - More counties in the **Southern and Superior regions** said that their CPP processes improved community perceptions of mental health and seeking services by increasing activities to reach the public.

3. Both counties and stakeholders agreed the CPP process most often improved community perceptions of mental health by reaching community members and involving them in community activities.
    - MHSA/CPP Coordinators felt that the community-based activities that promoted wellness were very effective.
    - Stakeholders said opportunities to share stories of lived experiences were effective.

> *"…since MHSA, the public's perceptions have improved and people are more easily engaged and willing to participate in planning processes and developing partnerships in the community."*
>
> Central County Stakeholder

Recommendations

Over the course of this project, the evaluation team has noted a number of potential recommendations for counties' future CPP processes. These recommendations stemmed from the evaluation team's critical review and interpretation of the data collected. In summary, the evaluation team's recommendations from this evaluation are as follows:

Inputs

- Increase staffing or designation of hours during periods of CPP outreach, planning, and implementation. It may be prudent for counties with limited resources to set aside dedicated funding to increase staff levels during times of high volume CPP work.
- Utilize community resources, such as community leaders, community based organizations (CBOs), and other service providers to help with CPP outreach activities.

Outreach

- Increase outreach strategies that capitalize on using informal social activities, dialogues, and on-the-ground personal interactions in addition to more formal outreach activities. Data across all county sizes and CMHDA regions indicates that word-of-mouth activities are an effective outreach method.
- To enhance outreach to stakeholders, counties might consider the following strategies:
  - Increase the use of social media
  - Increase the use of announcements at meetings
- If resources permit, provide stipends/other financial incentives to encourage stakeholder participation as this seems to increase stakeholder's satisfaction in the CPP process, sense of wellness, and perception that the CPP process is consistent with MHSA philosophies.
- Offer childcare services to promote stakeholder participation during CPP activities. Data suggests the provision of childcare correlates with the following positive outcomes:
  - Stakeholders' perception of accessibility was enhanced.
  - Stakeholders' perception of safety and trust in sharing feedback was enhanced.
  - Stakeholders' perception that their opinions are respected by the CPP facilitators was enhanced.

Participant Input

- Establish clear ground rules for how stakeholders are expected to participate in strategy roundtables/strategizing sessions. For counties using strategy roundtables/strategizing sessions, data seems to indicate a decrease in stakeholder's perception that their opinions and culture were respected.
- Increase the use of surveys/questionnaires. Data suggests using surveys/questionnaires in the CPP process might increase stakeholder's perception of accessibility, contribution, and safety.
- Explore ways in which to make public hearings more useful. County informants and stakeholders generally reported public hearings were ineffective. In addition, stakeholders found the bureaucratic processes confusing.
- Conduct further research exploring how to use translation/interpretation services in the most effective and culturally relevant manner. Approximately half of the counties utilize translation/interpretation services during the CPP process. Moreover, the majority of these counties find translation/interpretation services to be a successful strategy for encouraging stakeholder participation.

Training

- Refine expectations around stakeholder participation and revise participant trainings to match and communicate these expectations as a part of outreach efforts.
- Minimize the use of technical jargon to enhance stakeholders understanding of the material.
- Provide CPP activities and materials in languages other than English in order to increase accessibility and understanding of the CPP process.
- Expand support for external trainings as this could increase accessibility of the CPP process.
- For counties in the Bay Area, mental health departments might allocate more time for planning CPP activities with stakeholders. This could help stakeholders better understand their roles and expectations in the CPP process as well as provide them with enough information to effectively participate in CPP activities.

Evaluation

- Should the MHSOAC decide to implement a required evaluation component, it is recommended that the MHSOAC first formalize and standardize methods for counties to record participant attendance and demography, providing guidelines for how to use this information to improve future CPP processes.

Satisfaction with the CPP Process

- Aim to improve the structure of CPP meetings so that the planning process is more transparent, welcoming, safe, and meaningful.
- Increase efforts to include more consumers in leadership, planning processes, and policymaking.
- Encourage staff members who work in the mental health departments to participate in CPP processes.

Participant Impacts

- Activity facilitators should take care to make CPP activities accessible to participants—including establishing a safe environment free of stigma and providing adequate training so that participants know how and why they are participating
- Design CPP activities in alignment with MHSA principles. Factors to keep in mind during the planning process are adopting a recovery-oriented approach and being explicit about how participant input will be used to inform programming and service delivery.

Mental Health System Impacts

- Strive to include consumers and their family members in program planning, implementation, evaluation, and decision making. The inclusion of consumers and family members in higher-level planning has shown to be essential in building buy-in, trust, and utilization of the PMHS.
- Continue to involve consumers and their family members in all aspects of MHSA program development.

- Continue to require the representation from other health and human service providers in all aspects of MHSA program development.

Perceptions of the Broader Community Impacts

- Be proactive in developing a diverse stakeholder population. To further this goal, counties might consider building more opportunities for dialogue in a safe environment that fosters trust, understanding, and collaboration among the different constituencies. As a result, increased partnerships across stakeholder groups and sectors will help reduce stigma around mental health issues and accessing services.

Other Recommendations

- Counties across the state collect a vast amount of data on CPP processes; this data, however, varies in what and how it is collected. Standardizing the types of data collected, format, and reporting mechanisms for all counties would strengthen further evaluation of CPP processes.

Introduction

The purpose of the Mental Health Services Act (MHSA) Community Program Planning (CPP) Evaluation (herein "evaluation") is to use a participatory research process to measure the impact and effectiveness of CPP processes in California's 58 counties and two municipalities that provide public mental health services (herein "California counties" or "counties"). Community Program Planning (CPP) refers to the structured process implemented by Counties in partnership with stakeholders to determine appropriate uses for available MHSA funds. Counties are given relatively wide latitude to develop CPP processes in line with the needs and culture of their communities.

California's Mental Health Services Oversight and Accountability Commission (MHSOAC) contracted this participatory evaluation to identify the most promising CPP activities by assessing the content and quality of CPP processes, MHSA outcomes that result from CPP processes such as the number and diversity of participants, the quality of CPP processes for quality improvement purposes, and the perceived impact these processes have on CPP participants and the public mental health system (PMHS). This evaluation aims to provide a picture of CPP processes used across the state, strategies to which stakeholders react most positively, and identify promising CPP practices that could be replicated in future CPP processes. These promising CPP practices may be incorporated into the training and technical assistance that is to be made available upon request to a county entity and/or stakeholder to ensure meaningful stakeholder involvement and participation in local CPP processes throughout the State. In particular, immediately following the identification of promising CPP processes and within the greater scope of this project, the Client Stakeholder Project (CSP) will use the promising CPP processes identified to develop and conduct their CPP trainings and technical assistance with county entities and stakeholders to increase the meaningfulness of and participation in CPP processes.

This evaluation report serves as a comprehensive document that describes the following: the evaluation logic model and research questions; the methods utilized in the data collection and reporting within the evaluation; the data analyses conducted by the evaluation; and the findings discovered during the evaluation.

The findings from this evaluation are discussed with respect to two separate analyses. The Descriptive Evaluation produced overarching findings within each of the 10 CPP domains listed below and aims to provide a picture of CPP processes used across the state and strategies to which stakeholders react most positively. These findings are summarized at three levels: statewide, by CMHDA region,[1] and by county size.[2] The stratification of results by these three levels allows for more in-depth and nuanced interpretations of the broad set of results.

[1] The five California Mental Health Directors Association (CMHDA) regions [Bay Area, Central, Los Angeles, Southern, and Superior] and their respective counties are detailed at: http://www.cmhda.org/go/about-cmhda/organizational-structure.

[2] County size is determined by the total populations of each county. "Small counties" have populations under 200,000 persons, "medium counties" have populations between 200,000-800,000 persons, and "large counties" have populations over 800,000 persons).

- Inputs
  - *Input* items refer to the resources that counties have to conduct CPP processes.
- Outreach
  - *Outreach* items refer to the types of outreach activities that counties conduct, how often they are conducted, and how many stakeholders are reached.
- Participant Input
  - *Participant Input* items refer to how counties ensure that they have meaningful stakeholder participation in their CPP processes.
- Training
  - *Training* items refer to the training activities that counties provide to their stakeholders so that they can participate meaningfully in their counties' CPP processes.
- Evaluation
  - *Evaluation* items refer to the evaluation activities that counties conduct to assess their CPP processes.
- Stakeholder Perceptions and Satisfaction
  - *Stakeholder Perceptions & Satisfaction* items refer to CPP stakeholders' perceptions about the meaningfulness of their CPP participation.
- Participant Impacts
  - *Participant Impacts* items refer to how counties' CPP processes affect its participants.
- Mental Health System Impacts
  - *Mental Health System Impacts* items refer to how stakeholders' CPP participation affects their perceptions about the public mental health system.
- Perceptions of Broader Community Impacts
  - *Perceptions of Broader Community Impacts* items refer to how counties' CPP processes affect the community's perceptions about mental health.
- Stakeholders Who Did Not Participate in CPP Process
  - *Incentives & Barriers for Persons Who Have Not Participated in CPP* items refer to the activities that counties can do to engage potential CPP participants.

The Outcome Evaluation produced a second set of findings identifying the specific CPP practices that were significantly correlated with stakeholders' perceptions of targeted outcomes. The evaluation team identified variables that emerged as relevant themes from the qualitative data and that had associated data of sufficient quality and quantity to permit analysis, including: 1) CPP meeting effectiveness, 2) recovery orientation, 3) participants' sense of safety in their CPP participation, 4) participant training for CPP participation, 5) participants' perceptions of their contributions, and 6) respect of participant opinion and cultures. Then, the evaluation team identified outcomes from the logic model that had associated data of sufficient quality and quantity to permit analysis: 1) participant satisfaction, 2) participant trust in the public mental health system, and 3) participant perception of wellness related to CPP participation. The evaluation team performed an analysis to determine which of the six variables identified through the qualitative analysis contributed to the aforementioned outcomes, and then performed an analysis to determine which, if any, CPP processes and practices were correlated to either set of variables. Please see the methods section for a full discussion of the analytic methods used.

The Discussion section of the report provides summaries from examining the evaluation's findings to identify the crosscutting topics found across Descriptive and Outcome Evaluation sections described above. Due to their perceived effectiveness, seven discussion topics were identified as pervasive across multiple domains and pertinent to the evaluation's goal of identifying CPP activities and practices for implementation across California:

- *CPP Staffing and Effects on Activities*: The levels of staffing that counties designed to their CPP processes had effects on the CPP activities that they conducted.
- *Multilingual Capabilities*: Both counties and stakeholders identified the importance of CPP processes having multilingual capabilities to encourage more expansive participation.
- *Scale of CPP Activities*: The size of counties had effects on the types of CPP activities that counties conducted.
- *Community-Based Activities and Building Trust with Stakeholders*: Activities conducted in community-based settings built increased trust amongst stakeholders in their counties' CPP processes.
- *Alignment with MHSA principles*: Those CPP activities that were in alignment with MHSA principles were more effective in recruiting CPP participants and encouraging their meaningful participation.
- *Stakeholder Perceptions of Effective CPP Practices*: Specific CPP practices demonstrated statistically significant correlations with stakeholder perceptions of their counties' CPP processes.
- *Stakeholder Consistency*: Across the state, some counties have had a relatively static pool of individuals participating in counties' CPP processes.
- *Optimism of Future Impacts*: Looking ahead, both counties and stakeholders are encouraged by their counties' past CPP processes and feel optimistic about future CPP processes.

Methods

The evaluation of the effectiveness of MHSA CPP processes across the State of California requires a structured approach that is grounded in the underlying intents, processes, and outcomes of the CPP process. The evaluation team applied an approach based on principles laid out by the American Evaluation Association Ethics Committee to measure and document the quality, impact and effectiveness of current CPP processes and practices conducted throughout the state. These principles include:

- *Systematic Inquiry*: including measurable research questions, use of appropriate methods, and ongoing communication, which will allow others to understand, interpret, and critique evaluation findings.
- *Competence*: including sufficient training and skill development, experienced analysts, attention to cultural competency, and clarity about limitations.
- *Integrity/Honesty:* including openness about budget, roles and responsibilities, limitations of methodology, and potential conflicts of interest/biases.
- *Respect for People:* including participants and respondents, and abiding by standards related confidentiality, informed consent, and potential risk or harm to participants.
- *Responsibility for Public Welfare:* including an understanding of the implications and use of data, and a willingness to present findings in a manner that is understandable and respectful.[3]

One of the goals of this evaluation is to promote continuous quality improvement of CPP processes that are aligned to MHSA principles. The MHSA principles include:

- Consumer and family driven;
- Recovery, resiliency, and wellness focused;
- Cultural competence;
- Integrated service delivery; and
- Community collaboration.

The methods employed in the evaluation of California counties' CPP processes followed steps and procedures to ensure that:

- The evaluation would be properly planned and executed;
- The data collected would be of the highest quality possible;
- The analyses would examine the most important and latent issues pertaining to the state's overall CPP processes; and
- The reporting of the findings would be accessible to stakeholder audiences from a variety of backgrounds.

[3] Shadish, W., Newman, D., Scheirer, M. A., & Wye, C. (1994, January). *American evaluation association guiding principles for evaluators*. Retrieved from: http://www.eval.org/p/cm/ld/fid=51

The evaluation team recognizes that the vastness and intensity of this statewide evaluation required the resources and attention of many stakeholders and organizations. The evaluation team aims to provide a thorough and expansive interpretation of the data collected, complemented by an organizational approach that enables the reader to easily locate desired information so that the findings can be of the utmost utility to California's county mental health departments, consumers and family members, and all other stakeholders of the state's PMHS.

Evaluation Team

This evaluation is funded by the MHSOAC, whose staff members oversee all activities and approve all evaluation plans and final deliverables. Resource Development Associates (RDA) serves as lead evaluator, responsible for the development of the evaluation framework, research methods, and tools; the provision of training and technical assistance for data collection; preparation and analysis of all data received; and reporting that is accessible to a variety of stakeholder audiences.

MHSOAC also contracted with Peers Envisioning and Engaging in Recovery Services (PEERS) to partner with RDA and facilitate the participatory approach to this evaluation. PEERS subcontracted with the California Association of Mental Health Peer Run Organizations (CAMHPRO) and four regional partner organizations (herein "Regional Partners"). PEERS' subcontract and partnership with CAMPHRO in this project is formally recognized as the Client Stakeholder Project (CSP). The CSP was contracted to facilitate data collection, create an inventory of CPP processes, and develop and implement a curriculum and trainings based on promising practices identified from this evaluation. In addition, the CSP formed a Community Advisory Committee (CAC) to provide ongoing consultation and feedback for the duration of the contract. The CAC is comprised of representatives from the National Alliance on Mental Illness (NAMI), United Advocates for Children and Families (UACF), California Youth Empowerment Network (CAYEN), the California Association of Local Mental Health Boards and Commissions (CALMHB/C), the four regional partner organizations (e.g. Project Return Peer Support Network, Consumers Self Help Center, Mental Health Association of San Francisco, and an individual consumer activist), and others that were identified through a recruitment process.

Participatory Evaluation and the Client Stakeholder Project

Program improvement requires not only the input of administrators whose job is to implement and oversee the system, but also input from MHSA stakeholders[4]. In the spirit of the MHSA, the evaluation team sought and applied input from people with lived experience throughout all phases of the evaluation, from the initial evaluation planning phase through data collection and interpretation. This approach, called *participatory research* or *empowerment evaluation*, "aims to increase the likelihood that programs

[4] Stakeholders, as defined by Welfare and Institution Code 5848, include adults and seniors with severe mental illness, families of children, adults, and seniors with severe mental illness, providers of services, law enforcement agencies, education, social services agencies, veterans, representatives from veterans organizations, providers of alcohol and drug services, health care organizations, and other important interests ("Welfare and Institutions code section 5845-5848").

will achieve results by increasing the capacity of program stakeholders to plan, implement, and evaluate their own programs."[5]

Throughout the evaluation, RDA worked hand-in-hand with the Client Stakeholder Project (CSP). The evaluation plan and all of the data collection instruments for the evaluation were developed in conjunction with the CSP. The CSP and Regional Partners then implemented the data collection procedures for all five data collection instruments and collected the entirety of data used in RDA's analysis. During the data collection phase of the evaluation, RDA served as a source of technical assistance for the CSP and its Regional Partners. RDA also setup the data reporting mechanisms for the CSP and its Regional Partners to provide the data collected to RDA.

Stakeholder feedback from the CSP and its partners was sought and obtained throughout this project. At every stage of this project, RDA worked closely with the CSP to ensure that the evaluation plan and data collection phases were collaborative and that the CSP had the necessary technical assistance and support to execute the data collection. RDA worked to incorporate stakeholder feedback throughout the distinct phases of this project, including: 1) evaluation planning regarding the project's research questions and logic model, 2) development of the data collection instruments and protocols, and 3) analysis of evaluation data and presentation of evaluation findings prior to the identification of promising CPP practices. RDA plans to continue this collaboration for the identification of CPP promising practices via a summit by to be attended by the CSP and expert CPP stakeholders from across the State. Stakeholders are an integral part of CPP processes and were given many opportunities to provide their feedback and expertise in the development, implementation, and culmination of this project.

Evaluation Planning

To launch the project, RDA convened a two-day Evaluation Planning Summit with participation from the CSP, MHSOAC staff, and members of the CAC. The CAC members represented different geographical locations in California, brought varied professional expertise, and displayed diversity in gender, age, ethnicity, spoken language, and ability. The Evaluation Planning Summit was held at the PEERS office in Oakland, California, on May 22 and 23, 2013. The objectives of the summit were to:

- Develop a safe, supportive, and open environment for stakeholder contractors, MHSOAC, and RDA staff to build skills and share knowledge and experience about evaluation;
- Identify potential research questions and a theory of change (a tool that explains how a group of early and intermediate accomplishments sets the stage for producing long-range results);[6]
- Construct a draft logic model to inform the development of evaluation methods, tools, and research stimuli;

[5] Fetterman, D. M., & Wandersman, A. (2004). *Empowerment evaluation principles in practice*. New York, NY: The Guilford Press.

[6] Anderson, A. (2005). An Introduction to the theory of change. *The Evaluation Exchange*, *9*(2), 12-19. Retrieved from: http://www.hfrp.org/evaluation/the-evaluation-exchange/issue-archive/evaluation-methodology/an-introduction-to-theory-of-change

- Provide training on choosing methods and tool creation; and
- Elicit contributions from participants in drafting tools that RDA staff can finalize.

See RDA's report titled, "Deliverable 1: Report of Proposed Research Design and Data Collection Training Plan," for an in-depth description of the rationale, steps, and activities implemented during the Evaluation Planning Summit.

See "Appendix 7: List of RDA's Deliverables" for a list, including the approved deliverables that RDA has submitted to date.

Evaluation Logic Model

At the conclusion of the Evaluation Planning Summit, RDA assembled an agreed-upon logic model to serve as a guide for the evaluation. See "Appendix 1: Evaluation Logic Model."

The first portion of the logic model encompasses the *Processes* that were implemented when counties conduct their CPP work. The beginning *Inputs* section of the logic model pertains to the resources that counties invested to plan and conduct their CPP processes. The *Activities* section describes the specific CPP-related activities that counties conducted, as well as perceptions of the barriers and challenges to successfully and/or fully implementing these activities. The following are representative of the topics in the Activities section of the logic model: outreach and engagement, participation, promoting access, training, participant input, and CPP process and design.

Activities form the basis for the *Process Outcomes* of counties' CPP processes. In general, process outcomes items are intended to assess what CPP participation consists of. Sample process outcomes include who, how much, how often, and in what ways. Items regarding the *Process Outcomes* section of the logic model pertain to the same topics as the abovementioned items described in the *Activities* section.

The second portion of the logic model covers the *Outcomes* created by counties' implementation of CPP processes. Items measuring *Outcomes* explore how CPP participation affected participant wellness, how the CPP process affected the planning and delivery of public mental health services, and how the CPP process affected broader communities. Data collection items aimed at addressing the outcomes of counties' CPP processes were targeted for three levels of the mental health community: stakeholders, the mental health system, and the broader community.

Research Questions

Research questions developed at the Evaluation Planning Summit were designed to inventory current CPP activities, measure outcomes of these activities, and ultimately identify promising CPP practices. In order to describe the content and quality of CPP practices, the evaluation team identified 35 separate county-level research questions,[7] and developed tools and research stimuli to answer them. These served as a

[7] For a description of the selection process, see Deliverable 1: Report of Proposed Research Design and Data Collection Training Plan.

guide for documenting evaluation findings and presenting the results in this report. The research questions for this evaluation are as follows:[8]

Inputs: What resources do counties have to conduct CPP processes?

	Inputs
IN-01	Does the county designate positions or units responsible for the CPP process? If so, how many Full Time Equivalents (FTEs)? (CCR, 9 CA ADC § 3300).[9]
IN-02	Is training provided to county staff responsible for managing the CPP process? (CCR, 9 CA ADC § 3300). If so, what types of training?

Activities: *What CPP activities are counties engaged in?*

	Outreach
AC-01	What activities are used by the county to outreach to and engage stakeholders?
AC-02	Are clients with serious mental illness (SMI) and serious emotional disturbance (SED) and their family members targeted for outreach and given the opportunity to participate? If so, how? (CCR, 9 CA ADC § 3300).
AC-03	In what ways do counties outreach to unserved and/or underserved populations and family members of unserved/underserved populations? (CCR, 9 CA ADC § 3300).
	Participant Input
AC-04	What do counties do to ensure accessibility of CPP activities?
AC-05	What do counties do to ensure that the CPP process adheres to the general standards of MHSA? (i.e., community collaboration, cultural competence, client driven, family driven, etc.) (CCR, 9 CA ADC § 3320)
AC-06	What do counties do to ensure that the process is safe, free from stigma, discrimination and retaliation?
AC-07	What do counties do to retain participation?
AC-08	What do counties do to collect input from participants?

[8] To identify which research items from which tool is designed to answer each research question, see "Appendix 3: Crosswalk between SurveyGizmo Data Collection Instruments Items and CPP Inventory Data Fields". Description of methods and copies of tools are included in Deliverable 1: Report of Proposed Research Design and Data Collection Training Plan.

[9] Citations are provided for research questions that stem from a review of California codes and regulations related to MHSA CPP processes.

AC-09	Do counties post draft annual updates and 3-Year Program and expenditure plans for a 30-day public comment period, and does the Local Mental Health Board conduct a public hearing? Does the annual update include a summary and analysis of substantive recommendations and a description of methods used to circulate the plan (CCR, 9 CA ADC § 3315)?
AC-10	How is participation and input documented by the county?
	Training
AC-11	In what ways and to what extent is training and education provided to participants of the CPP process by the county? (CCR, 9 CA ADC § 3300)?
	Evaluation
AC-12	How do counties evaluate and attempt to improve their own CPP processes?

Process Outcomes: *Who, how many, and how often are stakeholders involved in the CPP process? Are stakeholders satisfied with the process?*

	Outreach
PO-01	How many stakeholders are outreached to for participation in the CPP process?
	Participant Input
PO-02	Who participates in the CPP process, including the specific stakeholder groups and demographics?
PO-03	Does participation include representatives of unserved and underserved populations and their family members? (CCR, 9 CA ADC § 3300)
PO-04	Does participation reflect the demographics of the county? (CCR, 9 CA ADC § 3300)
PO-05	Does participation involve clients with SMI and/or SED, and their family members? (CCR, 9 CA ADC § 3300)
PO-06	How long and with what frequency do people participate?
PO-07	Who is not participating in the CPP process, and why not?
	Training
PO-08	How many participants are trained to better participate in the CPP process? With what frequency? (CCR, 9 CA ADC §3300)

	Stakeholder Perceptions and Satisfaction
PO-09	To what extent do stakeholders feel that the CPP activities are accessible?
PO-10	To what extent do stakeholders feel that the CPP process is consistent with the philosophy, principles, and practices of the Recovery Vision? (WIC, §5813.5d).
PO-11	To what extent do participants feel that the CPP environment is safe and free from stigma, discrimination and retaliation?
PO-12	To what extent do participants feel that they have the training, knowledge and support needed to meaningfully participate in the CPP process? (CCR, 9 CA ADC § 3300)
PO-13	To what extent do participants feel that they contribute to program planning? (WIC, §5848a)
PO-14	To what extent do participants feel that their opinions and perspectives are respected?

Impacts: *How does the CPP process affect participants, the mental health system, and the broader community?*

	Participant Impacts
IM-01	How and to what extent does a county's administration of the CPP process affect participants' sense of empowerment, hope, self-determination, social connection, wellness and recovery? (WIC §5813.5d)
IM-02	How and to what extent does a county' administration of the CPP process affect participants' trust in and collaboration with the mental health system? (CCR, 9 CA ADC §3320)
	Mental Health System Impacts
IM-03	How and to what extent does a county's administration of the CPP process affect mental health policy, program planning and implementation, monitoring, quality improvement, evaluation, and budget allocations? (WIC, §5848a)
IM-04	How and to what extent does a county's administration of the CPP process affect trust and collaboration among mental health service providers; and between mental health providers and other health and human service providers? (CCR, 9 CA ADC §3320)
IM-05	How and to what extent does a county's administration of the CPP process promote mental health advocacy efforts at regional, national, and state levels?

	Perceptions of the Broader Community Impacts
IM-06	How and to what extent does a county's administration of the CPP process affect the community's perception of mental health diagnoses and/or seeking public mental health services (stigma)? (WIC, § 5840)
IM-07	What other impacts do stakeholders perceive the CPP process to have on the community at large, particularly related to MHSA-defined outcomes?[10] (WIC, § 5840)

Data Collection

Data Collection Instruments

The evaluators, with input from the CSP and the MHSOAC, determined that a mixed-methods approach (i.e., both qualitative and quantitative data collection tools) would maximize validity by allowing for the examination of the same phenomenon in different ways (e.g., triangulation).[11] Mixed-method approaches provide the flexibility to fill in gaps in the available information, to use triangulation to strengthen the validity of estimates, and to provide different perspectives on complex, multi-dimensional phenomena. When working under real-world constraints, a well-designed mixed-methods approach can maximize the range and validity of information.[12]

The items used in the evaluation's data collection instruments aligned with the various elements of the evaluation's logic model and responded to the research questions. In the initial stages of tool development, particular attention was paid to ensuring that each research question could be informed by more than one item from more than one data source (e.g. information from county staff as well as stakeholders). Quantitative data collection instruments were developed to measure how many/how much activity and participation occurred as well as stakeholder ratings of perceptions of CPP activities, experiences of participation, and perceived outcomes. Qualitative instruments were developed to better understand barriers, facilitators, strengths and weaknesses, and differing perspectives on CPP processes and outcomes.

[10] MHSA-defined outcomes include to: reduce duration of untreated Mental Illness; prevent Mental Illness from becoming severe/disabling improving timely access for underserved, reduce stigma; reduce the seven negative outcomes associated with untreated Mental Illness/ Emotional Disturbance (suicide, incarcerations, school failure/dropout, unemployment, prolonged suffering, homelessness, removal of kids from homes); increase the number of individuals receiving public mental health services; reduce disparities in access to care; increase educational progress; increasing employment; improve housing situation; reduce justice system involvement; implement recovery vision; improve health and mental health; and implement MHSA county plans. (Mental Health Services Act, 2004)

[11] Frechtling, J., & Sharp, L. (1997). *User-friendly handbook for mixed method evaluations*. National Science Foundation. Retrieved from http://www.nsf.gov/pubs/1997/nsf97153/start.htm

[12] Bamberger, B., Rao, R., & Woolcock, M. (2010). *Using mixed methods in monitoring and evaluation*. The World Bank,p. 11. Retrieved from: http://www-wds.worldbank.org/servlet/WDSContentServer/WDSP/IB/2010/03/23/000158349_20100323100628/Rendered/PDF/WPS5245.pdf

The evaluation team produced a variety of data collection tools for this effort in order to capture a diverse set of perspectives about each county's CPP processes. This large amount of data from several viewpoints enabled the evaluation team to develop a more complete picture of counties' CPP processes. Specifically, the evaluation uses five data collection methods/instruments: 1) a review of CPP documentation from MHSA Annual Updates; 2) a web-based data request to county mental health department MHSA/CPP coordinators or their designee; 3) key informant interviews with county MHSA/CPP coordinators or their designee; 4) focus groups with MHSA stakeholders; and 5) a web- and paper-based stakeholder survey. Please see "Deliverable 1: Report of Proposed Research Design and Data Collection Training Plan" for a more detailed description of these tools, and "Appendix 2: Data Collection Instruments" of this report for copies of each data collection instrument are included in. A brief summary of the tools follows:

- **County Web-Based Data Request:** All county MHSA/CPP Coordinators were asked to respond to a data request in the form of a web-based survey. The objective of this effort was to collect: 1) contact information for the most recent CPP participants to complement focus group recruitment efforts; 2) contact information for general stakeholders to enable survey dissemination; 3) data pertaining to CPP activities and participation; and 4) existing county documents related to the county's CPP process. The County Web-Based Data Request provided the counties' firsthand accounts and perceptions of their CPP processes.
- **MHSA Annual Update Document Review:** Regional partners and CSP reviewed each county's FY 12/13 Annual Update available online or from the MHSOAC, and completed individual data collection forms for each county's Annual Update. The Annual Update Review provided supplementary data to the county web-based data request, particularly the objective measures of CPP processes.
- **Key Informant Interview:** All county MHSA/CPP Coordinators were asked to participate in a one-hour interview in-person or via telephone. The purpose of the interview was to collect qualitative data to supplement the county web-based data request and gather perceptions of the county's CPP processes. These interviews provided MHSA/CPP Coordinators the opportunity to expound upon the quantitative nature of data that they provided via the County Web-Based Data Request with more qualitative, perceptions- and beliefs-focused discussions.
- **Focus Group:** Focus groups allowed participants to share their perceptions, attitudes, and beliefs about the counties' CPP processes and outcomes. The CSP facilitated one focus group in each county with 4-20 individuals who participated in CPP processes during planning for FY 2012/13 Annual Updates. The CSP invited all eligible stakeholders from their own contacts, as well as from a list provided by the MHSA/CPP Coordinator, and selected the first 16 interested respondents. They also reached out to and reserved four slots (for a total of 20 invited participants) for individuals recommended by the Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), California MHSA Multicultural Coalition (CMMC), California Reducing Disparities Program (CRDP), and other related resources for assistance in recruiting individuals who have traditionally been unserved/underserved to participate in the focus

groups. The Focus Groups, conducted with stakeholders[13] from each county, yielded more qualitative, perceptions- and beliefs-focused discussions.

- **Paper-Based and Electronic Stakeholder Survey:** The target population for the Stakeholder Survey was all MHSA stakeholders. Using stakeholder contact information obtained from the MHSA/CPP Coordinators, CSP emailed URL links of the English and Spanish versions of the stakeholder survey. Alternatively, some MHSA/CPP Coordinators sent the survey link directly to stakeholders to protect confidentiality of persons receiving service. CSP also requested contact information from REMHDCO, CMMC, and CRDP, and sent the survey links to those networks. Regional Partners administered paper-based surveys at community organizations, wellness centers, and other service locations with the explicit aim of reaching those who may not have access to the Internet and who may otherwise be disconnected from the local CPP process in their county. Survey questions asked about CPP outreach, engagement, training, and barriers to participation, as well as overall CPP perceptions. The questions in the paper and electronic stakeholder surveys were identical. The Stakeholder Survey provided a highly structured way for stakeholders to share accounts of their CPP participation and ideas of how their counties' CPP processes could be improved.

A summary of the data collection tools, informants, requested information, and data entry responsibility is provided in Table 1.

Table 1. Summary of Data Collection Tools

Tool	Data Source or Informant	Information Requested	Type of Data	Data Entry
County Web-Based Data Request	County MHSA/CPP Coordinator	Counties' accounts and perspectives about their CPP processes and impacts	Quantitative and Qualitative	County CPP/MHSA Coordinator
MHSA Annual Update Document Review	Regional Partners & CSP	Provides supplementary data about counties' CPP processes	Quantitative and Qualitative	Regional Partners & CSP
Key Informant Interview	Regional Partners (from County MHSA/CPP Coordinator)	Provides qualitative data to supplement County Web-Based Data Request	Qualitative	Regional Partners
Focus Group	Regional Partners (from Stakeholders)	Provides stakeholders' perspectives about their counties' CPP processes and impacts	Qualitative	Regional Partners

[13] Stakeholders, as defined by Welfare and Institution Code 5848, include adults and seniors with severe mental illness, families of children, adults, and seniors with severe mental illness, providers of services, law enforcement agencies, education, social services agencies, veterans, representatives from veterans organizations, providers of alcohol and drug services, health care organizations, and other important interests ("Welfare and Institutions code section 5845-5848").

Stakeholder Survey	Stakeholders	Provides individual stakeholders' perspectives about their counties' CPP processes and impacts	Quantitative and Qualitative	Stakeholders

All of the data collection instruments were piloted in a small number of counties throughout the state during a dedicated piloting period in Fall 2013. The purpose of the piloting period was to identify points for improvement to the data collection instruments, data collection protocols, facilitation methods, recruitment methods, and/or data entry methods and mechanisms. During the evaluation's piloting period, CSP, the Regional Partners, and RDA looked for ways to improve the quantity and quality of data that would be obtained for the evaluation while recognizing the time investment required by the counties and stakeholders to complete the tools. Notably, at the end of the piloting period, revisions were made to the County Web-Based Data Request and Key Informant Interview data collection instruments in order to improve the likelihood that the data collected would provide an accurate picture of CPP processes across California's counties. The data collection phase of the evaluation commenced upon finalization of the data collection instruments and protocols.

See the "Data Analysis" section below for a more detailed description of the evaluation's mixed-methods approach, the specific variety of quantitative and qualitative data analyses performed, and a description of the iterative process undertaken by RDA to ensure that relevant higher-order findings were explored in this evaluation.

Data Collection

The data collection for this evaluation was an immense undertaking for a large variety of partners. Regional Partners recruited, organized, set up, and conducted the Key Informant Interviews and Focus Groups. Additionally, the Regional Partners, along with CSP, recruited stakeholders to complete the Stakeholder Survey and completed the Annual Document Update Reviews for each county. Lastly, CSP recruited MHSA/CPP Coordinators from each county to complete the County Web-Based Data Request. Throughout the data collection period, RDA served as the source of guidance and support for the Regional Partners in their data collection efforts.

Sampling Plan

As noted above, the sample population for this evaluation traverses a number of stakeholders, all of whom were intentionally recruited for participation. Questions were asked of all MHSA stakeholders,[14] including MHSA/CPP Coordinators, service providers and other community based organizations, and community members, as well as mental health consumers and their family members. Respondents were eligible to participate if they met the selection criteria specified for each data collection tool described below in

[14] Stakeholders, as defined by Welfare and Institution Code 5848, include adults and seniors with severe mental illness, families of children, adults, and seniors with severe mental illness, providers of services, law enforcement agencies, education, social services agencies, veterans, representatives from veterans organizations, providers of alcohol and drug services, health care organizations, and other important interests ("Welfare and Institutions code section 5845-5848").

Table 2.

Table 2. Overview of Sampling Plan

Method/Tool	Number per County	Number of Participants	Target Population/Eligibility criteria
Focus Group	1	6 – 12 (Maximum of 20)	A diverse array of individuals who participated in the most recent CPP process
Key Informant Interview	1	1	MHSA/CPP Coordinator
Annual Update Document Review	1	N/A	For each County: Most recent MHSA Annual Update; Description of CPP process; County manuals or protocols for conducting the CPP process; CPP training or curriculum materials; County evaluations received from web-based data request
County Web-Based Data Request	1	N/A	MHSA/CPP Coordinator
Electronic Stakeholder Survey	1	Minimum number of surveys: 30 surveys per small county; 50 surveys per mid-size county; 100 surveys per large counties (see table below for a distribution by county size)	A diverse array of MHSA stakeholders; available in English and Spanish
Paper-based Stakeholder Survey	1	Approximately 25% of above minimum number of surveys estimated to be paper based	MHSA stakeholders with no/limited access to computers

It is important to note that the sizes of counties were not taken into account when designating the number of Key Informant Interviews and Focus Groups to be conducted there. For this project, one Key Informant Interview and one Focus Group were conducted in each county, regardless of size. County size was only taken into account when determining the target number of Stakeholder Surveys that the Regional Partners and CSP would collect from each county.

Table 3 includes the total counts of County Web-Based Data Requests, Annual Update Document Reviews, Key Informant Interviews, Stakeholder Focus Groups, and Stakeholder Surveys that were conducted or collected during this project.

Table 3. Total Counts of Evaluation Data Collection Instruments Conducted or Collected

	County Web Based Data Request	Annual Update Document Review	Key Informant Interview	Focus Group	Stakeholder Survey
STATEWIDE	**52**	**49**	**54**	**47**	**1,549**
CMHDA REGION					
Bay Area	14	11	13	11	304
Central	15	15	17	13	409
Los Angeles	1	1	1	1	117
Southern	9	10	9	9	482
Superior	13	12	14	13	237
COUNTY SIZE					
Large	13	11	13	13	749
Medium	13	16	15	13	413
Small	26	22	26	21	387

Transmission of Data

Regional Partners entered data from their Annual Update Document Reviews, Key Informant Interviews, Focus Groups, and paper-based Stakeholder Surveys into SurveyGizmo, a web-based survey instrument. SurveyGizmo was selected because of its accessible user interface and its HIPAA compliance certification, required for data collection with people receiving services. This platform provided a consistent mechanism to share data with RDA. Electronic Stakeholder Survey data, as well as data from the County Web-based Data Request, was entered by respondents directly into SurveyGizmo. The online survey instruments allowed for closed- and open-ended responses for all items, and data for all samples could be extracted into Microsoft Excel for cleaning, preparation, and analysis.

Technical Assistance

Throughout the data collection and reporting phases for the Regional Partners and the CSP, RDA served as a source of technical assistance for both parties. During the data collection and reporting phases of this project, RDA participated in weekly technical assistance calls with the Regional Partners and the CSP in order to field and respond to questions on how to administer the various data collection instruments as well as how to enter and report data to RDA via the online SurveyGizmo data reporting system. RDA also regularly reviewed data entered by CSP and the Regional Partners for quantity and quality and provided feedback. During these weekly calls, RDA was able to identify opportunities for modification and/or improvement to assist the Regional Partners and CSP. RDA made slight procedural modifications to the data collections instruments and the online SurveyGizmo data reporting system in order to improve the process and aid the Regional Partners and CSP in their work.

RDA kept a log of every piece of technical assistance that it provided to the Regional Partners and CSP. See RDA's "Appendix 1 – Summary of All Consultation Provided" in "Deliverable #3: Summary of

Consultation Provided to Client Contractors re: CPP Process Inventory" for a log of the consultation provided by RDA to the Regional Partners and CSP during this project.

Data Preparation

While it was important that the Regional Partners and CSP made every effort to report high-quality and consistent data, RDA recognized the additional burden that would be created if the data collectors were consistently asked to re-enter data that was either difficult to interpret or that provided insufficient information. Within reason, RDA used discretion in asking the Regional Partners and CSP to re-enter data; those requests were made only in cases where the meaning of the reported data was unclear. In the cases where data was missing, RDA followed up with the pertinent data collector(s) to determine why the data was missing and if it could be located and entered.

As data was reported during the data collection phase and afterward in the data analysis phase, RDA reviewed and catalogued every piece of information that it received. RDA created a master dataset (i.e., Microsoft Excel spreadsheets, SPSS datasets, etc.) to transfer and organize every piece of information. During the transference of data from the original reported sources to RDA's master dataset, RDA standardized certain pieces of data so that all data to be analyzed was coded or written consistently. Examples of the types of data that RDA revised include:

- If a respondent entered "Two FTE" when reporting the number of FTE the county had allotted to conduct CPP processes, RDA changed that response to "2" in its dataset, under the appropriate variable for tracking CPP FTEs. This allowed RDA to perform quantitative analyses with this data point.
- If a respondent entered a response for a particular focus group question that included information that was better suited for a response to a different focus group question, RDA moved that portion of the response to fulfill the more appropriate question. This did not substantially alter either response, but rather, allowed for both questions to be answered, rather than just one question.

If RDA had any questions about the reported data, evaluation team members either contacted the Regional Partner/CSP directly (for minor issues) or CSP (for larger issues that necessitated facilitated communication with a Regional Partner).

Quantitative Data Cleaning

The evaluation team obtained quantitative data from the following three data collection instruments: 1) County Web-Based Data Request, 2) Annual Update Document Review, and 3) Stakeholder Survey. Across these three instruments, data was collected via one online tool, SurveyGizmo. County MHSA/CPP Coordinators entered their data online for the County Web-Based Data Request; Regional Partners and CSP entered their data online for the Annual Update Document Review; and stakeholders entered their responses online for the Stakeholder Survey. Regional Partners transferred responses from Stakeholder Surveys administered via paper into the online tool. The evaluation team downloaded all of the online responses into Microsoft Excel spreadsheets; each spreadsheet held the comprehensive dataset from its respective instrument.

Cleaning the quantitative data was the first step undertaken by the evaluation team. Given the diversity of individuals who entered data across the three aforementioned quantitative instruments, the data received by the evaluation team varied in quantity and quality. In order to conduct quantitative analyses, the quantitative data needed to first be standardized in terms of format. For example, when examining an item that is numerical in nature (i.e., staff FTEs dedicated to counties' CPP processes), all of the responses need to be in a numeric format (e.g., "2" or "3.5"), rather than in a string format (e.g., "Two FTEs" or "Between 2 and three FTEs"). The evaluation team ensured consistency in how all data of this sort was re-entered by having only one team member perform all of the standardization steps.

Additionally, the evaluation team made minor modifications to particular pieces of string responses in order to standardize the terminology used across datasets, thus allowing comparisons to be made across all responses for any given item. In the quantitative data collection instruments, some items allowed for structured, open-ended responses. Variations in response style for any given data item imposed inherent challenges for the evaluation team, as they made it difficult to compare responses. In these instances, the evaluation team used its best judgment to modify entries to preserve the original intent and meaning, while allowing for comparison with other responses for the same item. All responses that necessitated re-entering were done so with as much fidelity to their original meanings as possible. The evaluation team took great care to avoid altering the original meaning or intent behind any of the responses given by the MHSA/CPP Coordinators, Regional Partners, CSP, and/or stakeholders. Quantitative data was only re-entered to permit its utility in statewide analyses that would allow for cross-cutting comparisons of all data points for each item across the state.

An example that illustrates the abovementioned step is as follows: When asked to indicate the CPP outreach activities that the county conducts, one MHSA/CPP Coordinator entered "Facebook posts" as one of its responses, another MHSA/CPP Coordinator entered "Twitter," and another MHSA/CPP Coordinator entered "social media." The evaluation team recognized that the common theme across these responses was that the counties were using social media as one avenue to conduct their CPP outreach efforts. Therefore, the evaluation team recoded these responses as "social media." This allowed the evaluation team to determine how often and across which counties "social media" was cited by counties as part of their CPP outreach strategies.

Data Analysis

The data collected across the five instruments provided many varied perspectives on counties' CPP processes. The methods used to analyze the evaluation's data were varied to accommodate the quantity and quality of data available. Furthermore, the analyses took on an iterative nature as the evaluation uncovered findings that warranted further exploration. Given the varied nature of the vast amounts of data collected for this evaluation, the mixed-methods approach to analyzing the information enabled the evaluation team to capture as many pertinent findings as possible. This evaluation sought to be comprehensive in its approach, while also being prudent in conducting analyses that had a foundational basis built on the evaluation's logic model (see the "Evaluation Logic Model" and "Appendix 1: Evaluation Logic Model" sections of this report).

The analytic methods planned for this evaluation (see Deliverable 2b: Analytic Plan) were developed immediately following the development of the evaluation plan, which included the research questions, logic model, and data collection tools. However, the data requested from the five data collection instruments substantially differed from the stakeholder and county data received. A number of variables that were key to the planned analysis were unavailable. Specifically, demographic data on CPP participants was not consistently available from counties, and the demographic data that was received was in varied formats that were not able to be standardized across counties because of the inconsistencies. This not only resulted in not being able to answer the question of "who participated in CPP processes," but the lack of demographic data also meant that effectiveness of activities could not be determined by using participant demographic data as one of the variables. For example, RDA had originally planned to determine the effectiveness of outreach activities by conducting a statistical analysis to determine if specific outreach activities were correlated with overall rates of participation as well as level of participation by various stakeholder groups named in the MHSA.

As such, the analytic methods employed in this evaluation were re-conceptualized immediately following the data collection phase to address the specific challenges with data quality, quantity, and inconsistency across the state. RDA paid particular attention to applying analytic methods that had data of sufficient quality and quantity, produced reasonably accurate results and reduced the likelihood of statistical error, and met the overall purpose of the evaluation (i.e. to determine effective CPP practices). While it is not unusual to modify analytic methods following data collection, the challenges with the data provided to RDA resulted in re-conceptualizing the entire analytic methodology. The only consistent component from planned to actual analysis was the overall approach to mixed methods research. However, the specific qualitative and quantitative analytic techniques used were developed post data collection in response to the challenges of this specific dataset.

The following sub-sections describe the mixed methods approach to data analysis, the specific quantitative and qualitative analytic procedures, and the step-by-step process of data analysis.

Mixed Methods

There are a variety of mixed methods approaches, all of which combine or integrate qualitative and quantitative data to maximize the strengths of the data while minimizing the weaknesses.[15] Research designs generally fall into two categories: 1) collecting qualitative and quantitative data concurrently and integrating data during the analysis, or 2) collecting and analyzing one type of data first (qualitative or quantitative) and then using the results to inform the next phase of the project where the other type of data will be collected. This evaluation was designed using the first option of collecting both types of data concurrently and integrating the data during the analysis phase. There are a number of ways that qualitative and quantitative data can be integrated during analysis, including:

[15] National Institute of Health: Office of Behavioral and Social Sciences. *Best practices for mixed methods research in the health sciences.* Retrieved March 31, 2014 from http://obssr.od.nih.gov/scientific_areas/methodology/mixed_methods_research/section2.aspx

- Use of qualitative data to supplement quantitative data to better understand the results of the quantitative analysis.
- Use of qualitative data to support or refute quantitative results.
- Quantifying of qualitative data (e.g. number of occurrences of a theme) to compare to quantitative results.

Most of the examples of integrating the two types of data rely primarily on quantitative data and 1) use qualitative data as supplementary to quantitative results; or 2) transform qualitative data into quantitative data to allow for comparison. The data received for this evaluation did not allow for such heavy reliance on quantitative data; therefore, RDA applied an analytic approach that relied as heavily on qualitative data as quantitative data. The analysis included the following methods of data integration:

1. Analysis of emergent themes from qualitative data compared with descriptive statistics from the quantitative data to identify areas where qualitative data supported or refuted quantitative results or led to additional questions for analysis.
2. Quantified qualitative data to compare with descriptive statistics from the quantitative data to identify areas where qualitative data supported or refuted quantitative results or led to additional questions for analysis.
3. Qualitative findings used to identify themes that could be further explored within the quantitative data; qualitative analysis directed the quantitative analysis.

In order to accomplish this, it required using a variety of qualitative and quantitative analytic techniques throughout the analytic process.

Quantitative Data Analysis

The quantitative analysis applied both descriptive and inferential statistical measures. Quantitative analyses were conducted with data from the County Web-Based Data Request, Annual Update Review, and Stakeholder Survey. This analysis produced descriptive statistics (e.g. means, frequencies) at the statewide, CMHDA region, and county size levels. The County Web-Based Data Request and Stakeholder Survey included items of sufficient quality and quantity to permit statistical testing. The evaluation team conducted inferential statistical measures, specifically linear regressions and t-tests, to understand relationships between variables.

Linear regressions are an approach for modeling the relationship between one dependent variable and a number of potential explanatory variables. This evaluation employed multiple linear regressions in which six independent variables identified as potentially important from the qualitative data were examined to understand and quantify the extent to which they contribute to or predict a CPP outcome.

The evaluation team also considered a number of statistical tests to understand the relationships between specific CPP activities and CPP outcomes. T-tests were selected as the most appropriate test, given the limitations of the data. T-tests are used to determine if there is a significant difference in means between two groups, specifically a significant difference in outcomes in counties that did or did not conduct a CPP activity.

Qualitative Data Analysis

The evaluation team obtained qualitative data from three data collection instruments: 1) Key Informant Interview, 2) Focus Group, and 3) Stakeholder Survey. The data for these instruments were also recorded via one online tool, SurveyGizmo. Regional Partners entered their notes online for the Key Informant Interview and Focus Group instruments as well as the paper-based Stakeholder Surveys. The evaluation team downloaded all of the online responses into Microsoft Excel spreadsheets; each spreadsheet held the comprehensive dataset for its respective instrument.

Given the large amount of qualitative data obtained for this evaluation (over 1,500 unique responses across the entire evaluation), the evaluation team identified the need for a systematic approach to the analyses, thus multiple dimensions of coding were implemented for each unique response. *Coding* refers to the assignment of values to each qualitative response, based on the reviewer's interpretation of the meaning(s). The evaluation team took care in ensuring consistency in interpretation and coding across the team in order to ensure high inter-rater reliability in the qualitative analyses.

In particular, the evaluation team underwent a two-step analysis process. First, the evaluation team met prior to beginning the qualitative data analysis and defined a set of qualitative codes to use in its analysis. All members of the evaluation team had a clear understanding on the underlying meanings of each code and how each one should be used when examining the project's qualitative data. Second, as each evaluation team member conducted his/her analysis of assigned portions of the project's qualitative data, he/she would create new codes and/or modify current codes so that the total realm of codes would be more representative of the information inherent in the data. Whenever a team member added or revised a code, he/she would communicate that change to the rest of the team and ensure that the entire team was aware of how the new and/or modified codes should be subsequently applied. Additionally, the project lead for this component of the analysis reviewed a sample of coded focus group and interview data to compare coding across the evaluation team members, make adjustments to code definitions, and provide feedback to evaluation team members. These steps of aligning every evaluation team member's understanding of the meaning behind each code and how to use it ensured that the project's qualitative data analysis achieved high inter-rater reliability throughout the process.

Content analysis was the primary method of qualitative data analysis. Content analysis refers to a process by which qualitative data is systematically classified and coded. Prescriptive and open coding are components of content analysis in which prescriptive coding applies a predetermined set of codes to a dataset where open coding identifies the dominant messages and themes within the text. This evaluation used both prescriptive and open coding during the analysis. As a result, the qualitative analysis is grounded in the actual data obtained as well as the theory of change specified in the logic model.

Levels of Analysis

The evaluation team examined counties' CPP processes from a statewide perspective, identifying trends and patterns seen across the entire state. Identifying CPP processes that are particularly effective or ineffective provide insights that can be shared and promoted throughout the state.

Additionally, the evaluation team recognized the importance of having a deeper understanding of the nuances of counties' CPP processes in relation to California's diverse geography. In particular, there were regional differences in the conceptualization and implementation of CPP processes; the evaluation team aimed to discern these regionally shared practices and how their stakeholders perceived and responded. The evaluation team used the five CMHDA regions, Bay Area, Central, Los Angeles, Southern, and Superior, in order to understand the data with respect to geography.

Furthermore, the evaluation team also understood that geographical population density influences how counties design and implement their CPP processes. For example, less densely populated counties may need to balance limited MHSA resources against the need for additional outreach strategies to engage more individuals in the outer reaches of their counties; in more densely populated counties, outreach activities may take on a different form targeting multiple densely populated areas of the county. In order to understand the data with respect to population density, the evaluation team analyzed size cohorts using the commonly accepted definitions based on total population levels: small (<200,000 persons), medium (200,000 – 800,000 persons), and large (>800,000 persons) counties.

Analytic Process

Phase I – Data Analysis by Research Question

First, the evaluation team organized all of the items from each data collection tool by research question and produced a chart that listed each research question with the tools and items that would respond to the specific research question. The majority of research questions had multiple corresponding data sources, including both qualitative and quantitative data. However, not all of the data requested was received. Some research questions had no corresponding data, and some research questions had limited data available that was not adequate to fully respond to the research question. Next, the evaluation team conducted a preliminary analysis of the data by research question using all available data. Research questions with no available data were removed from the analysis. Research questions with limited data were analyzed to the extent that the data allowed, but removed from subsequent analytic processes.

The research question that did not have corresponding data included:

- Does participation reflect the diversity of the demographics of the county?

The research questions that had limited data included:

- What do counties do to retain participation?
- Who participates in the CPP process, including the specific stakeholder groups and demographics?
- Does participation include representatives of unserved and underserved populations and their family members?
- How, and to what extent, does a county's administration of the CPP process promote mental health advocacy efforts at regional, national, and state levels?

See "Appendix 2: Data Collection Instruments" for the organization of this evaluation's items across the five data collection instruments into the research questions.

Quantitative Analysis – Descriptive Statistics

In order to fully understand all of the quantitative data that was collected, the evaluation team conducted an analysis of each quantitative item using the entirety of quantitative data available and produced tables, charts, and graphs that visually depicted the data. This included means and frequencies, as appropriate for the specific item and data received. This data was analyzed at the state, CMHDA region, and county size level.

Qualitative Analysis – Coding and Identification of Themes

In order to fully understand all of the qualitative data that was collected, the evaluation team reviewed each qualitative response obtained for each item from every county. The evaluation team created a long-form spreadsheet that included every qualitative response in its own unique row (herein "qualitative dataset"). Identifying variables were noted for each response to ensure that the evaluation team could use them as selection criteria when analyzing and comparing the data. The identifying variables included in the qualitative dataset were:

- County
- CMHDA Region
- County Size
- Data Source
- SurveyGizmo Item Number (the specific item in each data collection instrument)
- Inventory Item Number (the identifying code corresponding to the qualitative data theme that the response pertains to)

By creating these identifying variables, the evaluators had increased flexibility to navigate the large amount of qualitative information. For example, for any given item, the evaluation team could select only those responses fulfilling the following criteria: from a particular CMHDA region, from a particular CMHDA region and county size, from the county MHSA/CPP Coordinator perspective, for one theme, et cetera.

The first coding task was to assign a code, if applicable, for each response that provides a summative interpretation of the content of that response. Not every qualitative theme's responses leant themselves to having summative statements applied to them; the evaluation team selectively created codes for themes and responses when applicable. The evaluation team developed a set of codes (see "Appendix 5: Qualitative Data Codes") that encompassed the majority of the potential responses for items pertaining to their respective qualitative themes. After reading each unique response, the evaluation team assigned one or more codes to that response. These codes served to later inform the evaluation team of the quantity of comments that surfaced regarding each code. This also allowed the evaluation team to select responses by their codes when looking for comments regarding specific topics. For the particular responses that had content not included in the evaluation team's set of qualitative codes, they were assigned an "Other" code, and notes/comments were added to provide more information and clarification for the analysis phase.

The evaluation team recognized that each unique response could not always be pared down to one or a few summative statements ("codes"), but an evaluation with this magnitude of data required the qualitative data to be distilled down to a level that made it feasible to compare responses across counties and statewide. If each response was treated uniquely and no paring down was conducted, then the task of providing statewide and per-group statements would not have been possible.

The evaluation team also recognized that some of the items asked respondents for their subjective estimations of the effectiveness of counties' CPP practices, impacts of their counties' CPP processes on a host of factors, or their satisfaction with their counties' CPP processes. In these instances, the evaluation team assigned a numerical score for each response based on a 5-point scale (1 through 5). For responses pertaining to whether a county conducted certain types of CPP activities, a "1" represented not at all, a "5" represented always, and a "3" represented unknown or equal amounts of affirmative and negative responses. For responses pertaining to respondents' perceptions of impacts and satisfaction, a "1" represented a negative feeling, a "5" represented a positive feeling, and a "3" represented unknown or overall ambivalence. In all instances, scores of "1" or "5" were reserved for responses in which there were unequivocal agreement across all responses for any particular county; responses that were generally but not wholly negative were assigned a "2", and responses that were generally but not wholly positive were assigned a "4". The evaluation team recognizes the importance of standardizing interpretations across responses. By limiting its scoring assignments to a 5-point scale, the evaluation team aimed to introduce as little variability as possible across its team members' assignment of numeric scores.

Lastly, the evaluation team kept notes for all of the responses that it reviewed. Notes were used in a variety of ways: 1) to provide context and background for why particular codes and/or scores were assigned, 2) to provide summative statements of responses that were particularly lengthy, and 3) to provide short statements about each response that would aid the evaluation team later when analyzing the qualitative data. The evaluation team used the notes entry field with the aim of rounding out the summarization of each response in addition to the previous assignment of codes and scores. Particular attention was paid towards the data analysis phase when preparing the notes for each response, particularly how the data entered would be most useful to produce summative statements of findings.

The analysis of the qualitative data heavily utilized all of the previous coding work. For each of the qualitative data themes (see "Appendix 4: Qualitative Data Themes"), the evaluation team only selected the statements that pertained to the respective theme, by Key Informant Interview or Focus Group. For any qualitative data theme that had responses from both the Key Informant Interviews and Focus Groups, findings from each instrument were separated so that comparisons between the two could be easily accomplished.

Then, the evaluation team reviewed all of the codes, scores, and notes and produced a written summary analysis of the relevant findings emerging from the qualitative data. Where possible, qualitative data was quantified by frequency to allow for comparison with quantitative data. Next, the evaluation team narrowed the same set of responses by CMHDA region, then by county size, and produced a written summary analysis for each of those sub-groupings of data. In these sub-analyses, the evaluation team was then able to discern any regional or county size trends or patterns in the data that could not otherwise be

distinguished when examining the data as a statewide cohort. The evaluation team reproduced these analysis steps for each item across the various qualitative data themes.

Data Analysis Work Session

Following the preliminary analysis of the quantitative and qualitative data, RDA's evaluators initially met for a half-day meeting to review the results of this phase of data analysis. Using a systematic approach, the evaluation team went through each research question and reviewed the results from each tool that had available and relevant data. During the work session, the evaluation team set-up multiple projectors to enable the side-by-side viewing of preliminary results from different data collection tools simultaneously.

Particular attention was paid to:

- Results where data across data collection tools supported the same conclusion
- Results where data across data collection tools was contradictory
- Results that were surprising or stimulated further questions

In addition to understanding the major statewide results, the evaluation team also paid particular attention to diverging results emerging from any CMHDA region and/or county size sub-analyses to ensure a full representation of the sample population and CPP experience.

In the process of sharing results with each other for every research question, the evaluators identified particular points for further research. Questions naturally arose about the data as results were presented. Moreover, as the evaluation team began to formulate findings for each research question, the team began identifying themes that emerged across research questions that led to additional questions and analyses. The evaluation team took the new questions that emerged from the within- and among-research question analyses to guide further analyses. In such instances, the evaluation team developed supplementary research questions to explore further, in Phases II and III of the analytic process, and that would integrate findings across themes and could lead to practice implications. These areas of exploration fell into the following categories:

- Impact of Staffing and Resourcing on CPP Processes
- Perceived Value of Stakeholder Participation and Use of Strategy Roundtables
- Suggestions for Future Trainings for CPP Participants
- Extent to which CPP Activities Affect Post-MHSA Planning Activities
- Impact of CPP Activities on Increased Collaboration between Other Disciplines/Departments
- The role of Accessibility, Consistency with MHSA Principles, Participant Safety, Participant Training, Level of Contribution, and Respect of Participant Opinions

The results of this phase of data analysis are available in "Appendix 8: Supplementary Report – Results by Research Question". This report describes key findings for each research question based on an integrated analysis across data collection tools and data sources as well as the specific analyses from each data collection tool for each research question.

Phase II – Data Analysis by Domain

Evaluating counties' CPP processes required a structured approach to understanding the many facets that define CPP processes, as well as the variety of impacts that counties' CPP processes had on participants and their broader communities. The analysis began with answering each of the research questions, previously reported. Once the data had been analyzed by research question, the information was then organized into domains, as described in the logic model. The domains included in the analysis are described below. The data analytic domains used in this Phase II of the analysis process were identified from the logic model and are distinct from the categories that emerged from the qualitative data described in the preceding analytic phase.

A large portion of the items across this evaluation explored the specific CPP processes that county mental health departments implemented for their CPP processes. These CPP process domains include:

- *Input* items examined the variety of resources that county mental health departments provided into their CPP processes.
- *Outreach* items explored the activities that county mental health departments conducted to reach their communities regarding respective CPP activities.
- *Participant Input* items examined any activities county mental health departments conducted to receive specific CPP feedback from their stakeholders.
- *Training* items explored the activities that county mental health departments conducted or sponsored to either train their staff to conduct CPP activities and/or train stakeholders on how they could more effectively participate in their counties' CPP activities.
- *Evaluation* items examined the activities that county mental health departments used to assess the effectiveness of their CPP activities in soliciting meaningful feedback to utilize in the ongoing improvements of their counties' MHSA and CPP processes.

In addition to items about counties' CPP activities, this evaluation also yielded numerous items assessing participant response to CPP processes and activities, including the following domains:

- *Stakeholder Perceptions and Satisfaction* items explored stakeholders' perceptions about their respective counties' CPP processes, including which particular CPP activities were most or least effective.
- *Participant Impacts* items examined the degree to which counties' CPP processes had an impact on participants, with regard to the areas of personal wellness, stigma, trust in the mental health system, et cetera.
- *Mental Health System Impacts* items explored how CPP processes influenced the planning and delivery of public mental health services.
- *Perceptions of the Broader Community Impacts* items examined the counties' and stakeholders' thoughts on how their counties' CPP processes had affected the perceptions about mental health and mental health services amongst the broader communities in each county, including how local mental health policies may have shifted.

In each domain, the evaluation team extracted consistent results found across research questions and datasets to develop findings. The evaluation team also identified inconsistent or noteworthy differences in results between CMHDA regions and county size cohorts and provided recommendations for future practice and/or research. Specifically, results within each domain were analyzed to determine:

- Areas where results led to the same or similar conclusion
- Areas where results supported or further explained conclusions
- Areas where results led to disparate or contradictory conclusions
- Areas where results prompted additional questions or further inquiry

See the "Descriptive Evaluation" and "Discussion" sections of this report for the evaluation's findings of themes across the data for all of the domains.

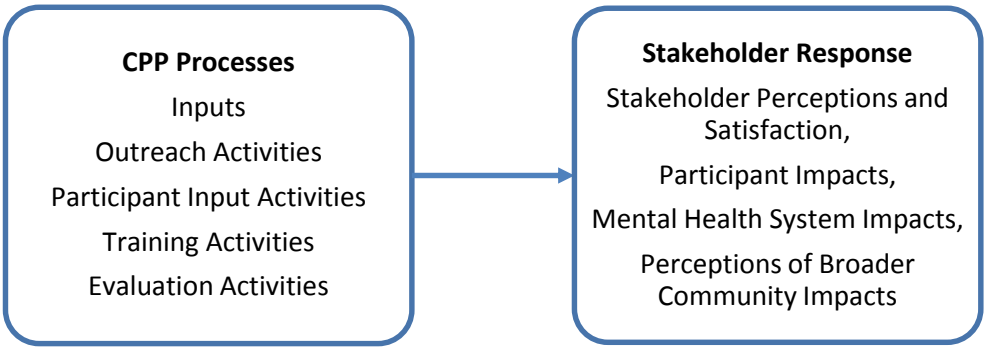
During this phase, the evaluation team also conducted additional qualitative analysis using processes previously described to understand:

- Impact of Staffing and Resourcing on CPP Processes
- Perceived Value of Stakeholder Participation and Use of Strategy Roundtables
- Suggestions for Future Trainings for CPP Participants
- Extent to which CPP Activities Affect Post-MHSA Planning Activities
- Impact of CPP Activities on Increased Collaboration between Other Disciplines/Departments

Phase III – Consolidated Data Analysis

Upon completing the analysis for each domain, the evaluators then sought to understand the relationships between the domains. The first five domains (inputs, outreach, participant input, training, and evaluation) largely represented activities that counties conducted as part of the CPP process. The second set of domains (stakeholder perceptions and satisfaction, participant impacts, mental health system impacts, and perceptions of broader community impacts) contained participant responses to the CPP processes represented in the first five domains. As such, the evaluation team then sought to analyze the data across domains to understand the relationships between the CPP processes and stakeholder response, as depicted in Figure 1 below.

Figure 1. Relationship Between CPP Processes and Stakeholder Response



To accomplish this task, the evaluators analyzed the key findings from each of the CPP Processes domains with each of the Stakeholder Response domains to determine relationships between CPP processes and stakeholder response. This relied heavily on descriptive statistical and qualitative analyses previously conducted.

The evaluation team also sought to identify if there was any quantitative data of sufficient quantity and quality to permit statistical testing of these relationships, as well as further explore the categories that emerged during the Phase I qualitative analysis, including:

- Accessibility
- Consistency with MHSA principles
- Participant safety
- Participant training
- Level of contribution
- Respect of participant opinions

The above categories were first identified in the descriptive analysis as emerging themes. During this phase of analysis, the evaluation team consulted the qualitative data to develop a deeper understanding of the categories and their meaning. Then, the evaluation team reviewed the Stakeholder Survey[16] to identify if there were any items that corresponded to the identified categories and had sufficient data to permit statistical testing. The categories were further refined as follows:

[16] The stakeholder survey was the only data collection tool of sufficient quantity and quality to permit statistical testing.

Table 4. Quantitative Variables of Interest from the Qualitative Data

Phase I Emerging theme from the qualitative data	Phase III Definition from the qualitative data	Corresponding variable for Phase IV analysis based on available survey data
Accessibility	This refers to the extent to which stakeholders were able to understand and follow along with CPP meeting activities.	Upon review of available data from the Stakeholder Survey, there were no items that specifically asked about CPP meeting accessibility or the ease of understanding CPP meeting activities. Qualitative data suggested that this category included meetings that were well structured, organized, and used language that stakeholders could understand. This category was operationalized to include the following items from the Stakeholder Survey: ❖ Meeting organization ❖ Preparation of facilitators ❖ Language This category was named CPP meeting effectiveness so as not to be confused with accessibility issues related to transportation, child care, meeting location, etc.
Consistency with MHSA principles	MHSA principles include: ❖ Wellness, recovery, and resiliency focused ❖ Client and family driven ❖ Culturally competent ❖ Community collaboration ❖ Integrated services	Upon review of available data from the Stakeholder Survey, the only survey item with face validity for any of the MHSA principles was recovery orientation of the CPP process. For the purposes of further analysis, this concept was operationalized as recovery orientation.
Participant safety	This refers to the extent to which participants felt safe to participate.	Upon review of available data from the Stakeholder Survey, there was a survey item that directly asked about participant safety and was named as such.
Participant training	This refers to the extent to which participants had enough training to participate.	Upon review of available data from the Stakeholder Survey, there was a survey item that directly asked about participant training and was named as such.

Phase I Emerging theme from the qualitative data	Phase III Definition from the qualitative data	Corresponding variable for Phase IV analysis based on available survey data
Level of contribution	This refers to the extent to which stakeholder input was taken into account when planning mental health services.	Upon review of available data from the Stakeholder Survey, there was a survey item that directly asked about perception of contribution and was named as such.
Respect of participant opinions	This refers to the extent to which participants felt that their opinions and culture were respected.	Upon review of available data from the Stakeholder Survey, there were survey items that directly asked about respect of participant opinions and culture, and the concept was named as such.

To measure *CPP meeting effectiveness*, survey respondents were asked to rate their level of agreement with the following statements on a Likert-type scale of 1-5 wherein 1 indicated "strongly disagree" and 5 indicated "strongly agree." Each stakeholder's responses to the following questions were aggregated into a mean score:

- "MHSA CPP meetings were well organized;"
- "MHSA CPP facilitators were well-prepared to lead meetings/activities;" and
- "The MHSA CPP meetings were in a language that I speak/understand."

To measure *recovery orientation*, survey respondents were asked to rate their level of agreement with the statement:

- "The CPP process was recovery-oriented."

To measure *participation safety*, survey respondents were asked to rate their level of agreement with the statement:

- "I felt safe participating in the MHSA CPP process."

To measure *participant training*, survey respondents were asked to rate their level of agreement with the statement:

- "I received enough training/info to meaningfully participate."

To measure *perception of contribution*, survey respondents were asked to rate their level of agreement with the statement:

- "Stakeholder input was taken into account for planning mental health services in the county."

To measure *respect of participant opinions and culture*, survey respondents were asked to rate their level of agreement with the statements:

- "My opinions were respected and listened to," and
- "The MHSA CPP facilitators respected my culture."

Linear Regressions

This evaluation employed multiple linear regressions to understand how the variables listed in Table 4 may be related to CPP outcomes.

The six independent variables used in the linear regressions were those that emerged from the qualitative data and were than mapped onto available quantitative data. These include:

- CPP Meeting Effectiveness
- Recovery Orientation
- Participant Safety
- Participant Training
- Perception of Contribution
- Respect of Participant Opinions and Culture

Dependent variables for this procedure were selected from the outcome section of the logic model and include outcomes related to stakeholder response to the CPP process; only variables that had data of sufficient quality and quantity to permit statistical testing were included. The dependent variables included in the linear regressions were:

- Participant satisfaction
- Participant wellness
- Trust in the public mental health system

To measure *participant satisfaction*, survey respondents were asked to rate their level of agreement with the statement:

- "Overall, I found the MHSA CPP process to be valuable."

To measure *participant wellness*, survey respondents were asked to rate their level of agreement with the statement:

- "Participating in the MHSA CPP process improved my sense of wellbeing."

To measure *trust in the public mental health system*, survey respondents were asked to rate their level of agreement with the statement:

- "Participating in the MHSA CPP process increased my trust in the mental health system."

In the statistical analysis program, PASW Statistics (also known as SPSS), the evaluation team aggregated individual survey responses to each of these survey items and ran a multiple linear regression analysis for each of the stakeholder response outcome variables.

Figure 2. Linear Regression Theoretical Model

The multiple linear regression equations created allowed the evaluation team to review whether the CPP variables of CPP meeting effectiveness, recovery orientation, participation safety, participant perception of contribution, and respect of participant opinions and culture, when combined were significant in predicting each of the participant outcomes and if so, to what degree. The specific equations used were:

Participant Satisfaction with CPP Participation = $\alpha + \beta_1$(*CPP meeting effectiveness*) + β_2(*recovery orientation*) + β_3(*participation safety*) + β_4(*participant perception of contribution*) + β_5(*respect of participant opinions and culture*)

Participant Wellness as a Result of CPP Participation = $\alpha + \beta_1$(*CPP meeting effectiveness*) + β_2(*recovery orientation*) + β_3(*participation safety*) + β_4(*participant perception of contribution*) + β_5(*respect of participant opinions and culture*)

Participant Trust in the PMHS = $\alpha + \beta_1$(*CPP meeting effectiveness*) + β_2(*recovery orientation*) + β_3(*participation safety*) + β_4(*participant perception of contribution*) + β_5(*respect of participant opinions and culture*)

If a multiple linear regression equation was found to be statistically significant in predicting an outcome, the inferential statistics also allowed the evaluation team to identify which predictor variables within said equation were significant contributors to the outcome and the amount of outcome variance accounted for by each significant predictor variable.

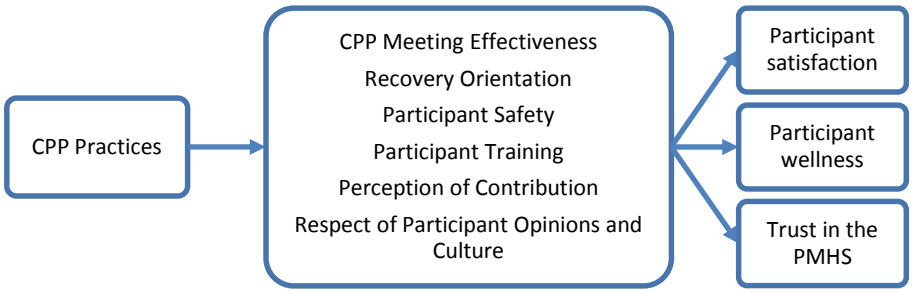
The multiple linear regressions resulted in the identification of all six independent variables significantly contributing to at least one of the independent variables (satisfaction, wellness, and trust in the public mental health system) and provided evidence that the categories identified from the qualitative data significantly contributed to CPP outcomes. The regression analyses, however, did not yield results that could be directly linked to specific CPP practices or activities. The evaluation team conducted further analysis to determine the effectiveness of CPP activities and identify promising practices, as described in the following phase.

The full results from the linear regressions are included in the section “Outcome Evaluation.”

Phase IV – Analysis of Outcomes

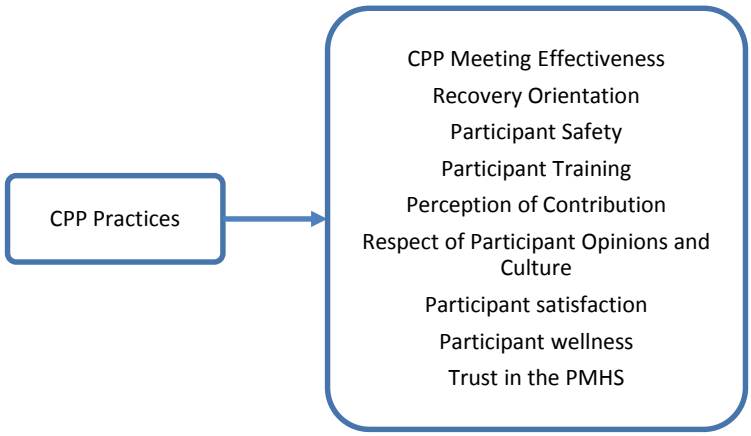
Both the independent and dependent variables from the linear regression are theoretically influenced by CPP practices. For example, the CPP practice of providing childcare may contribute to the perception of CPP meeting effectiveness which may contribute to participant satisfaction. Figure 3 depicts this theoretical relationship.

Figure 3. Theoretical Model of CPP Activities and Variables from Linear Regressions



The evaluation team considered a variety of statistical techniques that could examine the relationships described in Figure 3. However, the sample size (e.g. number of California counties) was not large enough to examine more than one distinct set of relationships. Therefore, the evaluation team redesigned the model to explore the relationship between CPP activities and any of the variables from the linear regressions, as depicted in Figure 4. In effect, the variables used as independent variables in the previous regression analysis were then treated as dependent variables, along with the previous three dependent variables in the regression analysis, in this subsequent analysis. In this report, from this point on, all variables from the linear regressions are subsequently referred to as outcomes or outcome variables in relationship to CPP activities.

Figure 4. Theoretical Model between CPP Activities and Outcome Variables



The CPP practices that were included in the significance testing analysis depicted in Figure 4 above included the following:

- <u>CPP Outreach Activities</u>
    - Posting Flyers/Posters/Brochures

  - Phone Calls/Invitations by Mental Health Department Staff
  - Emails to List-Servs
  - Radio/TV Announcements
  - Print Announcements
  - Social Media
  - Announcements at Meetings
- CPP Incentives
  - Transportation to Meetings
  - Transportation Vouchers
  - Meals at Meetings
  - Multiple Meeting Times
  - Stipends/Other Financial Incentives
  - Childcare
  - Continuing Education Credits/Certificates
  - Translation/Interpretation Services
  - Meetings in Languages Other than English
- CPP Trainings
  - Produce and Distribute CPP Educational Materials
  - Offer Professional Development or Continuing Education Credits
  - County-Specific Trainings on Participation In the Local Stakeholder Planning Process
  - Support for Participants to Attend Trainings Not Sponsored By the County
- CPP Participant Input Activities
  - Voting or Prioritization Activities
  - Surveys/Questionnaires
  - Focus Groups

The evaluation team considered a number of statistical tests to understand the relationships between specific CPP practices and CPP outcomes, and selected independent samples *t*-tests.[17] As each *t*-test situation was different, the details for each *t*-test is described in its respective results section. Because inferential statistics requires a large dataset for powerful analysis, the Stakeholder Survey was the most viable option. In the case of *t*-tests, the criteria for analysis was the need to compare the dichotomous choices of a predictor variable (e.g., CPP activity occurred or not) with an outcome variable (e.g., the extent of agreement with a survey item). The evaluation team used PASW Statistics (SPSS) to aggregate individual survey responses and ran an independent samples *t*-test to compare the mean responses between the two populations.

See the "Outcome Evaluation" and "Discussion" sections for the integrated findings of the initial cross-domain results and accompanying inferential statistics. See "Appendix 6: Results from Stakeholder Survey Significance Testing" for the detailed results for all *t*-test analyses.

[17] An independent samples *t*-test is a comparison of means between two populations to determine if the average outcomes for one population is different from the average outcomes of another population.

Iterative Process

The evaluation team continually repeated this iterative process of data analysis: sharing findings, allowing findings and questions to emerge from the data, and going back to the data to explore these questions. This iterative process produced a comprehensive study with multiple layers of analyses and findings.

Limitations of Methods

A host of personnel contributed to this project: the Regional Partners and CSP served as the data collectors; RDA developed the data collection instruments, created and maintained the online SurveyGizmo online data reporting system, provided technical assistance to the Regional Partners and CSP in their data collection and reporting efforts, and conducted the analyses of all of the data for this project's evaluation. With multiple parties involved, limitations to the evaluation were inadvertently introduced in the quantity of quality of data reported to the evaluation team. There is also no standard method currently by which counties record or report CPP participation, activities, and other CPP-related data, other than what is required under the MHSA. This led to some inconsistencies in what data counties had available and what data collectors were able to report during the data collection process. Additionally, this evaluation was designed as a retrospective study and requested that informants and stakeholders remember activities and perceptions completed in a previous time period. The challenges these and other evaluation limitations presented are discussed in further detail below.

Limited Data from Counties

For this evaluation, the County Web-Based Data Request instrument served as an integral data source of the counties' documentation and perspectives of their CPP processes. The County Web-Based Data Request instrument gave counties' MHSA/CPP Coordinators the opportunity to provide the following:

- First-hand accounts on the CPP activities that their counties conducted;
- Perceptions about their counties' CPP processes; and
- Counts and demographics of their counties' total CPP participants, as well as for participants of each one of their counties' individual CPP activities.

The County Web-Based Data Request requested the most in-depth information about CPP processes and was the source of most of the evaluation's quantitative data on counties' CPP activities, thus providing another layer of importance to this data source. Unfortunately, counties' did not provide consistent data or level of detail in their responses to the County Web-Based Data Request instrument, which we suspect was related to a lack of available data to report. In many instances, key elements, like the demographics of who had participated in CPP planning, were not available. This limitation of the evaluation's main source of quantitative data directly from the counties increased the importance of strategically and effectively using qualitative data throughout the evaluation. Implementation of a mixed-methods approach to this evaluation served to compensate for the lack of consistent and detailed quantitative information about previous CPP processes from counties across California.

Paraphrasing of Qualitative Data

The qualitative data collected by the Regional Partners from the Key Informant Interview and Focus Group instruments went through multiple stages of paraphrasing. First, the Regional Partners took extensive notes during their Key Informant Interviews and Focus Groups but did not record and transcribe the responses—some Regional Partners included verbatim responses while others included paraphrased responses. While it can be assumed that the Regional Partners did their best to take notes that were comprehensive and representative of what respondents voiced, a level of paraphrasing and subjectivity can also be reasonably assumed to have been introduced with this step.

Next, the Regional Partners relied on their notes when inputting qualitative data into the SurveyGizmo reporting system. The Regional Partners were asked, time permitting, to synthesize their notes and provide thorough and succinct responses for each item when sharing their qualitative data with RDA. This step naturally adds a second layer of paraphrasing—the Regional Partners having to synthesize their already-paraphrased notes from their Key Informant Interviews and Focus Groups can reasonably signal that some pieces of information were omitted and paraphrased-out when the final set of qualitative data was submitted to RDA.

Similar data paraphrasing issues were inherent in the Annual Update Document Review data collection instrument. The Regional Partners and CSP were tasked with reviewing each county's MHSA Annual Update report, particularly the CPP section of each report. The Regional Partners and CSP had to interpret what was presented in each county's Annual Update document and report to RDA, via the online SurveyGizmo reporting system, what it believed would address each of the items in the Annual Update Document Review instrument. For example, in some instances, it was clear that the Regional Partner or CSP had misinterpreted information (e.g., public hearing outreach was reported as a part of general CPP outreach) and the evaluation team was able to make data entry adjustments; but these instances suggest that other interpretation errors might have happened in the first paraphrasing step. These steps introduced a level of paraphrasing of the root data, what was actually written in each county's Annual Update document, by the Regional Partners and CSP.

Lastly, given the sheer volume of quantitative and qualitative data that RDA had to analyze for its evaluation, RDA also had to comprehend and synthesize the information that it received from the Regional Partners, CSP, MHSA/CPP Coordinators, and stakeholders. RDA approached its analyses by identifying key themes throughout the data. In doing so, RDA had to work through the data with varying lenses and filters to be able to recognize key themes. While an evaluation of this magnitude, with this large amount of information, is not possible without the informed and justified filtering of the data, it is important to acknowledge that levels of filtering were introduced in this evaluation's work and analyses.

CPP Processes vs. Mental Health Services Provision

The concept of CPP is implemented and referred to in a variety of ways throughout California's counties. As such, stakeholders from across the state often have varying understandings and perceptions about what the CPP process is, compared to the definitions and descriptions set forth by the MHSA's rules and

regulations. After in-depth review of the evaluation's data, RDA observed that a number of responses that stakeholders offered for the qualitative items were in reference to their counties' provision of public mental health services, rather than their counties' activities for MHSA CPP purposes. For example, some stakeholders reported on outreach for service engagement instead of outreach for CPP participation.

This project is not an evaluation of counties' MHSA services, but rather, counties' planning and implementation of CPP activities. For the purposes of this evaluation, qualitative data that was clearly commenting on counties' provision of public mental health services and/or counties' outreach services were not included in the analysis. While service provision and CPP processes are related, this effort is intended to evaluate CPP processes and not service delivery.

The evaluation team recognizes that one of the larger goals of the CPP process is to help counties achieve MHSA-defined outcomes, such as reduction of stigma, unemployment, and homelessness. In theory, an effective CPP process would solicit meaningful feedback from stakeholders that enables counties to adjust their services and service delivery systems accordingly. However, it was not possible within the scope of this evaluation to truly assess whether current CPP processes prompt positive outcomes, such as improved health and increased wellness, or reduce negative outcomes, like homelessness or incarceration, as the evaluation relied on stakeholder perceptions of outcomes as opposed to outcome data that was independently collected and reported. Unfortunately, the time period of evaluation for the reduction of negative outcomes did not line up with the time period for this evaluation, and the increase in positive outcomes have not yet been measured in a consistent manner across the state.

A major data repository in California is the Client & Service Information (CSI) system that collects client-level service utilization data about the state's county mental health programs.[18] However, a key limitation of CSI data is that it tracks decreases in negative outcomes amongst clients as well as client satisfaction, but does not track increases in positive outcomes regarding wellness and recovery. Given the aforementioned limitation, a future evaluation may be warranted in order to more rigorously assess potential associations between specific CPP practices and all MHSA-defined outcomes. In the interim, this evaluation focuses on outcomes identified as goals specific to the CPP process and will include both subjective and objective measures of those goals/outcomes.

Time Periods of Interest with Data Collection Instruments

A goal of this evaluation was to learn about and assess the CPP processes that counties across California conducted for the preparation of their Fiscal Year 2012/2013 MHSA Annual Update reports. Across the state, there was a lot of variability in how and when counties planned and implemented their CPP processes for their FY 12/13 Annual Update reports. During the data collection piloting period of this evaluation, it was found to be challenging to discern the specific time periods in which MHSA/CPP Coordinators and stakeholders were referring to when providing their accounts about their past CPP experiences.

[18] County Mental Health Client & Service Information (CSI) System. California Department of Health Care Services. Retrieved from: http://www.dhcs.ca.gov/services/MH/Pages/CountyMentalHealthClientServiceInformation(CSI)System.aspx

Across the state, some counties conducted their FY 12/13 CPP processes prior to the start of the fiscal year (prior to July 2012), while other counties conducted their CPP processes during the fiscal year (July 2012 – June 2013). Along the same lines, counties submitted their FY 12/13 Annual Update reports at various times. Some counties submitted their reports during the early part of the fiscal year, while other counties submitted their reports in the later part of the fiscal year or early the following fiscal year. Specifically, the CWDR listed discrete three month time periods, and counties endorsed whether or not they conducted CPP processes for their FY 12/13 Annual Update reports during these time periods. Given that CPP activities occurred over more than a 3 month time period, counties endorsed more than one time period. The breakdown of when counties (n=50) conducted their CPP processes for the FY 12/13 Annual Update reports is:

- Prior to July 1, 2011: 20%
- July 1, 2011 – September 30, 2011: 28%
- October 1, 2011 – December 31, 2011: 42%
- January 1, 2012 – March 30, 2012: 60%
- April 1, 2012 – June 30, 2012: 66%

The non-uniformity in the specific time periods in which all of the state's counties conducted their CPP processes also presented a challenge in this evaluation's recruitment of stakeholders for their perspectives about their counties' CPP processes. Stakeholders were generally unaware of the specific fiscal year's Annual Update that they were contributing their perspectives for. It was discovered that the stakeholders participating in this evaluation generally provided their thoughts and opinions about their counties' overall past CPP processes, not for a specific time period in the past.

The County Web-Based Data Request instrument asked MHSA/CPP Coordinators to provide responses regarding the CPP processes that their counties conducted to complete the FY 2012/2013 Annual Update. The Key Informant Interview instrument asked MHSA/CPP Coordinators to comment on the CPP processes that their counties conducted to complete their FY 12/13 Annual Update report. The Annual Update Document Review instrument was completed by examining every county's FY 12/13 Annual Update report. In sum, the data collection instruments implemented with MHSA/CPP Coordinators were assessing CPP processes conducted to complete their FY 12/13 Annual Update reports.

The Focus Group and Stakeholder Survey instruments asked stakeholders to provide responses regarding the CPP processes that they participated in during FY 12/13. This difference in time period from the instruments used with the MHSA/CPP Coordinators presents a limitation to this evaluation.

After the examining the qualitative data that was obtained from the Key Informant Interview and Focus Group instruments, the evaluation team found that the responses provided were not confined to a specific time period. Rather, respondents to both instruments commented on their counties' past CPP processes as a whole. This presented a mediation of the limitation regarding the variety of previous time periods that respondents could provide responses for as county and stakeholder respondents provided data about their CPP processes since the MHSA inception as opposed to limiting their responses to just the CPP processes that informed the FY 12/13 Annual Update reports. Specifically, counties and stakeholders alike

commented that their CPP processes had changed over time and that CPP processes used to develop 3 year program and expenditure plans for each MHSA component were more robust than the process to develop the FY 12/13 Annual Update reports. Given this, comments about past CPP processes as a whole can be appropriately compared to responses from the other data collections instruments that focused on particular time periods.

Limitations of Inferential Statistical Testing

This evaluation report presents findings from significance testing with data from the Stakeholder Survey. In particular, the tests were used to conduct a two-tiered analysis. The first tier of analysis explored the relationships between variables of interest identified from the qualitative data with specific outcome variables. The outcome variables were participant satisfaction, participant trust, and participant wellness. These outcome variables were those variables listed in the evaluation logic model that had associated data of sufficient quality to permit statistical testing. The variables identified, via statistical regression procedures, to have significant relationships with one or more of the three outcome variables were: accessibility, consistency with MHSA philosophies, participant safety, participant training, perceptions of contributions, and respect of participant opinions. While the six variables identified from the qualitative data did not represent the entire realm of possible variables that could affect the outcome variables, they were noted in the qualitative data as relevant themes, were able to be isolated from data of sufficient quality to permit statistical testing, and had significant statistical relationships within the data available for the evaluation.

After the first tier of analysis was conducted, the evaluation team determined whether counties' conduction of specific CPP practices led to significantly different stakeholder perceptions of outcomes. Using both sets of variables previously described and determined to be significant, the evaluation team determined the specific CPP practices that demonstrated a significant correlation with those variables. As noted before, this step presents a limitation in that the CPP practices deemed significant in this analysis do not represent all of the variables that could be significant. Rather, the CPP practices demonstrating significance are unique to this particular analysis and with the specific data available to the evaluation.

In the context of statistics, the significance testing conducted by the evaluation team was used to determine whether the data available could reject the null hypothesis that there was no difference in: 1) stakeholders' perceptions of the outcomes, and 2) stakeholders' perceptions of the outcome variables based on the presence or not of specific CPP practices in their respective counties. The findings that proved to be significant were those that rejected the abovementioned null hypotheses. Given the limitations noted above and the inherent limitations of using statistical procedures with defined data sources to represent entire populations, the evaluation team was aware of the possibilities for Type I and Type II error in the findings. Type I error represents the incorrect rejection of a true null hypothesis, or a false positive; Type II error represents the failure to reject a false null hypothesis, or a false negative. The evaluation only rejected the null hypothesis at $p < .05$, thereby limiting the likelihood of a Type I error, or false positive. However, the sample size of California Counties is small, thereby increasing the likelihood of a Type II error, or false negative, meaning that there may be CPP practices that did not have demonstrated significant relationships with the outcome variables that in fact did contribute to the

outcomes identified. Additionally, this evaluation ran t-tests for every CPP practice compared to every identified outcome. This likely resulted in correlations that are influenced by another variable not measured or available to this evaluation and should therefore be interpreted cautiously.

Descriptive Evaluation indings

In this section of the report, the evaluation team reports on the 10 domains examined in terms of CPP processes conducted by county mental health departments, and in terms of the impacts of the CPP processes:

- *Inputs*, in which the evaluation team reviewed the resources counties dedicated to conducting and monitoring CPP processes;
- *Outreach*, in which the evaluation team reviewed the types of activities counties conducted to reach and engage stakeholders throughout different stages of CPP and how effective these methods were in engaging stakeholders in meaningful participation;
- *Participant Input*, in which the evaluation team reviewed how counties solicited stakeholder input in program planning and the effectiveness of said solicitations;
- *Training*, in which the evaluation team reviewed whether participants were trained for CPP participation and if the training enabled meaningful participation;
- *Evaluation*, in which the evaluation team reviewed if and how counties evaluated the CPP processes to improve future CPP activities;
- *Stakeholder Perceptions and Satisfaction*, in which the evaluation team reviewed stakeholders' perceptions of the meaningfulness of CPP participation;
- *Participant Impacts*, in which the evaluation team reviewed how stakeholder participation in program planning affected them, particularly how it affected their wellness;
- *Mental Health System Impacts*, in which the evaluation team reviewed if and how CPP participation changed stakeholders' perceptions about the public mental health system;
- *Perceptions of Broader Community Impacts*, in which the evaluation team reviewed any changes in stakeholders' perceptions of mental health as a result of the CPP process; and
- *Stakeholders Who Did Not Participate*, in which the evaluation team reviewed the demography of those stakeholders who did not participate in CPP processes and reasons why they did not participate.

In each domain, the evaluation team extracted consistent results found across research questions and datasets to develop individual findings. The evaluation team also identified inconsistent or noteworthy differences in results between CMHDA regions and county size cohorts and provided recommendations for future practice and/or research.

Inputs

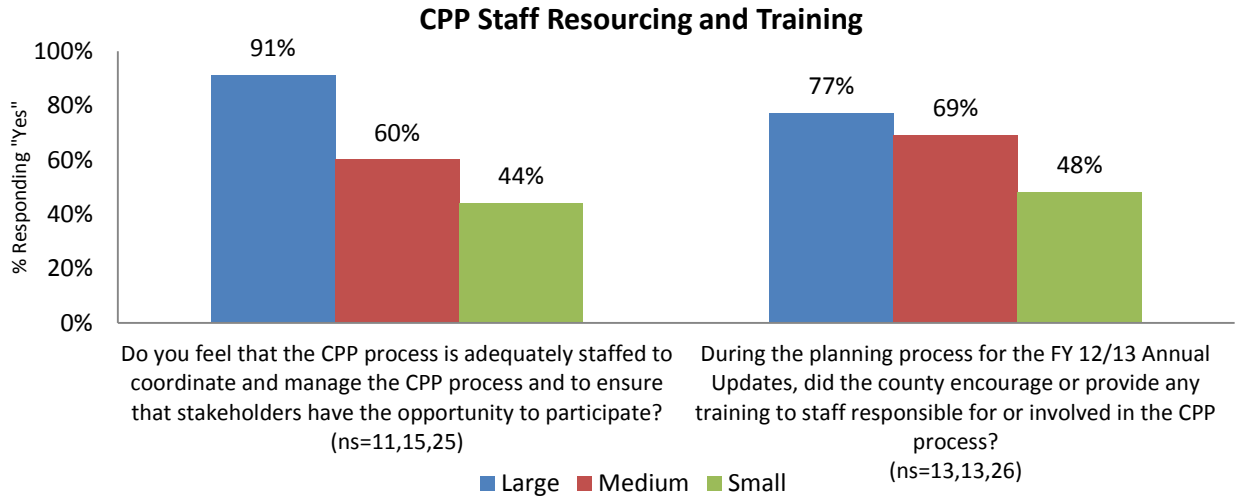
In this domain, the evaluation team looked to answer the question, *what resources do counties have to conduct CPP processes?* This involved reviewing factors such as if and to what extent counties have designated positions or units responsible for conducting and/or monitoring the CPP process and the types of training provided to those who staff these positions or units.

Across the state, counties designated an average of 1.84 FTEs to conduct and/or monitor the CPP process. The designation of FTEs was quite proportionate with county size as small counties designated the least FTEs (0.96 FTE) while the large counties dedicated the largest FTEs (3.58 FTE) to this. As a result, CMHDA regions with larger counties (Bay Area, Los Angeles, and Southern) were able to dedicate more FTEs as well. Overall, 59% of the 50 responding counties felt that their designation of staff was adequate, with larger counties (82%) more frequently reporting adequacy and small counties (40%) reporting the least adequacy.

In a large Central county, where the MHSA/CPP Coordinator supervises several analysts and has a senior analyst to oversee the CPP process and educate staff about MHSA programs and values, the county reported, "We are resource rich and have a solid infrastructure. It shows in the final product." On the other hand, several small, especially rural, counties reported feeling overburdened, executing the responsibilities of multiple roles in addition to their own. A small Central county MHSA/CPP Coordinator reported, "We could use more help. We're all wearing so many hats, and not getting what we need."

In addition to feeling inadequately staffed to conduct and/or monitor CPP processes, more than half (52%) the responding small counties (*n* = 26) also reported that they did not encourage or provide training to staff responsible for their CPP processes during FY 2012-13. Conversely, the majority (77%) of responding large counties (*n* = 13) reported that they did encourage or provide training to staff responsible for their CPP processes during FY 2012-13.

Figure 5. CPP Staff Resourcing and Training During the FY 12/13 Annual Update, by County Size ϕ



ϕ*SOURCE:* County Web-Based Data Request

Another input that was often raised by counties was that of multilingual ability. Counties expressed the importance of having staff with multilingual capability to increase CPP outreach and engagement and provide more channels for stakeholders with limited English proficiency to be able to participate in MHSA program development.

Given these findings, it would seem that small counties and CMHDA regions with many small counties (Central and Superior) are at a disadvantage for effectively implementing CPP processes, as they feel understaffed and undertrained to do so. Increasing staff or designation of hours during these times may help alleviate the burden and increase outreach efforts. Additionally, as a medium Central county MHSA/CPP Coordinator suggested, collaborating with community leaders and other service providers to conduct outreach may be helpful, "I think the way that we address that is we pull upon the program leaders from the community and get them to assist in the process. We could always use additional staff, but we feel we are able to reach stakeholders in the community."

Two small Bay Area and Central counties noted the importance of having dedicated staff during the times of the year that CPP activities are taking place at high volume. A small Bay Area county MHSA/CPP Coordinator suggested that "During large CPP processes I think the City could utilize at the minimum one additional staff member (a half-time person at least), to more adequately support the work in this area." Further, small counties often did not have a lot of MHSA staff members, directly impacting the level of staffing that they had to coordinate and execute CPP processes. It may be prudent for these counties to also set aside dedicated funding for increasing staff levels during times of high-volume CPP work. This is also important for counties with geographically-dispersed populations, where it is imperative for staff members to organize CPP processes that yield feedback from across the county's population.

Impact of Staffing and County Resources on CPP Processes

From the evaluation's qualitative data sources (Key Informant Interviews with MHSA/CPP Coordinators, and Focus Groups with stakeholders), counties and stakeholders expressed frustration over the loss of staff either because of retirement, lay-offs, or closing programs. In one county in particular, stakeholders and the county described the impact of losing staff and retirement of staff several times. Counties and stakeholders described how this impacted the continuity and institutional memory of the CPP process over the years and greatly limited resources. Stakeholders in another county described how staff turnover had created a lot of turbulence at CPP meetings and impacted trust; however, they went on to describe how the CPP process had been a vehicle to rebuild relationships and trust.

Across the state, the importance of counties' staff having bilingual and multilingual capabilities was noted often. Staff members' language capabilities could increase CPP participation levels by providing more channels for non-English speaking stakeholders to be able to have their voices heard and opinions fielded. Other counties felt they had not seen the impact of improved funding in staffing and program budgets. MHSA funding has not replaced positions that were cut during difficult fiscal years.

In one small county from the Superior region, it was noted that a lot of its Mental Health Department staff were currently in Master's educational programs. As a result, they were not as available and therefore are less accessible, which made it difficult for stakeholders to communicate with them. Two small counties noted that it was important to have dedicated staffing during the times of the year that CPP activities were happening.

Outreach

In this domain, the evaluation team looked at CPP outreach on several levels: what types of outreach methods are conducted and at what frequency, how outreach methods are used to target specific stakeholder groups, how stakeholders are incentivized to participate, barriers to participation that remain despite outreach and engagement efforts, and the ultimate level of engagement gained by outreach.

General Outreach Methods

To understand how counties conducted outreach and identified effective outreach methods, the evaluation team reviewed the frequencies of various outreach methods that counties used to engage stakeholders in both their planning process (i.e., needs assessment and strategizing) and the decision making process (i.e., public commenting and hearing on drafted plans). The evaluation team also studied which outreach methods participants reported hearing, seeing, or receiving and the types of outreach methods that non-participants thought would be effective in reaching and recruiting them for participation.

The results showed that counties across the state typically used multiple methods of outreach when trying to engage stakeholders in varying CPP activities. The methods and breadth of reach sometimes differed depending on the type of CPP practice. For instance, counties might conduct more direct outreach efforts, including placing personal phone calls to recruit participants for the needs assessment and program strategizing efforts, and less personal outreach efforts, such as simply posting to their website to solicit public comments and participation at public hearings once plans have been drafted (see Table 5).

Further, there was some discrepancy in the types of outreach methods counties reported doing and the types of outreach methods that reached participants or that non-participants preferred. While counties and their stakeholders were generally aligned in the top two outreach methods preferred and performed, the other outreach methods stakeholders preferred were more interpersonal (i.e., referrals from mental health department staff and phone calls), which were less commonly used by counties.

Table 5. Popular Outreach Methods Used Statewide by CPP Activity

	Most Popular Outreach Method	2nd Outreach Method	3rd Outreach Method	4th Outreach Method	5th Outreach Method	Least Popular Outreach Method
Planning Activities (n = 49)[μ]	Email 55%	Newspaper 43%	Physical Posting 22%	Radio/TV 14%	Referral from MH Dept 10%	Phone Call 4%
Public Comment Solicitation (n = 49)[μ]	Post to Website 86%	Physical Posting 44%	Email 42%	Newspaper 24%	Referral from Other Service Provider 22%	Phone Call 0%
Methods That Reached Participants (n = 590)[δ]	Email 78%	Physical Posting 49%	Referral from MH Dept 38%	Phone Call 17%	Referral from Friend/ Family 13%	Radio/TV 3%
Non-Participants' Preferred Outreach Method (n = 724)[δ]	Email 70%	Physical Posting 49%	Referral from MH Dept 30%	Phone Call 27%	Newspaper 21%	Referral from Other Service Provider 12%

[μ] *SOURCE*: Annual Update Data Request
[δ] *SOURCE*: Stakeholder Survey

A closer look at this data shows that medium counties tended to conduct more outreach activities at once, whereas large counties tended to rely on mass communication activities such as media outlets and email listservs. Small counties also tended to use multiple outreach activities at once; however, they conducted comparatively fewer outreach activities than medium and large counties. Moreover, the small counties typically understood that their outreach efforts could be improved, but they also reported being satisfied with their outreach efforts given their more limited funding and personnel. As a small Central county MHSA/CPP Coordinator said, they are "well [satisfied]. I think the process could be improved and it is a matter of time and resources."

Additionally, word-of-mouth emerged as a key outreach method across CMHDA regions as well as county size cohorts. Informants in the Central and Southern regions recognized that some of the most effective outreach activities were those that involved more one-on-one interaction with stakeholders. Informants described this as going out to the stakeholders, holding informal social activities (e.g., dinner and movie night, BBQs), having ongoing dialogue via particular venues such as wellness centers. As opposed to the traditional CPP activities, which had typically been discrete activities, these informal gatherings tended to be ongoing activities that occurred in addition to and beyond the times when high-volume CPP activities were being implemented. Overall, on-the-ground, personal interactions seemed to be an effective outreach activity. Moreover, these less formal activities (e.g., social gatherings) enabled community building and networking.

> "When you guys were here, grassroots manifested in the discussion. I think that has been more successful than the higher-level planning that has been done. The higher-level is like what

> happens at agency level or what plans programming. The grassroots movement includes the everyday activities at the wellness center or out in the community. It is more hands-on and easier to see, 'Oh, we participated in this and look what we've done.' There are quite a few consumers who participate in this center and get involved in the planning process. The grassroots movement is more concrete and easier to see than higher-level planning."
>
> – MHSA/CPP Coordinator, Small Superior County

Reaching Underserved Populations

WIC 5848 outlines that adults and seniors with severe mental illness (SMI) and families of children, adults, and seniors with SMI should be involved in the CPP stakeholder process. In the County Web-Based Data Request, counties of all sizes and across all CMHDA regions stated that the majority of their outreach efforts were also used to reach clients with SMI or severe emotional disturbance (SED), or family members of SMI/SED populations (see Table 6 and Table 7).

Large counties and counties in the Bay Area, Los Angeles, and Southern regions reported that 100% of their outreach methods were also used to reach these specific stakeholders. Counties of other sizes and in other regions reported using lower proportions of interpersonal methods (e.g., phone calls, announcement at meetings) to reach clients with SMI/SED and their families, as those types of outreach methods may have been targeted at reaching different types of stakeholders to ensure fair representation (e.g., persons of underserved demography, representatives from specific agencies). As a medium Southern county MHSA/CPP Coordinator stated, "It depends on the audience or agency involved. We approach people at public and other events and invite them to participate. We rely heavily on personal contact."

Table 6. Percentage of Respondents Indicating Outreach Method Targeted SMI/SED Populations by MHSA Region

Was this method used to outreach to clients with SMI, SED, or family members of SMI/SED populations? [1]	*Percentage Responding "Yes"* [ϕ*]				
	Bay Area	Central	Los Angeles	Southern	Superior
Post flyers/ posters/ brochures	100%	100%	100%	100%	100%
Phone calls/ invitations by Mental Health Department staff	100%	88%	100%	100%	82%
Emails to listserv	100%	90%	100%	100%	60%
Radio/ TV announcements	N/A	100%	N/A	100%	N/A
Print announcements (e.g., newspaper)	100%	100%	N/A	100%	100%
Social media (e.g., Twitter, Facebook)	100%	100%	N/A	100%	100%
Announcement at meetings	100%	100%	100%	100%	58%
Other	100%	93%	100%	100%	82%

ϕ *SOURCE*: County Web-Based Data Request

* Percentage represents only those counties that indicated utilizing the listed outreach method.

Table 7. Percentage of Respondents Indicating Outreach Method Targeted SMI/SED Populations by County Size

Was this method used to outreach to clients with SMI, SED, or family members of SMI/SED populations? [1]	*Percentage Responding "Yes"* ϕ*		
	Large	Medium	Small
Post flyers/ posters/ brochures	100%	100%	100%
Phone calls/ invitations by Mental Health Department staff	100%	88%	87%
Emails to list-serve	100%	100%	67%
Radio/ TV announcements	100%	N/A	100%
Print announcements (e.g., newspaper)	100%	100%	100%
Social media (e.g., Twitter, Facebook)	100%	100%	100%
Announcement at meetings	100%	93%	79%
Other	100%	97%	87%

ϕ *SOURCE*: County Web-Based Data Request

* Percentage represents only those counties that indicated utilizing the listed outreach method.

CCR 3300 outlines that the stakeholder process should include representatives of unserved and/or underserved populations and family members of unserved/underserved populations. The results from the County Web-Based Data Request on this information yielded results that were very similar to those targeted at reaching clients with SMI/SED and their families (see Table 8 and Table 9).

Large and medium counties, as well as counties in the Bay Area, Los Angeles, and Southern regions, reported that nearly all of their outreach methods were also used to reach these specific stakeholders. Counties of other sizes and in other CMHDA regions reported using lower proportions of interpersonal methods (e.g., phone calls, announcement at meetings) to reach those individuals who were unserved and/or underserved and their families, as those types of outreach methods may have been targeted at reaching different types of stakeholders to ensure fair representation (e.g., persons with SMI/SED, representatives from specific agencies). A medium Central county MHSA/CPP Coordinator said, "We make sure we're connected to cultural brokers. We attend community events, and try to become members of the community. This strategy increased stakeholder numbers and diversity by far." Additionally, these counties also reported slightly lower usage of flyers/posters/brochures to reach the unserved and/or underserved and their families—presumably, this method had not worked to engage these populations in services, so the small and more rural counties may not have seen as much value in continuing to target the unserved/underserved through this method.

Table 8. Percentage of Respondents Indicating Outreach Method Targeted Un/Underserved Populations by MHSA Region

Was this method used to outreach to un/underserved populations and family members of un/underserved populations?[1]	*Percentage Responding "Yes"* ϕ*				
	Bay Area	Central	Los Angeles	Southern	Superior
Post flyers/ posters/ brochures	100%	92%	100%	100%	91%
Phone calls/ invitations by Mental Health Department staff	100%	89%	100%	100%	91%
Emails to list-serve	88%	100%	100%	100%	60%
Radio/ TV announcements	N/A	100%	N/A	100%	N/A
Print announcements (i.e., newspaper)	100%	100%	N/A	100%	100%
Social media (i.e., Twitter, Facebook)	100%	100%	N/A	100%	100%
Announcement at meetings	100%	100%	100%	100%	75%
Other	100%	100%	100%	100%	100%

ϕ *SOURCE*: County Web-Based Data Request

* Percentage represents only those counties that indicated utilizing the listed outreach method.

Table 9. Percentage of Respondents Indicating Outreach Method Targeted Un/Underserved Populations by County Size

Was this method used to outreach to un/underserved populations and family members of un/underserved populations?[1]	Large	Medium	Small
Post flyers/ posters/ brochures	100%	100%	90%
Phone calls/ invitations by Mental Health Department staff	100%	100%	87%
Emails to list-serve	100%	92%	73%
Radio/ TV announcements	100%	N/A	100%
Print announcements (i.e., newspaper)	100%	100%	100%
Social media (i.e., Twitter, Facebook)	100%	100%	100%
Announcement at meetings	100%	100%	84%
Other	100%	100%	94%

ϕ *SOURCE*: County Web-Based Data Request

* Percentage represents only those counties that indicated utilizing the listed outreach method.

These findings suggest that larger and more urban counties took a blanketed multi-prong approach to CPP outreach whereas smaller and more rural counties had to strategically manage different types of approaches to engage specific groups of representatives. The evaluation team considered whether or not grounding CPP outreach activities in the community (e.g., through CBOs and cultural centers) increased communities' trust in the PMHS and/or served as an effective method to reach underserved populations. However, there was no data to determine whether or not counties performed this type of outreach and if it resulted in increased trust and participation among the underserved. Further study in the area may be warranted.

Engagement Strategies and Barriers

In addition to reaching out to stakeholders, most counties also provided some form of incentive to ensure attendance and increase engagement. As reported by counties in the County Web-Based Data Request and by stakeholders in the Stakeholder Survey, across counties of nearly all sizes and CMHDA regions, providing meals at meetings was the top incentive.

Stakeholders who had never participated in CPP processes also listed meals at meetings as the top incentive they would like to have during CPP processes. These stakeholders also cited inconvenient meeting times as the top barrier that kept them from participation, followed by inaccessibility of meeting locations. This was true across counties of all sizes and CMHDA regions, except for Los Angeles in which the barriers ranked closely but were in reverse order (49% identified inaccessibility of meeting locations and 46% identified inconvenience of meeting times). Proportionately fewer counties, in general, identified meetings times as a barrier to participation, but it was still a common barrier across the state. A small Bay Area county MHSA/CPP Coordinator rationalized this finding, saying, "I have also found that regardless of how many meetings you hold, there never seems to be the 'perfect' meeting time or location for everyone, that's why in most CPP [activities] we have offered multiple meeting times/locations as well as other ways to be involved in the process."

While time was not often identified as a barrier to participation during key informant interviews with MHSA/CPP Coordinators, counties frequently identified transportation to meetings as a large barrier, though many also shared that they provided transportation to better enable participation. It should be noted that transportation barriers were not necessarily the same as inaccessibility of meeting locations. Further, the challenges posed by transportation were experienced differently across CMHDA regions. For example, in more urban counties, the challenge with transportation was that due to the large geography of some counties, travel was too cumbersome, whereas in more rural counties the challenge was a lack of reliable public transportation. A small Superior county MHSA/CPP Coordinator said, "Transportation is one of our biggest barriers. We provide transportation, [because if] you want people to participate, you have to pick them up, you provide incentives. We go to them. People are spread out and public transportation is poor." Other important differences between barriers to participation identified by county and those identified by their stakeholders included stakeholder training, language, stigma, and childcare. While these barriers ranked lower on the list of stakeholders' participation concerns, they were frequently raised by counties across CMHDA regions. These findings suggest that there may be misaligned perceptions of what barriers to CPP participation are and how to address them.

Participant Input

WIC 5848 states that counties shall demonstrate a partnership with constituents and stakeholders throughout the CPP process that includes meaningful stakeholder involvement in the areas of policy, program planning, implementations, monitoring, improvements, evaluation, and budget allocations. The evaluation team reviewed which types and how many stakeholders participated in FY 2012-13 CPP

processes, how counties made CPP processes accessible and inviting to stakeholders as a means to enable participation, and how counties collected and used stakeholder input.

Participant Profile

Because counties did not consistently report data on CPP stakeholders, it was not possible to determine the total number of CPP participants engaged, nor the exact breakdown of their demographics. To build an approximate picture of who participated in the counties' CPP processes, the evaluation team extrapolated participant demographics from both the Stakeholder Survey, which represents 598 participants across 57 counties and municipalities, and the Annual Update Document Review, which represents 49 counties and municipalities. Across these sources, the evaluation team identified that the largest group of CPP participants were mental health consumers and/or their family members, followed by county mental health department staff. Stakeholders who were least represented in counties' CPP attendance were providers of veteran services. The representation of other stakeholder groups in attendance was less clear. For instance, stakeholders who identified as advocates constituted the third largest group responding to the Stakeholder Survey (27%) while the ranked among the least recorded in attendance by Annual Updates (31%). The reverse was true for law enforcement and educators.

The remaining demographic representation of CPP participants was deduced from the Stakeholder Survey, in which participants tended to be between the ages of 26 and 59 (64%, with only 3% being between 18 and 25), female (72%), not identifying as LGBTQ (91%), White (67%), and speaking English (97%). The demographics of CPP participants remained static across county size cohorts. Moreover, these demographics rarely changed across CMHDA regions, with the exception of Los Angeles County, in which the gender distribution was quite even (52% female), the majority race was Latino/Hispanic (50%), and the percentage of participants speaking only English was 75%.

Gaining Trust to Gather Input

To enable stakeholder participation, it is important that counties ensure that the CPP process is safe, and free from stigma, discrimination and retaliation. Counties across the state reported that one of the key elements to ensuring participation safety was building trust in the PMHS among stakeholders. To build this trust, counties from across the state emphasized the need for counties to be open, responsive, and respectful to/of communication at CPP meetings. There were slight variations in how trust was built between each of the CMHDA regions. Bay Area counties emphasized the importance of co-creating meeting goals and reaching out to stakeholder groups that were not involved previously, whereas Central counties highlighted the use of peer-led activities as an effective mechanism for building stakeholder trust. Counties in the Southern region attributed successful trust building to community-building events and retreats. Los Angeles County reported no substantial differences in how they built stakeholder trust, stating that trust and open dialogue already existed. On the other hand, Superior Counties had mixed experiences in building stakeholder trust, with many of the smaller counties reporting that they still struggled with how to reduce stigma.

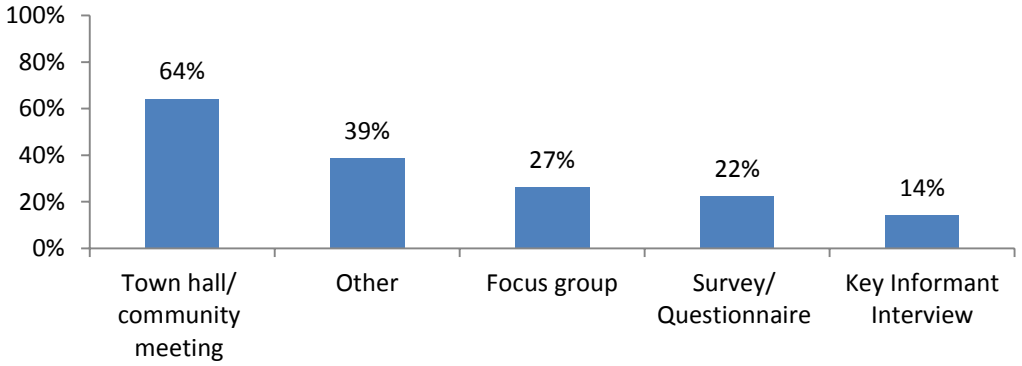
> "Having an open dialogue about what is going on and what this all means has inspired trust and collaboration. And it's not done... the mind-shift has yet to come full circle. It is still a work in progress. By taking the process out there, asking for input, and actually implementing the input, we are creating a sense of trust by following through with what we say."
>
> – MHSA/CPP Coordinator, Small Superior County

Gathering Input for Plan Development

Once they were able to reach stakeholders, counties engaged them in a variety of CPP activities, including leading CPP activities (i.e., through participation on a planning committee), needs assessment activities (e.g., town hall meetings, key informant interviews, focus groups, and surveys), strategic program planning (e.g., community work sessions, strategy roundtables, planning committees), and opportunities to provide feedback and approval of proposed program and funding plans (e.g., community feedback meetings, public hearings).

Figure 6. Activities to Collect Stakeholder Input Reported by Counties in the MHSA Annual Update Report, FY 2012-2013, Statewide [µ]

(n = 49)



[µ]*SOURCE:* Annual Update Document Review

Across the state, the majority of stakeholders (66%) reported participating on some type of MSHA committee, with counties and stakeholders reporting town hall/community meetings as the most common type of needs assessment activity counties used to gather stakeholder input on service strengths, needs, and gaps. A MHSA/CPP Coordinator from a large Southern county shared that they have well established stakeholder committees that have greatly contributed to the stakeholder input process, "[We have] several stakeholder groups, including PEI and a Community Leadership Committee (CLC), which developed mission statements, charters and policies/procedures with active involvement of stakeholder leadership."

In the County Web-Based Data Request, about half the counties (28 total) indicated holding town hall/community meetings to gather stakeholder input, of whom 71% felt that the activity was effective. However, in comparison to other stakeholder input opportunities, town hall/community meetings fell

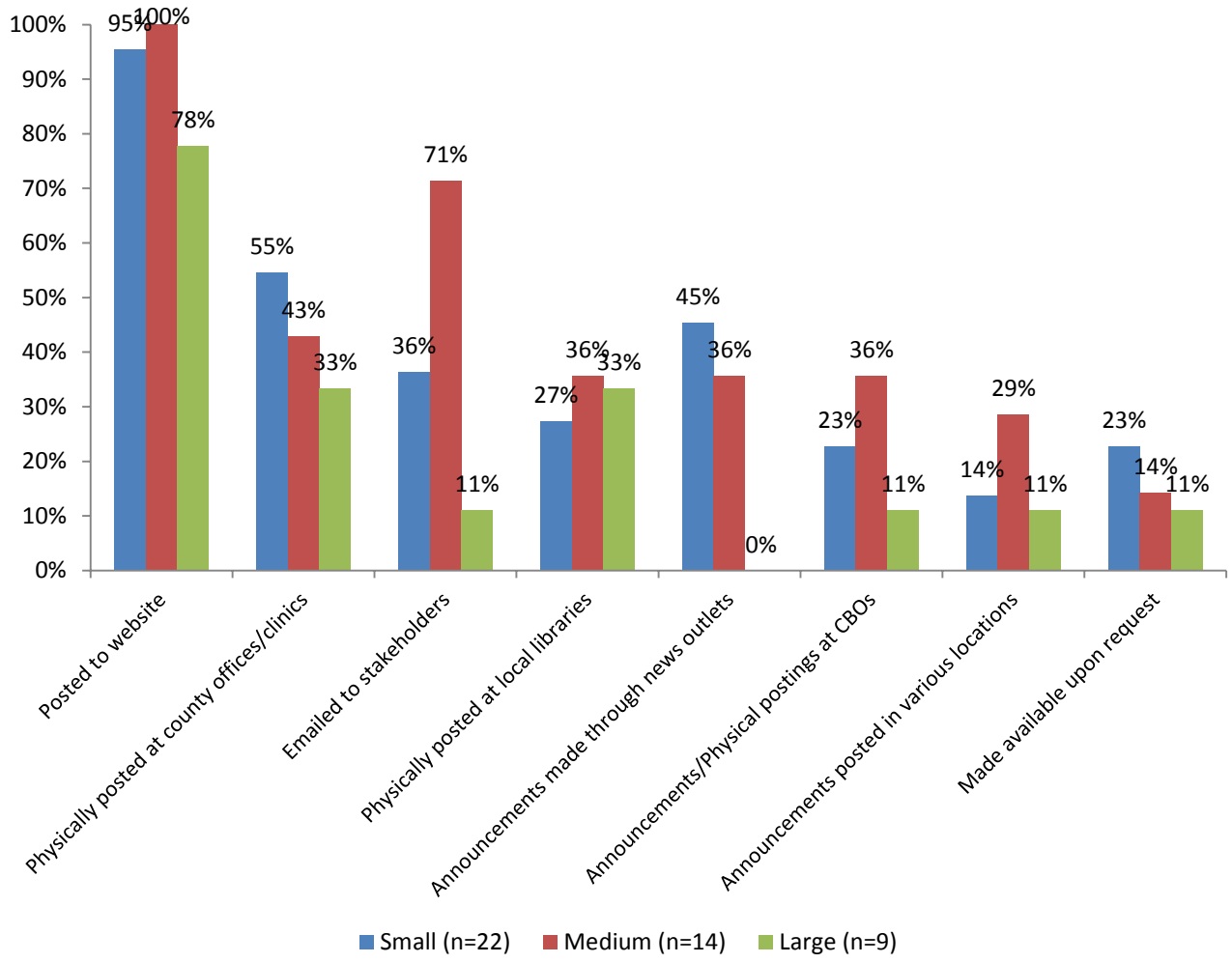
toward the bottom of the list, the top of which was surveys/questionnaires. Twenty-eight counties also reported using surveys or questionnaires to gather stakeholder input; 89% of these counties felt that this was an effective activity. About 83% of the 23 counties that conducted focus groups also felt that this was an effective way to gather stakeholder input. A small Central county MHSA/CPP Coordinator shared that "We had focus groups which were pretty effective in getting people to share their ideas to incorporate into the plan. Also, in the focus groups we would do surveys as a part of the focus groups."

> "Effective activities have included target specific population sites and locations, use of headsets/interpreters; simplifying fliers about the purpose of the meetings; having an email address to continue with input for those that do not submit at a meeting."
>
> – MHSA/CPP Coordinator, Large Central County

Gathering Input for Plan Finalization

One of the specifically required activities of gathering stakeholder input is posting program and expenditure plans for public commenting and approval (WIC 5848). Nearly all 49 counties that posted an MHSA plan in FY2012-13 (96%) explicitly reported a 30-day posting period and only 2% failed to hold a public hearing to collect final input in the finalization of program and expenditure plans. Counties often used multiple methods to post and announce their 30-day commenting periods, but, by far the most frequently used method of plan distribution was through their websites. As shown in Figure 7, large counties used fewer distribution methods than medium and small counties, focusing efforts on the required distribution methods (i.e., post to website, physically post at county offices, and physically post at libraries). Medium counties used a greater quantity of plan distribution methods, most frequently posting to websites (100%) and emailing to stakeholders (71%). Small counties also most frequently posted to websites (95%), but used various other methods at consistently lower frequencies. Compared to the thorough outreach work discussed in the above section of this report, the outreach for these final stakeholder engagement activities seems to be much less thorough with less breadth. Further, counties also indicated that public hearings were the least effective activity in gathering participant input.

Figure 7. Annual Update Distribution Methods in FY 2012-2013 by County Size[μ]



[μ] *SOURCE*: Annual Update Data Request

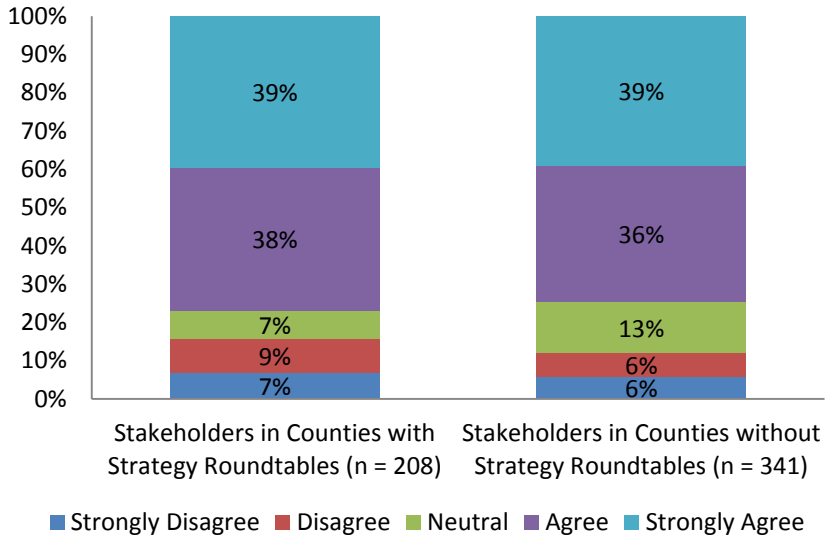
Perceived Value of Stakeholder Participation and Use of Strategy Roundtables

The evaluation team hypothesized that counties that included interactive strategy roundtables in their CPP processes may lead to increased positive perceptions of the value of CPP among participating stakeholders. The rationale behind this hypothesis was that because stakeholders were being meaningfully engaged in the brainstorming of program development as opposed to solely providing input through activities like focus groups, that it would result in greater stakeholder buy-in, therefore resulting in a greater sense of value for CPP processes.

Unfortunately, there was very little variance between CPP participants who responded to the Stakeholder Survey in the 19 counties that used strategy roundtables and those in counties that did not use strategy roundtables.

Respondents in those in counties that had strategy roundtables rated the item, "Stakeholder input was taken into account for planning mental health services in the county" an average of 3.94 (*n* = 208) whereas respondents from counties that did not have strategy sessions rated the statement an average of 3.96 (*n* = 341), on a 1-5 Likert-type scale in which 1 indicated "strongly disagree" and 5 indicated "strongly agree." Figure 8 presents the response details to this item between the two stakeholder groups.

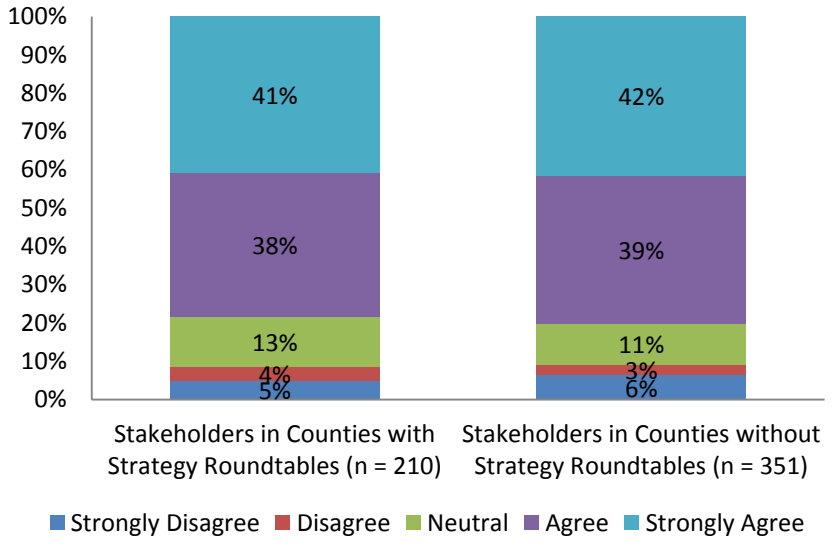
Figure 8. Stakeholder Perceptions of Their Input Being Used between Counties with and without CPP Strategy Roundtables



[δ] *SOURCE*: Stakeholder Survey

In rating the item, "Overall, I found the MHSA CPP process to be valuable," both sets of participants gave an average rating of 4.06. Figure 9 shows the detailed ratings of these items by each set of respondents. Further, an independent samples *t*-test showed no significant differences in how these participants responded to either survey item.

Figure 9. Stakeholder Perceptions of CPP Value between Counties with and without CPP Strategy Roundtables



[δ] *SOURCE*: Stakeholder Survey

Training

While the MHSOAC guidelines for CPP do not require participant training, it was apparent through county and stakeholder feedback that some degree of participant training was likely necessary to enable improved CPP efforts. Therefore, the evaluation team looked at whether or not counties provided training to participate in CPP processes, at what frequency, and which specific trainings would be useful in future practice.

A review of the County Web-Based Data Request showed that that across the state, only 56% of the responding 50 counties stated providing some type of CPP participant training, providing an average of one to two training activities to an average of 107 stakeholders. While 70% of CPP participants that responded to the Stakeholder Survey (*n* = 576) felt that they received enough training to meaningfully participate in CPP activities, county staff felt otherwise.

> "Lack of community understanding in how to provide the information needed [is a barrier to participation]. Most want to have a voice but they are not always on topic. [We need] additional training to the community, a clear plan update agenda outline, and a review of the planning process itself to improve how the community participates to increase learning and responses directed to resolving needs."
>
> – MHSA/CPP Coordinator, Medium Superior County

The most common training activity reported among these counties was the production and distribution of CPP educational materials (57% of counties that provided any kind of training) on a monthly or as-

needed basis, followed by county-specific trainings on participation in the local stakeholder planning process (46%), provided on an as-needed basis or one to three times per year. There was not much variation across regions and county sizes in the types of training activities counties provided, however, the number of provided trainings varied slightly by county size and CMHDA region (see Table 10) in which smaller and more rural counties tended to provide more trainings. Additionally, small and large counties, as well as counties in the Central and Superior regions, provided trainings to considerably more participants than medium counties and counties in the Bay Area, Los Angeles, and Southern regions. These findings were interesting given that in the Stakeholder Survey, FY 2012-13 CPP participants in medium counties cited having the least amount of CPP participation experiences but they reported the greatest level of agreement with receiving adequate training to meaningfully participate; the less active training provided within Bay Area and Southern counties seemed to coincide with having more experienced stakeholders. While a large majority of Southern region participants reported receiving sufficient training to meaningfully participate (73%), Bay Area region participants reported the lowest level of agreement with this statement (59%).

Table 10. CPP Training Efforts and Outcomes

		Average Number of Trainings[ϕ]	Average Number of Training Recipients[ϕ]	Stakeholders Reported Receiving Enough Training to Meaningfully Participate[δ]		Counties Reported Insufficient Participant Training/Knowledge as Barriers[β]	
	n			*n*	*%*	*n*	*%*
Statewide	**28**	**1.43**	**107.36**	**576**	**70%**	**38**	**42%**
Large Counties	10	1.40	106.13	246	69%	13	31%
Medium Counties	9	1.22	42.00	149	70%	15	40%
Small Counties	9	1.67	179.57	181	69%	26	23%
Bay Area Counties	9	1.00	25.14	109	59%	13	15%
Central Counties	8	1.63	154.80	127	71%	17	24%
Los Angeles County	1	1.00	10.00	32	72%	1	100%
Southern Counties	6	1.33	53.50	179	73%	9	44%
Superior Counties	4	2.25	360.33	129	71%	14	36%

[ϕ] *SOURCE*: County Web-Based Data Request
[δ] *SOURCE*: Stakeholder Survey, respondents who reported participating in FY 2012-13 CPP processes
[β] *SOURCE*: County Key Informant Interviews

The dissimilarity in stakeholders' and their counties' perceptions of training needs for meaningful participation in the Bay Area, Southern, and medium counties suggests that counties and stakeholders may have different expectations for participation. Further, the low numbers of trainings, participants reached through training, and proportions of stakeholders feeling adequately trained in the Bay Area region juxtaposed with the county's identity of training and knowledge as a low barrier suggests that counties may not fully understand their stakeholders' needs for participation.

Based on stakeholder and county feedback, some training adjustments that counties and CPP facilitators can make to ensure greater participant understanding include using less jargon to increase accessibility, and providing CPP activities in languages other than English for those with limited English proficiency. Respondents also suggested providing trainings and materials in advance of CPP activities, such as

incorporating participation expectations into standing MHSA meetings and providing printed and multimedia training and background information. Respondents also highlighted NAMI for providing trainings to stakeholders on how to participate in CPP processes, stating that increased opportunities to attend such trainings would be beneficial. Additionally, the evaluation team looked at what factors contributed to a "successful" CPP process. Many of the stakeholder and county responses highlighted preparation activities, such as building safe environments for participation, though this was notably more difficult in smaller and more rural counties, as well as being transparent about how participation will affect program planning and implementation.

Based on these findings, the evaluation team recommends that all counties define their participation expectations and refine participant trainings to match and communicate these expectations as a part of outreach efforts. Further, the evaluation team recommends that the Bay Area counties concentrate more time in planning CPP activities to ensure that stakeholders understand what is required of them, and to provide them with enough information to be able to effectively participate in CPP activities.

Evaluation

While evaluation of CPP processes are not currently an MHSOAC requirement for stakeholder engagement, evaluation is a necessary component of developing promising and evidence-based practices. Thus, the evaluation team sought to learn if and how any counties had been evaluating their CPP processes. Of the 50 counties who responded to the County Web-Based Data Request, 72% reported using one or more types of evaluation measures. These evaluation measures included: collecting participant attendance and demography (47%), administering participant satisfaction survey (39%), and hosting discussions or focus groups to evaluate the process (39%). Across the counties that used CPP evaluation activities, 94% reported using participant attendance and demography data to inform future CPP processes, 86% reported using information from discussions or focus groups, and 79% reported using data from participant satisfaction surveys.

Large counties more frequently reported using discussions or focus groups as a means to evaluate CPP processes (60%), where medium counties reported using them least (29%). This was also the only method Los Angeles reported using to evaluate and improve its CPP processes. All of the large counties that reported using this method of evaluation also reported using the gathered data to improve their future CPP processes, whereas 75% of the medium and small counties from the Bay Area and Superior regions reported using the data to improve their future CPP processes.

About 39% of responding counties reported using participant satisfaction surveys to evaluate CPP processes, however, they also reported using the findings least to improve their future CPP processes (79% of those who used participant surveys reported using findings to inform future CPP processes). A closer look at the data shows that while all the large and medium counties did use participant survey findings to inform future CPP processes, only half of the small counties who evaluated CPP processes using participant surveys actually used the data to inform their future CPP processes. Further, when it came to using evaluation data to inform future CPP processes, small counties reported lower rates of usage than

medium and large counties. This could be due to having relatively fewer human resources to capture and interact with the information—a sentiment echoed throughout smaller counties in all areas of this report.

These findings suggest that counties currently have the capacity to evaluate their CPP processes using participant attendance and demography, as well as to use data from these evaluation measures to improve their future CPP processes. Should the MHSOAC decide to implement a required evaluation component, it is recommended that the MHSOAC first formalize and standardize methods for counties to record participant attendance and demography, providing guidelines for how to use this information to improve future processes.

Stakeholder Perceptions and Satisfaction

In this section, the evaluation team reviews CPP participants' perceptions of how well CPP processes were aligned with MHSA principles and values. The evaluation team also reviews CPP participants' satisfaction with the CPP process and their suggestions for improvement.

MHSA Principles and Values

CCR Title 9 Section 3320 states that counties should adopt the MHSA standards of community collaboration; cultural competence; client-driven activities; family-driven activities; focus on wellness, recovery, and resilience; and integrated services experiences for clients and their families in the planning, implementation, and evaluation of their MHSA programs. Through the stakeholder survey, CPP participants felt that their counties' CPP processes generally adopted these standards, agreeing that CPP meetings were safe (79%), culturally competent (76%), stakeholder driven (72%), and recovery oriented (71%). However, far fewer CPP participants felt that participating in CPP processes increased their trust in the mental health system (62%) or improved their sense of wellness (49%). As a stakeholder from a medium Southern county shared, "It's helped a great deal. Before I attended meetings, I felt stigmatized and knew little about resources. The more meetings I attended, the more connected I became, and I felt better about myself."

Responses to these survey items were consistent among stakeholders from counties of difference sizes, with one exception. When asked to rate their level of agreement with the statement, "Participating in the MHSA CPP process improved my sense of wellness," only 40% of stakeholder respondents from medium counties (n = 151) agreed, 10% less than those from small counties (n = 179) and 14% less than those from large counties (n = 250). A review of the Stakeholder Focus Group data in this area did not indicate the reason for this difference.

Across these measures of adherence to MHSA principles and values, responding stakeholders from Bay Area counties were consistently less positive than stakeholders from other regions, whereas stakeholder ratings from Los Angeles and Southern counties were generally most positive. These less positive ratings from the Bay Area seem to stem from generally lower rates of satisfaction with the CPP process in Bay Area counties. However, a review of the Stakeholder Focus Group data showed no differences between

what Bay Area, Los Angeles, and Southern county stakeholders identify as CPP strengths, challenges, or areas for improvement.

Satisfaction with CPP Processes

Through the Stakeholder Survey and Stakeholder Focus Groups, CPP participants expressed being quite satisfied with the CPP processes. As a stakeholder from a large Bay Area county shared, "Being part of the CPP process taught me that I deserve to be at the table." The general sentiment was that stakeholders were satisfied with how far their counties have come in establishing a CPP process, but that there is room for improvement; as a Focus Group participant from a medium Bay Area county stated, "[I'm] very satisfied and happy, but there is definitely room for improvement with more client voice." In some cases, among smaller counties, participants were sometimes "resentful that the county is wasting resources" (Focus Group, Small Bay Area County Stakeholder). Table 11 shows stakeholder satisfaction ratings from across the state. Again, Bay Area stakeholders who participated in FY 2012-13 CPP processes tended to be less satisfied with the CPP process than stakeholders in other CMHDA regions.

Table 11. Stakeholder Satisfaction with MHSA CPP Processes

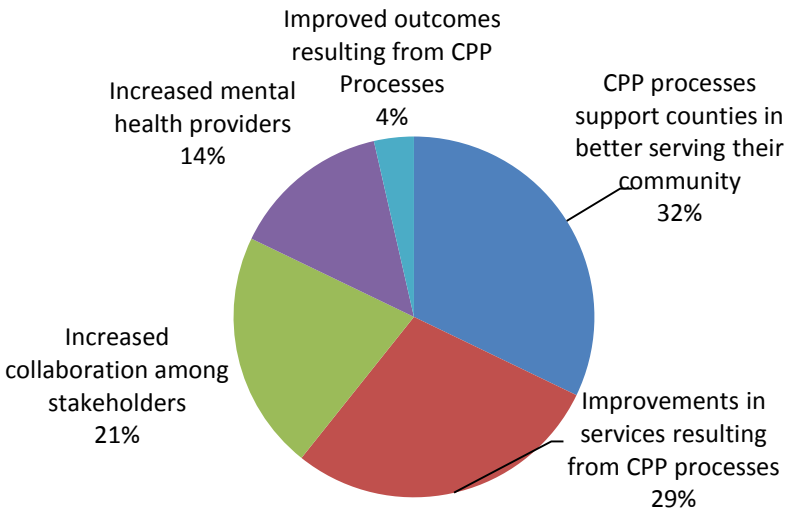
	I found the MHSA CPP process to be valuable [δ]	Overall, I m satisfied with the MHSA CPP process[Δ]
Statewide	**77.3% (*n* = 577)**	**76.6% (*n* = 47)**
Large Counties	78.5% (*n* = 247)	69.2% (*n* = 13)
Medium Counties	75.7% (*n* = 148)	92.3% (*n* = 13)
Small Counties	76.9% (*n* = 182)	71.4% (*n* = 21)
Bay Area Counties	60.7% (*n* = 110)	81.8% (*n* = 11)
Central Counties	77.3% (*n* = 128)	61.5% (*n* = 13)
Los Angeles County	90.6% (*n* = 32)	100.0% (*n* = 1)
Southern Counties	80.6% (*n* = 180)	77.8% (*n* = 9)
Superior Counties	76.2% (*n* = 130)	84.6% (*n* = 13)

[δ] *SOURCE*: Stakeholder Survey, respondents who reported participating in FY 2012-13 CPP processes
[Δ] *SOURCE*: Stakeholder Focus Groups, *n* accounts for total number of focus groups

A closer look at the satisfaction data showed that Stakeholder Survey respondents who participated in FY2012-13 and identified as county mental health department staff reported significantly higher levels of agreement with the statement, "Overall, I found the MHSA CPP process to be valuable," than those who did not identify as county mental health department staff ($t(557) = -2.83$, $p < 0.1$). This suggests that county mental health department staff may find value in participating that applies beyond their personal experience. As much of the CPP process includes a review of service needs and gaps in county mental health services, participants who work in county mental health departments may draw additional value that informs how they conduct work moving forward. This inference is supported by the Stakeholder Focus Group data in which participants 32% of the focus groups agreed that CPP processes support counties in better serving their communities (see Figure 10).

Figure 10. Reasons Identified for Stakeholder Satisfaction with CPP Processes

(n = 28)[Δ]



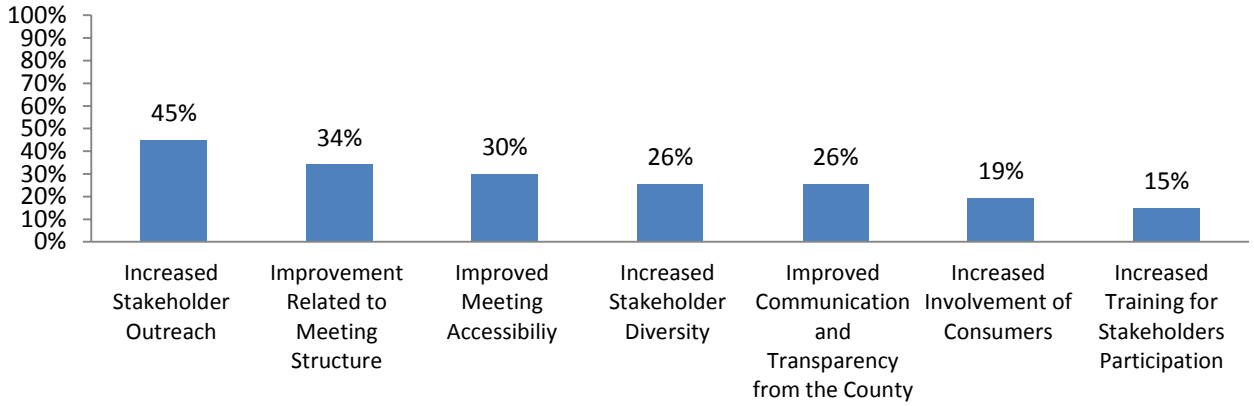
[Δ] *SOURCE*: Stakeholder Focus Groups

When asked what could be improved about CPP processes moving forward, Stakeholder Focus Group participants suggested increasing outreach to more and diverse stakeholder groups. A focus group in a medium Bay Area county recommended that counties "Include more consumers in leadership, in planning processes, in policy decision making. Reach out through peer-led centers and wellness centers, and invite more agencies to be included in planning." Many of the focus groups also recommended improving the CPP meeting structure so that the planning process is more transparent, welcoming, safe, and meaningful. A participant from a large Bay Area stakeholder focus group suggested that counties "Create an introduction sheet for 'new people' and have explanations regarding when and where one can share feedback. Have small support groups because they are how you make consumers and family members feel more safe and comfortable."

> "Show how feedback is utilized. Be transparent in usage of funds. Be more open to feedback. Don't wait to share information—share it at the beginning of the planning process. Teach consumers how to participate in CPP. More and better trained staff. Hands-on kind of workshops."
> – Stakeholder Focus Group Participant, Small Superior County

Figure 11. Stakeholder Suggestions for Future Improvement of CPP Processes

(n = 47)[Δ]



[Δ] *SOURCE*: Stakeholder Focus Groups

Differences in CPP Satisfaction between Stakeholder Groups

The evaluation team ran a series of independent samples *t*-tests (one for each stakeholder affiliate group) to determine if any stakeholder groups experienced significantly different levels of CPP process satisfaction when compared to all other stakeholder groups. To measure satisfaction, survey respondents were asked to rate their level of agreement with the statement, "Overall, I found the MHSA CPP process to be valuable," on a Likert-type scale of 1-5 wherein 1 indicated "strongly disagree" and 5 indicated "strongly agree." Overall, the survey respondents generally agreed with this statement (M = 4.06, SD = 1.08) [19] with only one stakeholder group reporting a significantly different level of agreement.

An independent samples *t*-test showed significant difference in how strongly survey respondents agreed with the statement, "Overall, I found the MHSA CPP process to be valuable," between respondents who identified as county mental health department staff and those who did not ($t(557) = -2.83$, $p < 0.1$)[20], such that respondents who identified as county mental health department staff reported greater levels of agreement (M = 4.33, SD = 0.10) than those who did not identify as county mental health department staff (M = 4.00, SD = 0.05).

[19] *M* indicates mean score, the average of all respondents' ratings. *SD* indicates standard deviation, which reports the extent to which all respondents deviate from the total mean score.

[20] This is the standard method of reporting a significant result of an independent samples *t*-test in which the *t*-ratio, is the ratio of difference between the two population (e.g., staff member vs. non-staff member) means. Additionally, the *p* represents the alpha level, or the probability of generating a false-positive result. The standard accepted alpha level is .05 (5%) or below.

Participant Impacts

The evaluation team asked participants how the CPP processes affected their sense of empowerment, hope, self-determination, social connection, wellness, and recovery as well as their trust in and collaboration with the PMHS.

When asked if participating in the CPP process improved their sense of wellness, Stakeholder Focus Group and Survey respondents were in mild agreement. Across both the Stakeholder Focus Groups and the Stakeholder Survey, respondents from Bay Area counties expressed the least amount of agreement with this statement while respondents from Los Angeles and Southern counties reported the greatest levels of agreement. These findings suggest that CPP participation has a mild effect on improving stakeholders' sense of wellness. As there were no direct relationships between participation and wellness, this may be difficult to accurately measure—reviewing mediating factors may lead to a more conclusive understanding of how CPP participation affects stakeholder wellness. Therefore, the evaluation team reviewed wellness in correlation to other participation factors, including accessibility of CPP meetings, safety in participation, consistency of meeting adherence to MHSA principles, sufficiency of participant training, and participants' perception of contribution to improving services. These factors proved to be significant in influencing participants' perception of wellness and recovery. The most impactful factor was the consistency of CPP meeting adherence to MHSA principles, suggesting that the more CPP activities are aligned with MHSA principles, the more positive impact the activities will have on participants' wellness. These findings are discussed in greater detail in the *Findings from the Outcome Evaluation* section immediately proceeding this section.

When asked if participating in the CPP process improved their trust in the PMHS, the majority of Stakeholder Survey respondents (62%) reported some level of agreement. These results mirrored those of wellness wherein respondents from Bay Area counties reported the lowest levels of agreement and respondents from Los Angeles and Southern counties reported the highest levels of agreement. Again, these findings suggest that CPP participation has a mild effect on improving stakeholders' trust in the PMHS. The evaluation team also looked at how mediating factors (accessibility of CPP meetings, safety in participation, consistency of meeting adherence to MHSA principles, sufficiency of participant training, and participants' perception of contribution to improving services) impacted participants' trust in the PMHS. As with wellness, the combination of these factors had a significant impact on participants' trust in the PMHS. The combination of factors actually impacted trust in PMHS more than it impacted participant wellness. In predicting trust, participants' perception of contributing to the PMHS was the most impactful factor in generating trust in the PMHS, suggesting that the more participants felt that they were contributing to programming and service delivery design, the more they their trust in the PMHS grew. These findings are discussed in greater detail in the *Findings from the Outcome Evaluation* section immediately proceeding this section.

Additionally, the evaluation team asked participants if they agreed that CPP processes were recovery-oriented. Generally, stakeholders across the state agreed that their counties' CPP processes were recovery-oriented, with some variances between CMHDA regions and county sizes. Large counties tended to have more agreement that their CPP processes were recovery-oriented. This was reflected in Los

Angeles and Southern counties, the regions with the greatest levels of agreement. However, this was not reflected among Bay Area counties, whose stakeholders expressed the least amount of agreement.

Table 12. Stakeholders' Perception of CPP Recovery Orientation

The CPP process was recovery oriented	*n*	% Stakeholder Who Responded "Agree" or "Strongly Agree [δ]
Statewide	**575**	**71%**
Large Counties	246	74%
Medium Counties	149	68%
Small Counties	180	69%
Bay Area Counties	109	60%
Central Counties	126	72%
Los Angeles County	31	84%
Southern Counties	181	75%
Superior Counties	128	70%

[δ] *SOURCE*: Stakeholder Survey

The evaluation team thus recommends that to maximize positive impacts on participants' wellness and trust in the PMHS, counties and activity facilitators should take care to make CPP activities accessible to participants—including establishing a safe environment free of stigma and providing adequate training so that participants know how and why they are participating—and to design activities in alignment with MHSA principles such as recovery orientation, and to be explicit about how participant input will be used to inform programming and service delivery.

Mental Health System Impacts

To review the impacts that CPP has on the PMHS, the evaluation team asked counties and their stakeholders how the county's administration of the CPP processes affected mental health policy and program development and the extent to which the CPP processes impacted trust and collaboration among mental health service providers and other health and human service providers.

Responses from counties and stakeholders demonstrate that CPP processes have resulted in increased stakeholder input in program planning and development, from planning to evaluation. The respondents reported a stronger voice among stakeholders, resulting in strengthened communication between counties and their stakeholders. The respondents also reported that CPP processes have resulted in establishing a better understanding of the needs and gaps in service delivery for underserved communities, leading to the development of effective and targeted programming for the underserved, especially among large counties. A stakeholder from Los Angeles county shared, "We have seen a lot of transformation: a huge impact that has improved the whole system in terms of communication, collaboration and better and more services. The 'no wrong door' approach had helped build deeper relationships and partnerships."

Moreover, stakeholders highlighted the shift toward a more community-driven approach that emphasizes wellness, recovery, and resiliency rather than focusing on illness. Small counties particularly stressed how the CPP process had resulted in greater awareness of mental health services and mental health within the general public. A small Central county MHSA/CPP Coordinator elaborated on this saying, "I think we have shifted to providing services in the community more. We are looking for ways to have community based services, home visits and case management services; we are not expecting people to come in to them for services." For these counties, stakeholders and county staff shared that community-based programming has been most effective in engaging the broader community and reducing stigma.

The evaluation team also found that the CPP processes have led to increased trust and collaboration between mental health providers, other health and human service providers, and consumers and their family members. Stakeholder and county responses indicated that CPP processes had helped break up silos between providers and cultivate communicative working relationships in which providers work together and with their consumers to build innovative projects. A medium Southern county MHSA/CPP Coordinator stated that "With PEI and subsequent stakeholder processes, we worked to find ways to get people to collaborate. We established a providers' network which really took off. We try to create common activities." Among counties who had been able to reach and engage other stakeholder groups (e.g. law enforcements, educators, faith-based organizations, etc.), the CPP processes had brought more awareness to issues of mental health, decreasing stigma, and increasing the appropriateness of other programs interacting with individuals and families with mental illness. For instance, several counties had reported that other agencies had worked with county mental health services to develop staff and community trainings to increase awareness and knowledge about mental health. A large Southern county MHSA/CPP Coordinator reported that the county's CPP processes had resulted in the development of several collaborative programs across agencies, including "One stakeholder-generated program, the Community Response Team, in which law enforcement and mental health 'work hand-in-hand' on crisis intervention." Similarly, a small Central county MHSA/CPP Coordinator reported, "A lot of networking with the faith based community to educate these groups on the importance of getting training and education about resources to serve their communities. It is helping reduce stigma and there has been increased dialogue and education through these groups to the community. They have an increased group of participants in prevention, enhanced community collaborations in unexpected ways that are beneficial to the community."

While the CPP processes have been successful at improving these relationships, counties reported the remaining difficulties collaborating with various other community partners—they have acknowledged increased law enforcement and educator involvement but expressed that more work needs to be done to foster these and other relationships. This struggle was more commonly expressed among smaller counties in which human resources are already quite limited. To address this, a small Central county MHSA/CPP Coordinator said, "We are exploring doing a community needs assessment in collaboration with other community organizations, First 5, community foundation, social services and a couple of other government agencies and community based non-profits, to help us see the bigger picture of the needs of their community and how to meet those needs more effectively and collaboratively."

These findings suggest that including consumers and their family members in program planning, implementation, evaluation, and decision making had been essential in developing their buy-in, trust, and use of PMHS services. The evaluation team recommends that counties continue to involve consumers and their family members in all aspects of MHSA program development. The MHSOAC guidelines for involving various other community stakeholders in CPP processes have also brought on positive changes, including the seamlessness of service provision across providers. The evaluation team also recommends that counties continue to require representation from other health and human service providers in all aspects of MHSA program development.

Extent to which CPP Activities Affect the Public Mental Health System

Stakeholders and counties described ways that CPP processes supported system changes that bettered MHSA principles in the PMHS. . The information presented here refers to the five MHSA principles:

Cultural Competency: Stakeholders noted that CPP participation served mental health departments by supporting counties efforts to better outreach and engage the various communities they serve. Counties noted that CPP participation helped them better understand perceptions and needs of various specific minority groups.

Community Collaboration: Both counties and stakeholders noted more collaboration overall. Stakeholders and counties described how engagement at CPP meetings led to increased trust among stakeholders as well as new partnerships between stakeholders, providers, and the mental health department. A discussion of inter-agency collaboration immediately proceeds this section.

Integrated Services Experience: Some counties and stakeholders noted new partnerships between primary care and mental health services. Additionally, stakeholders and counties noted how CPP processes facilitated better collaboration and new partnerships between mental health departments and criminal justice, public health, education, and probation departments. For criminal justice, counties noted an increase in mental health training for law enforcement, correctional, and probation officers that resulted from CPP planning.

Family- and Client-Driven: Stakeholders and counties agreed that their counties' CPP processes led to system changes that bettered the family- and client-driven principle in their counties. Stakeholders and counties described how CPP participation created a deeper sense of understanding and empathy towards lived experience of people with mental issues among county officials, family members, providers, and the community at large. Stakeholders noted that CPP processes led to greater support networks for family members by providing them with a better understanding of the services and supports that are available. Counties and stakeholders also agreed that the CPP processes helped create a sense among family members and consumers that they belong at CPP processes. It was also noted that CPP processes facilitated an increased dialogue with families about mental health issues, recovery, and stigma.

Recovery-Oriented: Stakeholders and counties believed that their counties' CPP processes had furthered the understanding of the recovery vision in their communities. Stakeholders who participated in CPP processes described having a greater sense of self-worth and efficacy after participating. Counties and

stakeholders noted how participation in the CPP processes by stakeholders and community members created a ripple effect in the community of awareness of mental health issues, hope, and recovery.

Impact of CPP Activities on Increased Inter-agency Collaboration

Counties and stakeholders described how collaborative planning between stakeholders from different disciplines and department increased and improved integration of mental health services with other disciplines and led to a more seamless service delivery model or "no wrong door" approach. Counties and stakeholders also felt that participation of new stakeholders from other departments and disciplines resulted in a greater understanding of mental illness, mental health issues, and services among a larger and more diverse pool of community members. Counties described how new partnership with other departments and disciplines resulted in liaisons in other departments to provide mental health technical assistance and foster better collaboration between departments. In addition, counties and stakeholders noted a positive impact of inviting new and diverse stakeholders from non-government institutions, such as faith-based communities, to participate in CPP.

Collaboration with Criminal Justice Departments: Counties and stakeholders felt that participation of stakeholders from criminal justice departments created positive relationships between law enforcement and mental health departments, reduced stigma about mental health among law enforcement, and increased capacity of criminal justice departments to positively interact with members of the community that have mental illness. Counties and stakeholders described ongoing and discrete activities that resulted from CPP that supported these improvements including collaborative courts, coordination between probation and mental health departments around discharge planning, and mental health training for correctional and probation officers.

Collaboration with Educational Departments: Counties and stakeholders described an increase in the school based programs that resulted from increased collaboration between education and MHSA stakeholders at CPP meetings. They also noted how the ongoing participation of education stakeholders had created a unified understanding on mental health needs in schools and on campuses. In one county, CPP activities that involved stakeholders from the education department created an opportunity to integrate the recovery model into teacher trainings to further their capacity to understand a student's behavioral problems.

Collaboration with Public Health Departments: Counties and stakeholders described how CPP participation resulted in greater collaboration and integration of public health and mental health services. This had created opportunities to pool resources, identify service gaps, and share information to best serve clients.

Collaboration with Non-Governmental Institutions: Both counties and stakeholders described how the participation of stakeholders from faith-based groups led to collaboration with churches in addressing mental health issues in communities. Stakeholders and counties also noted that involvement of stakeholders from churches had created opportunities to outreach to a larger community, reduce stigma among church members, and support recovery. It was also mentioned that stakeholders from churches were going back to their church groups and educating their members about mental health issues.

Counties and Stakeholder also felt that CPP participation had fostered better collaboration with providers in the community. Stakeholders noted that when providers and consumers worked collaboratively together, it changed how providers viewed clients and vice versa.

Perceptions of the Broader Community Impacts

As community-driven and publically-funded work, the CPP process inevitably affects the broader community. To understand the impacts, the evaluation team asked counties and stakeholders to describe some of the ways that the CPP process impacts the community's perception of the PMHS as it relates to stigma and outcomes. Overall, respondents felt that MHSA efforts and CPP activities had positive impacts on the broader community, bringing more awareness to mental health and reducing stigma against mental illness. About 77% of responding counties and 50% of responding stakeholders felt that CPP had a positive impact on the community's perception of mental health services and mental illness. A stakeholder from a small Central county expressed this during an interview, stating that "since MHSA, the public's perceptions have improved and people are more easily engaged and willing to participate in planning processes and developing partnerships in the community."

Among the positive impacts that CPP processes have brought to communities, counties and stakeholders cited that it has helped most often through outreach and engagement efforts. Overall, counties were more optimistic about CPP activities' impacts on the broader community than stakeholders. For example, there was some discrepancy between stakeholders and counties about the effectiveness of promoting mental health awareness through community-based activities, wherein over a third of responding counties (35%) felt that the activities were effective and only 13% of responding stakeholders agreed. The positively weighted responses from counties perhaps represent their optimism for impact.

> "It is my hope that through CPP processes and through making myself available at all times to listen, take input and answer questions from community members and stakeholders, that the public's perception of Mental Health and MHSA funded services is one that shows transparency, openness, collaboration, inclusiveness and reduces stigma and discrimination for people with mental illness."
>
> – MHSA/CPP Coordinator, Small Bay Area County

Table 13. County and Stakeholder Perceptions of How CPP Activities Impacted Community Perceptions of Mental Health Services and Mental Illness[21]

	Stakeholder Focus Groups[Δ]	County Key Informant Interviews[β]	Overall
Statewide	***n* = 30**	***n* = 52**	***n* = 82**
Increased Outreach and Engagement about Mental Health Services and Issues	37%	37%	37%
Community-Based Activities to Promote Mental Health Awareness	13%	35%	27%
Opportunities to Share Lived Experiences of Mental Illness	23%	27%	26%
Increased Access to Services	13%	25%	21%
Integration of Mental Health Services into Other Disciplines	13%	23%	20%
Large Counties	***n* = 8**	***n* = 15**	***n* = 23**
Increased Outreach and Engagement about Mental Health Services and Issues	38%	13%	22%
Community-Based Activities to Promote Mental Health Awareness	13%	27%	22%
Opportunities to Share Lived Experiences of Mental Illness	25%	20%	22%
Increased Access to Services	0%	27%	17%
Integration of Mental Health Services into Other Disciplines	25%	13%	17%
Medium Counties	***n* = 12**	***n* = 23**	***n* = 35**
Increased Outreach and Engagement about Mental Health Services and Issues	33%	22%	26%
Community-Based Activities to Promote Mental Health Awareness	8%	22%	17%
Opportunities to Share Lived Experiences of Mental Illness	25%	22%	23%
Increased Access to Services	25%	9%	14%
Integration of Mental Health Services into Other Disciplines	8%	26%	20%
Small Counties	***n* = 10**	***n* = 38**	***n* = 48**
Increased Outreach and Engagement about Mental Health Services and Issues	40%	32%	33%
Community-Based Activities to Promote Mental Health Awareness	20%	24%	23%
Opportunities to Share Lived Experiences of Mental Illness	20%	16%	17%
Increased Access to Services	10%	18%	17%

[21] Responses from the Los Angeles region were generally positive, but respondents did not cite specific examples. Therefore, the region is not included in this table.

Integration of Mental Health Services into Other Disciplines	10%	11%	10%
Bay Area Counties	***n* = 4**	***n* = 16**	***n* = 20**
Increased Outreach and Engagement about Mental Health Services and Issues	25%	19%	20%
Community-Based Activities to Promote Mental Health Awareness	25%	25%	25%
Opportunities to Share Lived Experiences of Mental Illness	25%	38%	35%
Increased Access to Services	0%	0%	0%
Integration of Mental Health Services into Other Disciplines	25%	19%	20%
Central Counties	***n* = 12**	***n* = 25**	***n* = 37**
Increased Outreach and Engagement about Mental Health Services and Issues	25%	28%	27%
Community-Based Activities to Promote Mental Health Awareness	25%	32%	30%
Opportunities to Share Lived Experiences of Mental Illness	25%	12%	16%
Increased Access to Services	25%	8%	14%
Integration of Mental Health Services into Other Disciplines	0%	20%	14%
Southern Counties	***n* = 9**	***n* = 17**	***n* = 26**
Increased Outreach and Engagement about Mental Health Services and Issues	44%	18%	27%
Community-Based Activities to Promote Mental Health Awareness	0%	18%	12%
Opportunities to Share Lived Experiences of Mental Illness	22%	18%	19%
Increased Access to Services	11%	29%	23%
Integration of Mental Health Services into Other Disciplines	22%	18%	12%
Superior Counties	***n* = 5**	***n* = 18**	***n* = 23**
Increased Outreach and Engagement about Mental Health Services and Issues	60%	33%	39%
Community-Based Activities to Promote Mental Health Awareness	0%	17%	13%
Opportunities to Share Lived Experiences of Mental Illness	20%	11%	13%
Increased Access to Services	0%	33%	26%
Integration of Mental Health Services into Other Disciplines	20%	6%	9%

[Δ] *SOURCE*: Stakeholder Focus Groups, *n* accounts for total number of focus groups
[β] *SOURCE*: County Key Informant Interviews

Conversely, stakeholders more often cited increased outreach and engagement activities as having a positive impact on the community than counties. This could be because stakeholders are feeling seen and heard when outreach is conducted and non-consumer stakeholders are also engaged. A stakeholder from a small county in the Superior region shared that "The community has been meeting people with mental illness and this has given people an opportunity to have greater understanding and see them as people with other strengths."

Stakeholders and counties indicated that this opportunity to bring together diverse groups of stakeholders in a collaborative process in which they might not have otherwise interacted has been a positive side effect of CPP activities. A stakeholder from a large Southern county stated that "We've been given the opportunity to learn about each other and share knowledge." Another impact both counties and stakeholders noted was that CPP has helped the broader community increase their understanding of and trust in outcome-driven planning and evaluation of mental health services. A medium Central county MHSA/CPP Coordinator said, "Doing what we say we are going to do and providing an evaluation (even self-evaluation) on what we are doing creates trust in the process and makes the community at large believe in what we're doing."

Among the few stakeholders (4%) that felt that their counties' MHSA efforts and CPP processes had been detrimental, their concerns were about the counties involving clients and family members as token voices only as required by MHSOAC guidelines. Stakeholder Focus Group members from a large Southern county explained that they felt the county was unintentionally creating stigma by targeting consumers and family members by "offering limited and non-impactful access to participation for client, family member and community based stakeholders."

Overall, the increased visibility of how programs were developed and funded had resulted in greater awareness of services, increased understanding of community impacts, and improved trust of the PMHS throughout the broader community. These findings suggest that proactively reaching and engaging diverse stakeholders and providing safe environments in which they can learn about each other and work together toward a common goal increases trust and collaboration while reducing stigma.

Stakeholders Who Did Not Participate in CPP Process

Stakeholders who did not participate in CPP process in FY2012-13 and those who have never participated in a CPP process reported the best methods to reach them, incentives they would like to have in return for participation, and barriers to their CPP participation. The demography for these respondents were similar to those who did participate in FY2012-13 CPP processes, with a slightly higher representation of stakeholders in the 25–59 age range (12% more) and in the Central region (12% more), and slightly lower representation of stakeholders who identified as White (12% less).

Table 14. Stakeholder Survey Demographics of Non-CPP Participants vs. CPP Participants[δ]

	Did Not Participate	Did Participate
County Size	***n* = 757**	***n* = 595**
Small	20%	31%
Medium	27%	26%
Large	53%	43%
CMHDA Region	***n* = 757**	***n* = 595**
Bay Area	19%	19%
Central	30%	22%
Los Angeles	9%	6%
Southern	32%	31%
Superior	10%	22%
Age Range	***n* = 697**	***n* = 507**
18 – 24	6%	3%
25 – 59	76%	64%
60 or older	18%	33%
Gender	***n* = 689**	***n* = 503**
Male	71%	72%
Female	28%	27%
Transgender/Other	1%	1%
LGBTQI Orientation	***n* = 561**	***n* = 414**
Yes	9%	9%
No	91%	91%
Race/Ethnicity	***n* = 693**	***n* = 502**
Asian/Filipino/Pacific Islander	7%	3%
Black/African American	9%	6%
Latino/Hispanic	17%	12%
Tribal/Native American	4%	3%
Two or More Races	5%	5%
White	55%	67%
Other	3%	4%
Language Spoken at Home*	***n* = 653**	***n* = 482**
English Only	91%	96%
Language(s) Other Than English	5%	2%
English and Another Language	4%	2%

*Estimated proportions
[δ] *SOURCE*: Stakeholder Survey

Across the state, the stakeholders who did not or had never participated in their counties' CPP processes (*n* = 724) reported that emails (70%) were the top format in which they would like to receive MHSA information and CPP invitations, followed by notification through flyers, posters, and brochures (49%). This was true across all five CMHDA regions and in counties of all sizes. Stakeholders from small (35%, *n* = 135) counties, and those in the Central (34%, *n* = 220) and Superior (29%, *n* = 70) regions, also identified phone calls as an effective outreach method. Meanwhile, medium (27%, *n* = 195) and large (31%, *n* = 394)

counties, as well as those from the Bay Area (33%, *n* = 134), Los Angeles (45%, *n* = 66), and Southern (29%, *n* = 234) regions, reported that referrals from the mental health department were effective.

Across the state, within all CMHDA regions and county sizes, stakeholders (*n* = 704) identified the top three barriers to participation as: inconvenient meeting times (60%), inaccessible meeting locations (42%), and not having enough knowledge or training to be able to participate (26%). When asked what barriers there were to CPP participation, a stakeholder from Los Angeles said, "[I am] uncomfortable going to new locations and [I did not have] enough knowledge about meeting." When asked which types of incentives would encourage them to participate, the responding stakeholders reported a varied set of incentives: providing meals at meetings (47%), multiple meeting times (43%), stipends or financial incentives (33%), and transportation to meetings (32%). At the bottom of the list for incentives among these participants, however, were translation and interpretation services (6%).

Based on these findings, while the responding stakeholders who did not participate in their counties' CPP processes were not distinctly different from stakeholders who did participate in their counties' CPP processes, they may experience different barriers and have different motivations for CPP participation. As several of the barriers and incentives seem related (e.g. timing and accessibility), counties may consider studying these stakeholders' time and location preferences, piloting events at different and multiple times and locations, and providing transportation modalities for prospective CPP participants. For instance, a stakeholder from a large Southern county suggested, "[We] should have meetings after 5 p.m. and on weekends."

Outcome Evaluation Findings

In this section of the report, the evaluation team reports on which CPP activities demonstrated a significant correlation with CPP outcomes. For the purposes of this analysis, CPP activities were limited to four distinct categories, including outreach activities, incentives, stakeholder trainings, and input activities. Each of these categories is described below.

- Outreach Activities: Announcements at meetings; Post flyers/posters/brochures; Emails to list-serve; Phone calls/invitations by Mental Health Department staff; Print announcements (i.e., newspapers), Social media, and Radio/TV announcements.

- Incentives: Transportation to meetings; Transportation vouchers; Meals at meetings; Multiple meeting times; Stipends/other financial incentive; Childcare; Continuing education credits; Translation/interpretation services; and Meetings in languages other than English.

- Stakeholder Trainings: Produce and distribute CPP educational materials; Offer professional development or continuing education credits; Voting or prioritization activities; County specific trainings on participation in the local stakeholder planning process; and Support for participants to attend training not sponsored by the county.

- Input Activities: Surveys/questionnaires; Focus groups; Town hall/community meetings to gather input; Public hearings; Key informant interviews; Suggestion boxes; Stakeholder steering Committee/stakeholder planning committee; Strategy roundtables/strategizing sessions; Voting or prioritization activities; and Community meetings and town hall meetings to plan, prioritize, or make decisions.

The outcomes considered were limited to those outcomes that had data of sufficient quality and quantity to permit statistical testing, and include the nine variables listed and described below:

1. CPP Meeting Effectiveness: To measure *CPP meeting effectiveness*, survey respondents were asked to rate their level of agreement with the following statements on a Likert-type scale of 1-5 wherein 1 indicated "strongly disagree" and 5 indicated "strongly agree":
    - MHSA CPP meetings were well organized;
    - MHSA CPP facilitators were well-prepared to lead meetings/activities; and
    - The MHSA CPP meetings were in a language that I speak/understand.
2. Recovery Orientation: To measure *recovery orientation*, survey respondents were asked to rate their level of agreement with the statement, "The CPP process was recovery oriented."
3. Participation Safety: To measure *participation safety*, survey respondents were asked to rate their level of agreement with the statement, "I felt safe participating in the MHSA CPP process."

4. Participant Training: To measure *participant training*, survey respondents were asked to rate their level of agreement with the statement, "I received enough training/info to meaningfully participate."

5. Perception of Contribution: To measure *perception of contribution*, survey respondents were asked to rate their level of agreement with the statement, "Stakeholder input was taken into account for planning mental health services in the county."

6. Respect of Participant Opinions and Culture: To measure *respect of participant opinions and culture*, survey respondents were asked to rate their level of agreement with the statements, "My opinions were respected and listened to," and "The MHSA CPP facilitators respected my culture."

7. Participant Satisfaction: To measure *participant satisfaction*, survey respondents were asked to rate their level of agreement with the statement, "Overall, I found the MHSA CPP process to be valuable."

8. Participant Wellness: To measure *participant wellness*, survey respondents were asked to rate their level of agreement with the statement, "Participating in the MHSA CPP process improved my sense of wellbeing."

9. Trust in the Public Mental Health System: To measure *trust in the public mental health system*, survey respondents were asked to rate their level of agreement with the statement, "Participating in the MHSA CPP process increased my trust in the mental health system."

The first six variables were identified as emerging themes from qualitative data, and were then mapped to available quantitative data from the Stakeholder Survey to permit further analysis. Variables seven through nine were identified from the logic model as desired outcomes for a CPP process. In the regressions analysis phase of this evaluation, the first six variables identified from the qualitative data were the independent variables and served to identify the relationships between the first six variables and the last three variables of CPP participants' reports of satisfaction, wellness, and trust in the public mental health system as a result of CPP participation, which served as the dependent variables for the regressions. These regressions allowed the evaluation team to confirm that the first six variables identified through the qualitative data were significant in contributing to the positive CPP outcomes of satisfaction, wellness, and trust in the public mental health system.

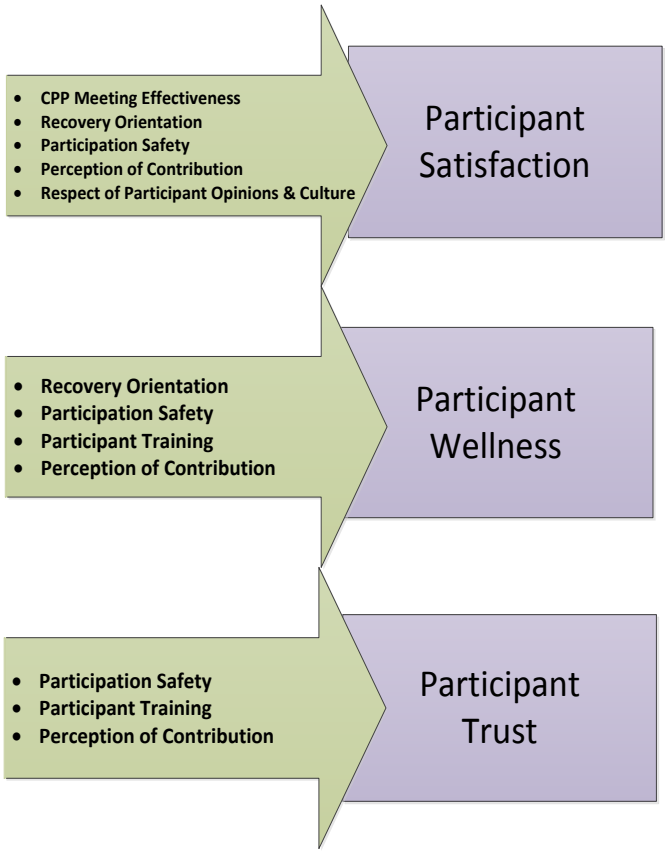
Once the evaluation team determined that the six variables identified from the qualitative data were significant to producing positive CPP outcomes, the evaluation team then ran a series of correlations to determine what specific CPP activities were correlated with any of the nine variables listed above.

Based on the relationships found between CPP practices and outcomes, the evaluation team prepared a series of recommendations for improving the CPP process. However, the evaluation team understands that there are a number of limitations in our approach to analysis and the section immediately following highlights those known limitations.

Relationships between CPP Outcomes

Figure 12 shows the significant relationships found between the variables identified from the qualitative data with the variables listed as CPP outcomes in the logic model. The subsequent sections provide additional detail about the relationships between CPP outcomes.

Figure 12. Relationships between CPP Outcomes



Predicting CPP Participant Satisfaction

To assess satisfaction, survey respondents were asked to rate their level of agreement with the statement, "Overall, I found the MHSA CPP process to be valuable." This was measured on a Likert-type scale of 1-5 wherein 1 indicated "strongly disagree" and 5 indicated "strongly agree."

The equation predicting CPP participation satisfaction was supported with CPP meeting effectiveness, recovery orientation, participation safety, perception of contribution, and respect of participant opinions and culture identified as significant contributors to participant satisfaction. The equation accounted for

77% of the variance[22] in satisfaction ratings with participants' perception of contribution as the largest contributor, accounting for 11% of the variance in satisfaction ratings.

Technical Report of Findings: The predictive model for CPP participant satisfaction was significant, accounting for 76.6% of the variance in satisfaction ($F(6,457) = 254.00$, $p < .001$; adjusted R Square = .77)[23]. In this model, all the variables, except participant training were significant predictors. Perception of contribution accounted for 10.89% of the variance when all other factors were held constant (beta = .29, $p < .001$; partial $r = .33$)[24]. Recovery orientation accounted for 6.92% of the variance when all other factors were held constant (beta = .22, $p < .001$; partial $r = .26$). CPP meeting effectiveness accounted for 5.02% of the variance when all other factors were held constant (beta = .22, $p < .001$; partial $r = .22$). Participation safety accounted for 2.07% of the variance when all other factors were held constant (beta = .12, $p < .01$; partial $r = .14$). Respect of participant opinions and culture accounted for 1.69% of the variance when all other factors were held constant (beta = .06, $p < .01$; partial $r = .13$).

Table 15. Multiple Linear Regression Analysis for Variables Predicting Participants' Satisfaction with MHSA CPP process (*n* = 463)

Variable	*B*	*SE B*	β
CPP Meeting Effectiveness	.28	.06	.22***
Recovery Orientation	.24	.04	.22***
Participant Safety	.12	.04	.12**
Participant Training	.01	.04	.01
Perception of Contribution	.27	.04	.29***
Respect of Participant Opinions and Culture	.16	.06	.14**
R^2		.77	
F		254.00	

*$p < .05$, **$p < .01$, ***$p < .001$

Given these findings, it is clear that the factors of CPP set-up, facilitation, and outputs affect participants' level of satisfaction with CPP participation. It is important to leverage these variables to maximize the positive participant outcomes. The significant factors provide areas of priority that counties and CPP facilitators should prioritize in planning and executing a CPP engagement.

[22] In statistics, *variance* indicates the extent to which all scores in distribution (i.e., all responses to a single survey item) vary from that distribution's mean. This is the equivalent of squaring the standard deviation and can be referred to as the *R Square*.

[23] This is the standard method of reporting a significant result of a multiple linear regression analysis in which the *F*-ratio, is the ratio of difference between the test variable means (i.e., CPP meeting effectiveness, participant safety, etc.). Additionally, the *adjusted R Square* represents level of variance in the distribution of scores as described above.

[24] This is the standard method of reporting a significant contributing variable in a multiple linear equation in which the *beta coefficient* indicates the degree to which its variable changes the outcome of the equation. Further, the *partial r correlation* indicates the degree to which its corresponding variable affects the outcome, ruling out all other variables in the equation.

Predicting CPP Effects on Wellness

To assess survey respondents' outcomes in wellness as a result of CPP participation, respondents were asked to rate their level of agreement with the statement, "Participating in the MHSA CPP process improved my sense of wellbeing." This was measured on a Likert-type scale of 1-5 wherein 1 indicated "strongly disagree" and 5 indicated "strongly agree."

The equation predicting the CPP effects on participant wellness was supported with consistency with recovery orientation, participant safety, participant training, and perception of contribution identified as significant contributors to wellness. The equation accounts for 51% of variance in wellness ratings with consistency with recovery orientation as the largest contributor, accounting for over 7% of variance in wellness and recovery ratings.

Technical Report of Findings: The predictive model for wellness and recovery was significant, accounting for 50.9% of the variance in CPP participants' wellness and recovery as a result of CPP participation ($F(6,456) = 80.87$, $p < .001$; adjusted R Square = .51). In this model, all the variables, except CPP meeting effectiveness and respect of participant opinions and culture were significant predictors. Recovery orientation accounted for 7.34% of the variance (beta = .33, $p < .001$, partial $r = .27$). Participant safety accounted for 3.72% of the variance when all other factors were held constant (beta = .24, $p < .001$; partial $r = .19$). Perception of contribution accounted for 1.56% of the variance when all other factors were held constant (beta = .15, $p < .01$; partial $r = .13$). Participant training accounted for 1.54% of the variance when all other factors were held constant (beta = .14, $p < .01$; partial $r = .12$).

Table 16. Multiple Linear Regression Analysis for Variables Predicting CPP Effects on Participants' Wellness and Recovery (*n* = 462)

Variable	*B*	*SE B*	β
CPP Meeting effectiveness	-.25	.08	-.02
Recovery Orientation	.37	.06	.33***
Participant Safety	.25	.06	.24***
Participant Training	.14	.05	.14**
Perception of Contribution	.14	.05	.15**
Respect of Participant Opinions & Culture	-.01	.08	-.01
R^2		.51	
F		80.87	

*$p < .05$, **$p < .01$, ***$p < .001$

These factors of CPP set-up, facilitation, and outputs accounted for over half respondents' ratings that CPP participation affected their wellness and recovery. As the state and counties move toward increasing community wellness through CPP participation, it is important to leverage these variables to maximize the positive participant outcomes. Making sure that CPP processes are recovery oriented and safe should be areas of priority for counties and CPP facilitators as they plan and execute CPP engagements.

Predicting CPP Effects on Participants' Trust in the PMHS

To assess the effects of CPP participation on survey respondents' trust in the PMHS, respondents were asked to rate their level of agreement with the statement, "Participating in the MHSA CPP process increased my trust in the mental health system." This was measured on a Likert-type scale of 1-5 wherein 1 indicated "strongly disagree" and 5 indicated "strongly agree."

The equation predicting CPP effects on participants' trust in the PMHS was supported with participant safety, participant training, and perception of contribution identified as significant contributors to trust. The equation accounts for 65% of the variance in respondents' ratings of trust in PMHS with perception of contribution as the largest contributor, accounting for over 13% of the variance in ratings of participant trust in the PMHS.

Technical Report of Findings: The predictive model for measuring CPP effects on participants' trust in the PMHS was significant, accounting for 64.6% of the variance in CPP participants' trust in the PMHS ($F(6,456) = 141.58$, $p < .001$; adjusted R Square = .65). In this model, participant safety, participant training, and perception of contribution were significant predictors. Perception of contribution accounted for 13.18% of the variance when all other factors were held constant (beta = .39, $p < .001$; partial $r = .36$).Participant safety accounted for 3.57% of the variance when all other factors were held constant (beta = .20, $p < .001$; partial $r = .19$). Participant training accounted for 1.02% of the variance when all other factors were held constant (beta = .09, $p < .05$; partial $r = .10$).

Table 17. Multiple Linear Regression Analysis for Variables Predicting CPP Effects on Participants' Trust in the Public Mental Health System (*n* = 462)

Variable	*B*	*SE B*	β
CPP Meeting Effectiveness	.11	.08	.08
Recovery Orientation	.08	.05	.07
Participant Safety	.21	.05	.20***
Participant Training	.10	.05	.09*
Perception of Contribution	.39	.05	.39***
Respect of Participant Opinions and Culture	.10	.07	.08
R^2		.65	
F		141.58	

*$p < .05$, **$p < .01$, ***$p < .001$

These factors of CPP preparation and facilitation accounted for nearly two-thirds of the respondents' ratings that CPP participation affected their trust in the PMHS. As it is the intent of the CPP process to expand outreach to and engage stakeholders from various mental health affiliations, building trust among current participants would provide them with greater incentive to continue participation and recommend participation to other stakeholders. Making sure that CPP participants feel heard and effective, ensuring participant safety, and providing participants with information about how they can effectively participate should be areas of priority for counties and CPP facilitators as they plan for and follow-up after CPP engagements.

Relationship between CPP Practices and Outcomes

The follow sections highlight four distinct categories of CPP processes and practices that were found to have a significant correlation with specific outcomes. These four categories include: outreach activities, incentives, trainings, and input activities. Each of these sections begins with a graphic representation that summarizes the positive and negative correlations between the categories and the identified outcomes/impacts. Within each subsection another graphic representation highlights the correlation that was found to be significant.

Outreach Activities

The following outreach activities showed a significant correlation with specific outcomes. These outreach activities include: 1) radio/TV announcements, 2) social media, and 3) announcements at meetings.

Radio/TV Announcements

Radio/TV Announcements

CPP Meeting Effectiveness

Using radio/TV announcements was linked to stakeholders feeling as if CPP meetings were less effective This finding should be interpreted with caution and does not suggest that radio/TV announcements are not useful outreach methods. Further research would be required to understand this relationship.

According to the County Web-Based Data Request, the use of radio/TV announcements were among the least frequently reported outreach activities that counties used to encourage stakeholder participation in CPP activities, with 10% of counties (n = 52) indicating that they used this outreach method. However, of those counties that did use radio/TV announcements, half (50%, n = 4) rated the outreach activity as "successful" or "highly successful" in helping counties to meet MHSA goals.

Social Media

Social Media

Perception of Contribution
Participation Safety
Participant Trust
Participant Wellness

Using social media to reach stakeholders was linked with stakeholders feeling as though they contributed more, felt safer to participate, had more trust in the public mental health system, and had an increased sense of wellness as a result of participating in the CPP process. Not using social media to reach stakeholders was linked with a decrease in stakeholder perceptions of contribution, safety, trust, and wellness as a result of participating.

According to the County Web-Based Data Request, the use of social media was among the least frequently reported outreach activities that counties used to encourage stakeholder participation in CPP activities,

with 15% of counties (*n* = 52) indicating that they used this outreach method. However, of those counties that did use social media, all (100%, *n* = 8) rated the outreach activity as "successful" or "highly successful" in helping counties to meet MHSA goals.

Both county informants and stakeholders noted that counties did not effectively leverage social media as a way to outreach to stakeholders, though many expressed interest in doing so. A mental health director from a large Bay Area county suggested that counties could create a "Facebook page or Twitter account to improve outreach". Another mental health director from a small Superior county stated, "Given the county's size and low population density, social media would increase the county department's reach among isolated communities."

While the use of social media was generally not a common practice, the counties that did use this approach indicated it was successful and those that did not were interested in expanding outreach activities to include the use of social media. Therefore, increasing the use of social media as an outreach activity may result in improved stakeholder perceptions of contribution, safety, trust, and wellness.

Announcement at Meetings

Announcements at Meetings

Perception of Contribution
Participant Trust

Using announcements at meetings to encourage stakeholder participation in CPP activities was associated with significantly higher ratings of perception of contribution and trust. Not using announcements at meetings to outreach to stakeholders was correlated with a decrease in stakeholder's perceptions of contribution and trust.

According to the County Web-Based Data Request, the use of announcements at meetings was among the most frequently reported outreach activities that counties used to encourage stakeholder participation in CPP activities, with 85% of counties (*n* = 52) indicating that they used this outreach method. Similarly, of those counties that did use this outreach method, 86% (*n* = 44) rated the outreach activity as "successful" or "highly successful" in meeting MHSA goals.

As the results from the County Web-Based Data Request suggest, stakeholders frequently reported hearing about the CPP process through announcements at meetings. These meeting spaces varied from MHSA steering committee or mental health board meetings to local organizational meetings such as NAMI and support groups. One stakeholder from a large Southern county reported, "During the formation phase of the CPP groups, county representatives or staff of county-contracted agencies would approach clients in group settings, such as drop-in centers, programs that held group meetings or in classes offered to clients." Additionally, stakeholders at several focus groups mentioned that counties conducted outreach to un/underserved populations by making announcements at community meetings. However, stakeholders reported being unsure as to whether this was an effective method since members of these un/underserved populations have not participated in the CPP process. Stakeholders emphasized the importance of personal contact, particularly during the early phases of the CPP process, suggesting that using such an approach may increase stakeholder's desire to participate in the CPP process.

The use of announcements at meetings was generally a common practice and counties that did use this approach indicated that it was successful in encouraging stakeholder participation. Therefore, increasing the use of announcements at meetings as an outreach activity may result in improved stakeholder perceptions of contribution and trust.

Summary of Recommendations: Outreach Activities

Based on the correlations described in the previous sections combined with data from the County Web-Based Data Request, county key informant interviews, and stakeholder focus groups, the following recommendations are intended to improve outcomes associated with outreach activities:

- Consider further research to understand the relationship between radio/TV announcements and perception of CPP meeting effectiveness
- Increase the use of social media
- Increase the use of announcements at meetings

Incentives

The following incentives showed a significant correlation with specific outcomes. These incentives include: 1) stipends/other financial incentive, 2) childcare, and 3) translation/interpretation services.

Stipends/Other Financial Incentives

Stipends/Other Financial Incentives

Participant Satisfaction
Recovery Orientation
Perception of Wellness

Providing stipends/other financial incentives to encourage stakeholder participation was correlated with stakeholders feeling more satisfied and that the process was more recovery oriented as well as a perception of an increased sense of wellness as a result of CPP participation. Not providing stipends/other financial incentives to encourage stakeholder participation was associated with a decrease in stakeholder's perceptions of satisfaction, recovery orientation of the process, and sense of wellness as a result of CPP participation.

According to the County Web-Based Data Request, 35% of counties (n = 51) reported providing a stipend/other financial incentives to CPP participants. However, of those counties that did provide this incentive to CPP participants, 76% (n = 17) rated this incentive as "successful" or "highly successful" in encouraging stakeholder participation.

Stakeholders reported that mental health departments provided stipends to make CPP activities more accessible and inviting. One stakeholder from a large Central county reported, "[The] CPP process [was] instrumental in establishing a stipend policy for leadership involvement in MHSA activities." Another stakeholder from a large Southern county discussed how they appreciated the stipends the county offered as they have been participants in the CPP process for many years. For those counties that did not provide a stipend, stakeholders' feedback indicates that financial struggles may have served as a barrier to participating in CPP activities. County informants' responses corresponded with stakeholder feedback.

That is, county informants indicated that stipends are often offered to counter barriers to stakeholder participation in the CPP process. They recognized that stakeholders have multiple commitments and impacted schedules and that it may be particularly challenging for members of low-income communities to participate. One county informant stated, "Low-income populations don't have the time or financial resources to attend meetings." As such, offering stipends can encourage greater stakeholder participation among populations that may not normally participate in the process due to financial constraints.

While providing stipends/other financial incentives was generally not a common practice, there were still some counties that used this approach to encourage stakeholder participation, and those that did found the incentive successful. Therefore, increasing the use of stipends/other financial incentives may result in improved stakeholder perceptions of satisfaction, recovery orientation, and perception of wellness as a result of CPP participation.

Childcare

Childcare

CPP Meeting Effectiveness
Respect of Participant Opinions & Culture
Participant Safety
Participant Trust

Providing childcare to encourage stakeholder participation was correlated stakeholders feeling that CPP meetings were more effective and safe and that their opinions and culture were respected as well as increased their trust in the public mental health system. Not providing childcare was linked with a decrease in stakeholder's perception of CPP meeting effectiveness, respect of participant opinions and culture, safety, and trust.

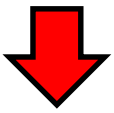
According to the County Web-Based Data Request, 6% of counties (*n* = 51) reported providing childcare to CPP participants. However, of those counties that did provide this incentive to CPP participants, 50% (*n* = 2) rated this incentive as "successful" or "highly successful" in encouraging stakeholder participation.

County informants recognized that a lack of childcare was one of the primary barriers that prevented stakeholders from participating in the CPP process. For instance, a mental health director from a medium Bay Area county reported, "Families and children are often underrepresented in the CPP process because of scheduling and childcare." This statement suggests that issues around childcare could decrease accessibility in CPP participation. Stakeholders echoed this sentiment, indicating that not providing childcare prevented some stakeholders from participating in CPP activities.

While providing childcare was generally not a common practice, of those counties that did provide this incentive, half found it to be successful in encouraging stakeholder participation. Therefore, increasing the availability of childcare may result in improved CPP meeting effectiveness, respect of participant opinions and culture, safety, and trust.

Translation/Interpretation Services

Translation/Interpretation Services



Participant Wellness

Providing translation/interpretation services as a method for encouraging participation in CPP activities was associated with significantly lower ratings of a sense of wellness as a result of CPP participation. This does *not* suggest that translation/interpretation services is not useful. Rather, this outcome represents a correlation that may be influenced by a number of factors, including a difference in stakeholder groups (e.g. English speakers versus other language speakers) and/or how this activity is currently conducted. Further research could be useful to understand the most effective and culturally relevant ways in which to engage people with LEP in CPP activities.

According to the County Web-Based Data Request, 53% of counties (*n* = 51) reported providing translation/interpretation services to CPP participants. Of those counties that did provide this incentive to CPP participants, 56% (*n* = 27) rated this incentive as "successful" or "highly successful" in encouraging stakeholder participation.

Both county informants and stakeholders agreed that language barriers prevented some populations from participating in the CPP process. In addition to offering translation services, county informants have also begun organizing meetings specific to a cultural community. For example, one county informant stated they held meetings in Spanish for their Latino stakeholders, while another county informant from a large Southern county reported recently creating a Latino subcommittee.

Nonetheless, while county informants identified the provision of translation/interpretation services as a successful strategy for increasing stakeholder participation in the CPP process, limitations were also raised. In addition to the absence of translation/interpretation services at some community engagement events, stakeholders also reported inadequate translation at meetings. Additionally, the mental health director of one Southern county observed that while the county provides translators and headsets at CPP meetings, they "are not often used." In addition to translation services, county staff has also looked to build trust and rapport among ethnic groups by working with cultural brokers in the community and hiring more bilingual staff.

Stakeholders also noted that while translation/interpretation services were available during CPP activities, it was just as important to ensure that outreach activities, including the notification of meeting dates, times, and locations, were available in other languages. A mental health director from a small Superior county stated, "We also keep an eye on whether we have a growing population we are unaware of. We make sure that we have an interpreter service for Latino folks who come into the wellness center or the agency. We don't have a huge populace of that…but try to keep up to be ahead of the game."

Translation/interpretation services were used in approximately half of all counties and of those that did use this incentive, just over half found it be successful in encouraging stakeholder participation. Both county informants and stakeholders noted that as it becomes necessary, CPP activities may be conducted

entirely in another language or use cultural brokers/community partners to reach populations that do not speak English. However, because stakeholder focus groups were not translated, the opinions expressed may not be representative of those who may have utilized translation/interpretation services. Therefore, further research is needed to explore translation/interpretation services.

Summary of Recommendations: Incentives

Based on the correlations described in the previous sections combined with data from the County Web-Based Data Request, county key informant interviews, and stakeholder focus groups, the following recommendations are intended to improve outcomes associated with incentives:

- Increase the use of stipends/other financial incentives
- Increase the availability of childcare services
- Conduct further research to explore translation/interpretation services and the most effective and culturally relevant ways to engage people with LEP.

Trainings

The following training showed a significant correlation with specific outcomes. This training includes: 1) support for participants to attend trainings not sponsored by the county.

Support for Participants to Attend Trainings not Sponsored by the County

Support for External Trainings

CPP Meeting Effectiveness

Providing support for external trainings was associated with stakeholders feeling that CPP meetings were more effective. *Not* providing support for external trainings to encourage stakeholder participation was correlated with a decreased stakeholder perception of CPP meeting effectiveness.

According to the County Web-Based Data Request, 18% of counties (n = 28) reported providing support for participants to attend trainings not sponsored by the county. Of those counties that did provide this training, 50% (n = 4) indicated the training was "successful" or "highly successful" in teaching stakeholders about participation in the location planning process.

Stakeholders in two focus groups indicated that counties provided them with support to attend trainings not associated with the county. Focus group participants from a small Central county noted that the county supported them in attending trainings that offered CEUs by "providing transportation to trainings and offered financial support to help pay for tuition associated with trainings." While another focus group participants from a small Superior county described the county as having an "open door policy" for stakeholders to participate in activities not-sponsored by the county. Stakeholders in focus groups described participating in trainings such as immersion training on integrative services and the recovery model and mental health first aid training.

Stakeholders in focus groups also noted that MSHA-related trainings were provided by outside organizations such NAMI. Stakeholders in a focus group from a large Southern county said the county did

not provide training, but outside agencies and other providers did provide MHSA-related trainings for their own stakeholders.

While providing support to attend external trainings was not common practice, nor was it primarily viewed as "successful" or "highly successful", stakeholders did discuss participating in external trainings. Therefore, increasing support for external trainings may result in improved CPP meeting effectiveness.

Summary of Recommendations: Trainings

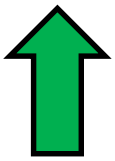
Based on the correlations described in the previous sections combined with data from the County Web-Based Data Request, county key informant interviews, and stakeholder focus groups, the following recommendations are intended to improve outcomes associated with trainings:

- Increase support for external trainings

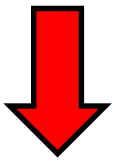
Participant Input Activities

The following participant input activities showed a significant correlation with specific outcomes. These input activities include: 1) strategy roundtables/strategizing sessions, 2) surveys/questionnaires, 3) public hearings, 4) suggestion boxes, and 5) voting or prioritization activities.

Strategy Roundtables/Strategizing Sessions



Strategy Roundtables/Strategizing Sessions



Respect of Participant Opinions & Culture

Conducting strategy roundtables or other strategizing session was linked with stakeholders feeling as if their opinions and culture were less respected. Conversely, not using strategy roundtables/strategizing sessions was correlated with an increase in stakeholder's perception that their opinions and culture were respected.

According to the County Web-Based Data Request, 43% of counties (n = 44) reported using strategy roundtables/strategizing sessions. However, unlike previous activities, counties were not asked to rate the perceived success of this activity.

Stakeholders in focus groups described participating in planning meetings and brainstorming sessions, but did not use the same terms as "strategy roundtables/strategizing sessions." Stakeholders indicated that they enjoyed participating in these activities when they were engaging, less formal, and felt that what they were doing was important. Stakeholders in one focus group said they participated in stakeholder forums. However, they only enjoyed forums when they felt their voice as was heard at the event. Stakeholders said they disliked forums when they felt their "voice of an advocate was of no importance." In a similar regard, stakeholders in a focus group from a large Bay Area county described disliking the stakeholder planning workgroup in their county at times because "there is too much arguing." Some

stakeholders disliked when there appeared to be a little follow up on decisions or recommendations that came out of planning meetings.

Based on stakeholder feedback, it appears that during some activities there was arguing or an inability to be heard, which suggests that strategy roundtables/strategizing sessions and other similar activities, may function best with clear ground rules that establish expectations for how stakeholders should participate in this process. Doing so could potentially create a more inclusive environment, which allow participants to feel heard and not argue, and may decrease the perception that stakeholder's opinions and culture were not respected.

Surveys/Questionnaires

Using surveys/questionnaires was linked with stakeholders feeling that CPP meetings were more effective and safe and that they contributed more. Not using surveys/questionnaires was linked with a decrease in stakeholder's perception of CPP meeting effectiveness, contribution, and safety

According to the County Web-Based Data Request, 59% of counties (*n* = 51) reported using surveys/questionnaires to collect input from stakeholders during the CPP process. Of those counties that did use this activity, 89% (*n* = 28) indicated the activity was "effective" or "highly effective" in collecting input from stakeholders during the CPP process.

Stakeholders in focus groups mentioned surveys as way that they provided counties with their input. During one county's focus group, stakeholders described how the county used surveys to solicit ideas from stakeholders for innovation projects. Stakeholders described online surveys as an effective tool to engage stakeholders in the CPP process. One focus group described surveys as way "to engage everyone in the community planning process and participate equally, whether they are able to attend meeting or not. This allows them to express their opinions without being swayed."

Stakeholders also noted that surveys and questionnaires were effective tools for creating a safe space for dialogue around a difficult or sensitive topic. In a small Superior county, stakeholders described how surveys can create opportunities for dialogue and openness at meetings. In this county, responses to a question on a MHSA survey regarding the LGBTQ community resulted in greater discussions about inclusivity and sensitivity as well as an opportunity for education and dialogue with community members with a more conservative perspective.

While the surveys/questionnaires were used in just under 60% of counties, those counties that did use this method consistently rated that activity as "effective" or "highly effective". Stakeholders noted that surveys/questionnaires provided them with an opportunity to provide their feedback if they are unable to attend a meeting. Therefore, it appears that surveys/questionnaires may be a valuable tool for soliciting stakeholder feedback on what may be more sensitive topics and ensuring that feedback is heard from stakeholders regardless of their ability to attend a CPP activity.

Public Hearings

Public Hearings

CPP Meeting Effectiveness
Respect of Participant Opinions & Culture
Participant Training
Participation Safety
Recovery Orientation
Participant Trust
Participant Wellness

Public hearings were associated with reported significantly lower ratings of CPP meeting effectiveness, respect of opinions and culture, training, safety, recovery orientation, trust, and sense of wellness as a result of CPP participation. This finding does not suggest that counties should not conduct public hearings in accordance with the legislation but does suggest that further research would be indicated to understand these correlations.

According to the County Web-Based Data Request, 84% of counties (*n* = 51) reported using public hearings to collect input from stakeholders during the CPP process. Of those counties that did use this activity, 63% (*n* = 41) indicated the activity was "effective" or "highly effective" in collecting input from stakeholders during the CPP process.

Stakeholders in focus groups said they participated in public hearings or similar CPP related meeting as a way to provide input to the county and receive information on CPP processes. Stakeholders reported mixed feeling about the impact public hearings had on their satisfaction with the CPP process. Stakeholders felt that public hearing meetings were effective when stakeholders had an opportunity to offer their input to counties. Meetings that prioritized public commentary were most popular among stakeholders in focus groups. Stakeholders also noted meetings that were less formal and more personal provided and safe and engaging atmosphere for them.

However, a number of stakeholders felt that public hearing were ineffective. They described how public hearings could often be long and filled with dense information and bureaucratic procedures. Stakeholders felt public hearings were an ineffective CPP activity because there is "often a lack of outcomes that result from discussions at meetings." Stakeholders from a medium Superior county also noted that public hearings sometimes lacked transparency because facilitators were unwilling to provide information regarding funding or outcomes.

While public hearings were among the most commonly used strategy to gather stakeholder input, just under two-thirds of counties that used this method thought it was "effective" or "highly effective". Stakeholders generally reported that public hearings were ineffective, and found the bureaucratic processes confusing. However, some stakeholders noted that public hearings (or other similar processes) were most effective when they were less formal and more personal. Therefore, it appears that the current processes for conducting public hearings may be too formalized and/or confusing for effective stakeholder participation, and that providing stakeholders with some additional context about what this aspect of the

CPP process is intended to do may result in improved stakeholder perceptions of CPP meeting effectiveness, respect of opinions and culture, training, safety, recovery orientation, trust, and wellness.

Suggestion Boxes

Suggestion Boxes

Recovery Orientation
Participant Trust

The use of suggestion boxes is associated with significantly lower ratings of recovery orientation of the CPP process and participant trust in the public mental health system.

According to the County Web-Based Data Request, 14% of counties (*n* = 51) reported using suggestion boxes to collect input from stakeholders during the CPP process. Of those counties that did use this activity, 33% (*n* = 6) indicated the activity was "effective" or "highly effective" in collecting input from stakeholders during the CPP process.

Although the County Web-Based Data Request indicates that suggestion boxes were used in some counties, stakeholders in focus groups did not discuss the use of suggestion boxes. Stakeholders in one small Superior county described that they have a process through which stakeholders can write in suggestions or changes to be considered in the CPP plan.

Few counties reported using suggestions boxes, and of those that did, only a third found them to be "effective" or "highly effective". Stakeholders provided very little feedback regarding the use of suggestion boxes, which may relate to their limited use among counties. Therefore, limiting the use of suggestion boxes may result in increased stakeholder perceptions of recovery orientation and trust.

Voting or Prioritization of Activities

Voting or Prioritization of Activities

Participant Wellness

The use of voting or prioritization activities was correlated with a decreased sense of wellness as a result of CPP participation. Conversely, not using voting or prioritization activities was associated with an increase in sense of wellness as a result of CPP participation. This finding does not suggest that voting or prioritization activities are not useful but suggests that further research would be necessary to understand this relationship.

According to the County Web-Based Data Request, 54% of counties (*n* = 44) reported using voting or prioritization activities to collect input from stakeholders during the CPP process. However, unlike previous activities, counties were not asked to rate the perceived success of this activity.

Stakeholders in focus groups described difficulties associated with voting and prioritization activities. They described how accessibility barriers at CPP meetings, specifically meeting locations and times, made

voting and prioritization activities difficult. In one small Superior county, stakeholders described how low attendance among MHSA board members made it difficult to have a quorum for voting purposes.

When successfully conducted, stakeholders felt that voting and prioritization activities could have a positive impact on programs and services. Stakeholders from a small Central county described a prioritization activity in which stakeholder feedback is used to develop a priority lists as to what should get funded when resources become available. Due to this process, stakeholders reported, "we now have strong programs for Latinos, and have expanded the hours of our peer programs."

While voting or prioritization activities were generally not a common practice across counties, and challenges related to inconvenient meeting locations and times, stakeholders generally noted the potential positive impact that this approach could have. Therefore, further research is needed to explore the use of voting or prioritization activities.

Summary of Recommendations: Participant Input Activities

Based on the correlations described in the previous sections combined with data from the County Web-Based Data Request, county key informant interviews, and stakeholder focus groups, the following recommendations are intended to improve outcomes associated with participant input activities:

- Establish clear ground rules for how stakeholders are expected to participate in strategy roundtables/strategizing sessions
- Increase the use of surveys/questionnaires
- Provide stakeholders with additional information and context about the public hearing process
- Further explore the use of suggestion boxes
- Conduct further research to understand voting or prioritization activities

Other Considerations

Both county size and CDMHA region can influence the ways in which counties carry out their CPP processes. County size may be among the largest driver influencing the availability of staff to conduct outreach and gather stakeholder input, while CDMHA region may influence the culture in which this process takes place. Each of these factors must be carefully considered to understand how it may impact the CPP process in a given county. Further considerations of both county size and CDMHA region are presented here.

County Size Considerations

Counties of different sizes face their own set of unique challenges. County size was often indicative of the availability of resources to carry out the CPP process. Smaller counties typically had fewer FTEs when compared to both medium and large counties. However, larger counties had to contend with reaching larger populations. While it may have been feasible for a smaller county to engage stakeholders through more personal forms of communication, such as phone calls or personal invitations, larger counties often

had to rely more heavily on mass communication, such as media outlets and emails to listservs, in order to reach a similar proportion of the population.

County size could have also impacted whether stakeholders were able to travel to the locations of CPP activities. Smaller counties often lacked viable public transit options, which made it increasingly difficult to reach more isolated communities. However, in larger counties, transportation challenges typically had more to do with the county's large geography and travel being too cumbersome for stakeholders. In smaller counties, populations were often centered in a few pockets throughout the county. While those locations may have had a relatively higher population density to warrant holding CPP activities in those locales, it did create a challenge of reaching those more isolated and rural communities that may have had distinct mental health needs.

Regional Considerations

CMHDA region could have played a considerable role in the culture in which a CPP process took place. Each region had its own unique set of characteristics that often influence stakeholder's expectations for their county's public mental health system. In the Bay Area region, for example, stakeholders typically had greater access to a variety of CPP processes and practices when compared to other regions, yet tended to express greater dissatisfaction. Understanding stakeholder expectations and the political climate (e.g. a longstanding culture of advocacy) in which they occur may help counties develop processes that better serve their unique stakeholder populations.

In a similar vein, understanding regional differences in demographics may help guide the approaches that counties use. For example, in the Los Angeles region there were a greater percentage of Spanish speakers than in other CMHDA regions, indicating a need for information in that language. Paying attention to the regional differences in minority populations, including ethnic/racial minorities as well as LGBTQ populations, may help regions leverage cultural brokers or community-based organizations in order to reach those distinct populations.

Both county size and CMHDA region are important factors in developing effective CPP processes, and should be considered not only during the initial stakeholder outreach phase, but also while gathering stakeholder input.

Discussion

This section of the report provides summaries that examine evaluation findings across multiple research questions and CPP categories. Seven discussion topics were identified as relevant across multiple domains and pertinent to the evaluation's goal of identifying CPP activities and practices for further exploration and implementation across California.

CPP Staffing and Effects on Activities

Ensuring that counties provide enough staff time to conduct their CPP processes is important to their success in engaging stakeholders and receiving meaningful feedback to inform their future MHSA and CPP endeavors. Counties across the state staffed their CPP processes in varying levels, but these staffing levels were generally consistent across similarly-sized counties. Statewide, on average, counties designated 1.84 FTEs to conduct and/or monitor their CPP processes. Specifically, small counties designated 0.96 FTEs, medium counties designated 1.91 FTEs, and large counties designated 3.58 FTEs.

CPP Staffing Levels and Discordance with Stakeholder Needs

The differences in county staff FTE designated for CPP processes across counties of different sizes can be assumed to be reflective of counties' population sizes. Counties with large populations have larger county mental health departments and can dedicate more staff to their CPP processes, and counties with small populations have smaller county mental health departments and can dedicate less staff to their CPP processes. However, the evaluation team did not find the aforementioned assumption to be true. Across the state, 59% of the 50 responding counties felt their levels of staff designated to CPP processes were adequate.[25] Specifically, 82% of large counties felt their levels of staff designated to CPP processes were adequate, while 40% of small counties felt similarly.

These findings signify that while small counties may have to designate fewer FTEs to staff their CPP processes, their county mental health departments were generally dissatisfied with these low levels of staffing and would like to have additional resources to dedicate more staff to their CPP processes. This suggests that there may be a minimum threshold level of CPP staffing that all counties need to maintain in order for their CPP processes to be adequately staffed. The minimum levels of FTEs for CPP staffing to meet counties' needs is a point for further exploration in future work evaluating counties' CPP processes.

CPP Staffing Levels and Evaluation Activities

The types of evaluation activities that various counties chose to conduct were correlated with their counties' total population sizes. Large counties most frequently reported having used discussions or focus groups with stakeholders as a means of evaluating their CPP processes (60% of large counties). Of the

[25] Data obtained from the County Web-Based Data Request data collection tool.

large counties that used discussion or focus groups as CPP evaluation activities, all reported using the data to help improve their future CPP processes.

Medium counties, on the other hand, reported the least usage of discussion or focus groups as CPP evaluation activities (29% of medium counties). Of the medium and small counties that used discussion of focus groups as CPP evaluation activities, 75% reported using the data to help improve their future CPP processes. Provided this, compared to California's large counties, a much smaller percentage of the state's medium and small counties utilized stakeholder discussion and focus group CPP evaluation data to aid in informing changes to their future CPP processes.

Participant satisfaction surveys were another mode of data collection that counties utilized to assess their CPP processes. All large and medium counties used participant survey findings to improve their future CPP processes. However, only half of small counties that evaluated their CPP processes with participant satisfaction surveys actually used that data to inform their future CPP processes.

Leading stakeholder discussion or focus groups and administering participant satisfaction surveys requires dedicated staffing from county mental health departments. A majority of the state's large counties used stakeholder discussion or focus groups and/or participant satisfaction surveys to gather information to improve their future CPP processes. Additionally, large counties had the highest levels (FTEs) of county mental health department staffing for their CPP processes. Given this, it is conceivable that large counties' higher levels of CPP staffing allowed for their increased implementation of discussion or focus groups and participant satisfaction surveys, as well as their abilities to make use of the data collected. It is also plausible to assume that small and medium counties, which generally would like to have more dedicated CPP staffing, would have been more likely to conduct discussion or focus groups and participant satisfaction surveys, as well as the capacity to utilize that information to further improve their future CPP processes, if they had higher CPP staffing levels.

Multilingual Capabilities

Counties' abilities to provide CPP participation opportunities with multilingual capacities were important to both county mental health departments and stakeholders across the state. Throughout key informant interviews with MHSA/CPP Coordinators, stakeholders with monolingual capabilities were frequently identified as underrepresented groups in the state's CPP processes. In particular, monolingual Spanish speakers were most commonly noted as a priority population for counties to target in their CPP outreach endeavors. Identifying needs for bilingual staff, in order to better accommodate the language needs of their CPP participants, was not unique to any particular CMHDA Region or County Size. One MHSA/CPP Coordinator from a small Central region county commented that, "Everything is bilingual now." Given this, many of California's county mental health departments noted that they were actively trying to retain and recruit staff members with bilingual and multilingual capabilities.

Across the state, stakeholders also identified the importance of their counties' CPP processes being conducted with multilingual capabilities. In focus groups, stakeholders noted that they would like to see their counties increase CPP outreach and engagement efforts to stakeholders with limited English

proficiency. In particular, focus group stakeholders often commented that they would like their counties' CPP-related meetings to either be monolingual (conducted in one language other than English) or multilingual (conducted in English with accommodations for stakeholders with limited English proficiency).

Conducting CPP-related meetings with non-English language capabilities would increase stakeholders' comfort in attending and more openly participating. This would lead to the greater provision of constructive stakeholder feedback to counties, both in their CPP stakeholder feedback solicitation efforts and their future CPP process improvement strategies. The abilities of counties to accommodate the language needs of their stakeholders was directly related to their prioritizations of the importance of receiving meaningful feedback from all of their stakeholder populations, not just those that can speak English.

Scales of CPP Activities

The varying sizes of California's counties, by total population sizes, provide indications of the types and amounts of CPP activities that they conduct. In particular, the types of CPP outreach and input activities that counties chose to conduct were found to have relations with county sizes.

CPP Outreach Efforts and County Sizes

Medium and small counties often conducted multiple outreach activities at once during their CPP outreach periods. By conducting a variety of activities at the same time, these counties were able to execute a more targeted approach in their outreach efforts to stakeholders. The types of CPP outreach activities that medium and small counties often implemented included: announcements at meetings, emails to listservs, flyers/posters/brochures, and phone calls and other types of direct invitations from county staff. These sorts of CPP outreach activities required significant levels of effort and resources from the counties, but when widely distributed across the medium and small counties, these outreach activities can potentially reach a larger number and greater variety of stakeholders. For those stakeholders that may be more difficult to reach due to geographic isolation (i.e., living in rural areas as opposed to more urban areas), language barriers, or a multitude of other possible reasons, having a variety of outreach methods may increase the likelihood that these types of stakeholders are reached and notified. These sorts of methods can be particularly useful in medium and small counties, as their communities tend to be more geographically dispersed and their stakeholders' non-English language capabilities potentially more limited.

On the other hand, large counties more often relied on one-time mass-communication activities for their CPP outreach efforts. For example, across the state, large counties were more likely to use radio and television announcements to advertise their CPP activities than medium or small counties. It is plausible to conjecture that large counties recognized the immense variety and quantity of stakeholders within their counties and believed that the more targeted and diverse outreach approaches undertaken by medium and small counties would not be as fruitful or cost-effective in their larger-sized counties. Large

counties may have posited that less resource- and staff-demanding outreach activities, such as radio and television announcements, would produce a turnout of similar numbers of stakeholders participating in their CPP activities. In counties with large population sizes and diverse types of (potentially more engaged) stakeholders, those county mental health departments may have determined the amount of stakeholders that it could handle at its CPP activities and accordingly tailored its CPP outreach activities to yield that maximum threshold of stakeholders.

CPP Participant Input Activities and County Sizes

Across California, counties used multiple methods to post and announce their MHSA plans during their 30-day open stakeholder commenting periods. Most often, counties used their websites to share their MHSA plans with their stakeholders. Medium and small counties implemented a wider variety of methods to share their MHSA plans with stakeholders. In particular, all medium counties posted their MHSA plans to their websites and most (71% of medium counties) used emails to list serves to share their plans. Small counties most frequently posted their plans to the websites (95% of small counties), but they also used a wider variety of other distribution methods compared to medium counties. Large counties, compared to the aforementioned medium and small counties, used a smaller variety of distribution methods of its MHSA plans and received CPP feedback.

It can be conjectured that while large counties have larger total population sizes (and presumably larger stakeholder population sizes), they do not need to have more targeted efforts to share their CPP information with a meaningful portion of their stakeholders. As with CPP outreach activities, large counties may have determined that, in order to fulfill their requirements of CPP stakeholder involvement and distribution of plans with their stakeholders, the increased resources required to implement more targeted distribution methods were not necessary for their feedback distribution efforts to be meaningful and received by significant portions of their stakeholder populations. Larger counties across California, despite generally having more county mental health department staff allocated to their CPP processes, have actively chosen to limit the resources that they dedicate to distribution methods of their CPP feedback received.

Community-Based Activities and Building Trust with Stakeholders

The CPP process is grounded in stakeholders having trust in their county mental health departments. In order for stakeholders to attend CPP activities and provide their open and honest feedback to the counties, it is important for stakeholders to believe that: (a) their counties do respect stakeholders' opinions and do want their stakeholders to provide open and honest feedback, and (b) their feedback to the counties will be considered in meaningful ways and acted upon accordingly if deemed appropriate to do so. This foundation of trust between counties and their stakeholders is integral for CPP processes to be meaningful, effective, and sustainable. Throughout this evaluation, stakeholders frequently commented on the importance of building and having trust in and with their counties, in order for stakeholders to openly participate both now and in the future.

CPP Outreach Efforts with Ongoing Community Activities

Grassroots outreach efforts were identified as key methods in engaging stakeholders in counties' CPP processes. In California's Central and Southern regions, where most of the state's small counties and their geographically disparate stakeholder populations are located, it was often recognized that some of the most effective CPP outreach activities were those that involved more one-on-one and word-of-mouth interactions with stakeholders. Less formal activities and settings (e.g., social gatherings, retreats, etc.) were identified as effective avenues for counties to implement one-on-one and word-of-mouth outreach strategies with stakeholders.

Additionally, to this end, stakeholders specifically and frequently commented that it was important for counties to leverage the current ongoing activities that were already happening in the communities. Activities and standing meetings with community members that were ongoing have a built-in constituency base, location, and setting that counties did not have to manufacture in their CPP outreach efforts. Rather, these sorts of ongoing activities and meetings afforded counties the opportunities to leave their premises and enter communities to conduct their CPP outreach efforts. Stakeholders commented their desires for CPP activities and interactions with county mental health department staff to occur outside the confines of the actual mental health department facilities, which often introduced levels of formality that stakeholders believed inhibited their open and meaningful CPP participation. By entering into the stakeholder communities and asking for CPP participation in settings that were already familiar and comfortable for stakeholders, counties were able to increase their CPP participation and collection of more meaningful feedback.

Mental Health Stigma

Throughout the state, stakeholders commented that, as a result of their counties' CPP processes, they had witnessed a shift in their counties toward community-driven mental health service approaches that emphasize wellness, recovery, and resiliency rather than focusing on mental health illnesses. Stakeholders from small counties, presumably the counties with the most geographically disparate stakeholder populations, stressed that their counties' CPP processes had resulted in greater awareness by stakeholders of mental health services and mental health within the general public. Additionally, stakeholders and county mental health department staff from the state's small counties commented that community-based programming had been most effective in engaging broader stakeholder communities and helping reduce the stigma of mental health within their communities. This was in alignment with the previously mentioned concept that utilizing more grassroots strategies to engage CPP stakeholders could not only increase CPP participation levels, but also decrease the stigma associated with mental health amongst various communities. It is presumable that California's small counties determination of the effectiveness of employing grassroots and community-based approaches for CPP efforts can also be effective within the state's medium and large counties, where stakeholder populations may be slightly more geographically similarly located and homogenous in their mental health services desires and needs.

Alignment with MHSA principles

This evaluation examined the statistical correlations between CPP participants' wellness and a variety of participation factors. The following factors were found to be significant in influencing participants' perceptions of wellness and recovery: accessibility of CPP meetings, safety in participation, consistency of adherence to MHSA principles, sufficiency of participant training, and participants' perception of contribution to improving public mental health services. Of all the aforementioned themes, the "consistency of adherence to MHSA principles" theme served as a common foundation for the other participation factors. Of note, this evaluation found that the most impactful factor on participant wellness was the consistency of the state's CPP processes adhering to MHSA principles. This finding suggests that the more CPP activities were aligned with MHSA principles, the more positive impacts the activities had on CPP participants' wellness. Moreover, this finding provides further confirmation that MHSA principles were notably relevant and positively impactful on MHSA/CPP participants.

In addition to CPP participants identifying the importance of their county mental health departments adhering to MHSA principles in their MHSA and CPP efforts and the positive impacts that would have on participants' wellness, they also noted that they felt their counties' CPP processes had indeed adopted MHSA principles. CPP participants who responded to the Stakeholder Survey believed that their counties' CPP meetings were safe (79% of participants), culturally-competent (76% of participants), stakeholder-driven (72% of participants), and recovery-oriented (71% of participants). Along these lines, one focus group stakeholder from a small Superior region county commented that, "The CPP gives me a goal when I participate and helps in my recovery."

It is encouraging to note that California's CPP participants had not only identified the importance of MHSA principles on wellness, but also experienced their counties actually incorporating MHSA principles into their CPP processes. As counties continue to develop and improve their CPP processes, they should feel positively reassured that stakeholders are recognizing their implementation of MHSA principles into their CPP endeavors.

Stakeholder Perceptions of Effective CPP Practices

Across the state, counties conducted an immense variety of CPP activities with their stakeholders, including activities related to: 1) CPP outreach, 2) incentives for CPP participation, 3) training for county staff and stakeholders to conduct or participate in CPP activities, and 4) CPP participant input activities. This evaluation explored stakeholders' perceptions on a range of outcome variables with respect to the aforementioned county-conducted CPP activities. The purpose of this particular analysis was to determine which CPP activities – comparing counties that did and did not implement each of them – had statistically significant effects on the respective county's stakeholders' perceptions of specific outcomes resulting from their CPP participation. The outcome variables of interest were: 1) accessibility, 2) consistency with MHSA philosophies, 3) participant safety, 4) participating training, 5) perceptions of contributions, and 6) respect of participant opinions. The impact variables of interest were: 1) participant satisfaction, 2) participant trust, and 3) participant wellness.

Outreach Activities

Using social media strategies and making announcements at MHSA meetings were the two CPP outreach activities that were significantly associated with increased participants' sense of trust in the public mental health system as well as their perceptions of the value of their contributions in CPP processes. Additionally, social media strategies were significantly associated with increased participants' feelings of safety in their CPP participation as well as their overall wellness as a result of their CPP participation. From the standpoint of county mental health departments, all of the counties that implemented social media strategies believed that these strategies were successful, corresponding with stakeholders' increased perceptions of the aforementioned outcome variables. Additionally, over 85% of counties that used social media and announcements at meetings believed that these strategies were successful, thus also corresponding with stakeholders' perceptions of specific outcome variables. In summary, increasing the use of targeted social media strategies and announcements at MHSA meetings may results in improved stakeholder perceptions of outcomes from their CPP participation.

Radio and television announcements conducted by counties were significantly associated with reduced stakeholders' perceptions of the accessibility of counties' CPP processes. Of the counties that did implement radio and television announcements of their CPP activities, only half rated the activity as successful. The underwhelming response by stakeholders and counties alike regarding the effectiveness of radio and television announcements for CPP activities suggests that counties may look to limit their use of radio and television announcements. However, given the vast reach that radio and television announcements have, perhaps ensuring increased targeted methods will improve their effectiveness when outreaching to potential CPP participants.

Incentives

The presence of stipends and other financial incentives for participation in CPP activities where shown to be significantly associated with increased CPP participants perceptions of satisfaction with CPP processes and their own wellness as well as counties' consistency with MHSA philosophies. Over three-quarters of counties that gave out stipends at their CPP activities believed that their stipends were successful. Along with stipends, providing childcare with CPP activities was shown to be significantly effective in increasing participants' sense of accessibility to CPP processes, respect of participant opinions, participants' sense of safety in partaking in CPP activities, and participants' sense of trust in CPP processes. For those stakeholders that have children and for whom finding childcare would be a prohibitive factor to their participation in CPP activities, having childcare accompanying CPP activities would greatly reduce that barrier and encourage their participation. In the future, pursing the two strategies of providing stipends and childcare may lead to more open and sustained participation in counties' CPP processes by stakeholders across the state.

The provision of translation and interpretation services at CPP activities was shown to be significantly associated with decreased participants' sense of wellness from their CPP participation. About half of the counties that offered translation and interpretation services at their CPP activities believed that they were successful, thus confirming the lack of an overwhelmingly positive response to having these sorts of

services as incentives for CPP participation. While it may be counterintuitive to have translation and interpretation services to the significantly decrease participants' sense of wellness, it is important to understand that such services come with a lot of nuances. How stakeholders communicate through spoken and written modalities varies immensely from person to person. In order for a county to provide thorough and effective translation services at their CPP activities, they must pay attention to all of the content (spoken, written, and nonverbal cues) that their stakeholders will need to fully understand to be able to participate meaningfully. Additionally, California's minority populations are constantly growing in numbers and variety; counties must be cognizant of this and tailor their translation/interpretation services accordingly to promote continued meaningful CPP participation by their stakeholders.

Trainings

At multiple points in this evaluation, the value of having external organizations training stakeholders on how to participate in counties' CPP processes was reinforced. A variety of counties brought in external organizations, such as the National Alliance on Mental Illness (NAMI), to assist in training their stakeholders to be able to meaningfully participate in their CPP processes. Of all the training activities that counties conducted or supported, providing support for external organizations to conduct trainings and/or for stakeholders to attend external trainings was the only training method that was significantly associated with participants' perceptions of the accessibility of counties' CPP processes. Perhaps the inclusion of external organizations in training CPP participants demonstrates an openness by counties for their stakeholders to attend and meaningfully participate in their CPP processes. Otherwise, keeping all of the trainings in-house perhaps signifies a sense of counties' CPP processes being closed-off and uninviting. Moving forward, as counties plan their CPP training activities for their stakeholders, it will be important to think about the potential effectiveness and utility of having external organizations offer some trainings on behalf of the counties and/or provide support for stakeholders to attend trainings conducted by external organizations.

Participant Input Activities

California's county mental health departments implement a large variety of participant input activities during their CPP processes, in order to solicit as much open and meaningful feedback from stakeholders as possible. Of the realm of CPP participant input activities assessed in this evaluation, only surveys/questionnaires were significantly associated with positive perceptions by stakeholders. Specifically, surveys/questionnaires significantly increased participants' senses of accessibility of CPP processes, perceptions of their contributions, and perceptions of their safety during participation. Nearly 90% of counties that used surveys/questionnaires believed that they were successful, which aligns with stakeholders' perceptions of their effectiveness. From this finding, it can be inferred that the less direct method of soliciting stakeholder input through surveys/questionnaires really encouraged stakeholders to be more open with their participation and feel that their contributions were valued by their counties.

Conversely, a number of other participant input activities were shown to be significantly associated with decreased stakeholder perceptions on a variety of outcome variables. In particular, strategy roundtables or strategizing sessions were significantly associated with reduced participants' perceptions of their

counties' respect for their opinions, suggestion boxes were significantly associated with decreased stakeholders' trust in CPP processes and their beliefs that the CPP processes were consistent with MHSA philosophies, and voting or prioritization activities were significant associated with decreased participant wellness. Additionally, public hearings were significantly associated with decreases in a host of outcome variables: accessibility of CPP processes, respect of participant opinions, participant training, participant safety, consistency with MHSA philosophies, participant trust, and participant wellness. Interestingly, 84% of the counties that conducted public hearings believed that they were successful.

While the four abovementioned CPP participant input activities were shown to have significant associations with decreases in a large variety of stakeholder outcome variables, those strategies should not be discounted as ineffective. Rather, it will be important for counties to reassess how they conduct these types of participant input activities and determine the specific aspects about them that may not be optimal for participants. These strategies could provide a wealth of useful information when conducted in manners that are open and encouraging, rather than closed-off and prohibitive to sustained meaningful feedback from participants.

Stakeholder Consistency

In some particular counties across California, MHSA/CPP Coordinators reported that the individuals in their CPP participant populations had generally been consistently the same individuals from year to year. In one medium county, the MHSA/CPP Coordinator commented that, "At most public meetings, the same people show up every year." In one small county, the MHSA/CPP Coordinator commented that, "When we have regular stakeholder meetings with agencies, the same individuals come, and there are not a lot of them." Throughout the state, some counties have conducted their CPP processes enough times to notice that the same groups of participants were showing up each year and that the viewpoints and opinions that they brought to the table were the same and potentially not fully representative of the changing needs of their respective public mental health consumer populations.

In the counties that MHSA/CPP Coordinators noted a lack of diversity of CPP participating individuals from year to year, stakeholders also noted a similar sentiment, commenting that they believe their CPP participating populations needed to be reinvigorated and refreshed with new individuals in order to bring new ideas to counties' MHSA and CPP work. The notion that those individuals providing feedback to counties' CPP processes needed to change from year to year was confirmed by both MHSA/CPP Coordinators and stakeholders. Public mental health consumers' needs and challenges are constantly evolving, thus the feedback provided to counties need to also be reflective of those changing needs; therefore, either the CPP participating populations need to continue to evolve based on needs or the viewpoints that they present from year to year need to be representative of the true needs of consumers at the current point in time.

Optimism of Future Impacts

Across California, both the counties and their stakeholders generally felt optimistic about their counties' CPP processes and the positive impacts that those processes were having in their counties. This evaluation attributed numerical values to key informant interview and focus group responses' overall satisfaction with their counties' CPP processes; on a scale of 1-5, with 1 being very negative to 5 being very positive. Across all of the MHSA/CPP Coordinators interviewed, the average statewide county CPP satisfaction score was 3.9, indicating general positive feelings and satisfaction. Across all of the focus groups conducted with stakeholders, the average statewide stakeholder CPP satisfaction score was 3.7, indicating general positive feelings and satisfaction, but slightly lower satisfaction levels than noted by the MHSA/CPP Coordinators.

Regional and county size variations in overall CPP process satisfaction demonstrated notable trends of the parts of California that were conducting CPP processes resulting in higher levels of overall satisfaction. In the Bay Area, Central, Los Angeles, and Southern regions of the state, MHSA/CPP Coordinators provided CPP process satisfaction comments that equated to approximately 0.2–1.0 points higher than those of focus group stakeholders, thus indicating a slightly higher overall satisfaction with their counties' CPP processes. Conversely, in the Superior region, their MHSA/CPP Coordinators had overall CPP satisfaction levels (3.4 average score) that were slightly lower than those of their stakeholders (3.5 average score). Across the three different county sizes, MHSA/CPP Coordinators from large and small counties generally had overall CPP process satisfaction scores of 0.2–0.4 points higher than those of their stakeholders (3.6 and 3.4 average scores in large counties, and 3.9 and 3.5 average scores in small counties, respectively). In medium counties, MHSA/CPP Coordinators and stakeholders had the same and higher overall CPP process satisfaction scores (4.3 average scores).

The abovementioned results demonstrate that the CPP processes that the Superior region and/or medium counties were conducting had slightly increased overall stakeholder satisfaction, which is notable given the importance of stakeholders buying into and meaningfully participating in counties' CPP processes. In general, across the state, there was a slight discrepancy between how MHSA/CPP Coordinators and stakeholders view their counties' CPP processes. As counties move forward and conduct their future CPP processes, it will be important for them to keep in mind that their stakeholders generally did not feel as positively as they previously had about their CPP processes. Additionally, counties should continue to identify strategies to further engage their stakeholders in CPP planning and feedback processes.

Recommendations

Over the course of this project, the evaluation team has noted a number of potential recommendations for counties' future CPP processes. These recommendations stemmed from the evaluation team's critical review and interpretation of the data collected. In summary, the evaluation team's recommendations from this evaluation are as follows:

Inputs

- Increase staffing or designation of hours during periods of CPP outreach, planning, and implementation. It may be prudent for counties with limited resources to set aside dedicated funding to increase staff levels during times of high volume CPP work.
- Utilize community resources, such as community leaders, community based organizations (CBOs), and other service providers to help with CPP outreach activities.

Outreach

- Increase outreach strategies that capitalize on using informal social activities, dialogues, and on-the-ground personal interactions in addition to more formal outreach activities. Data across all county sizes and CMHDA regions indicates that word-of-mouth activities are an effective outreach method.
- Consider further research to understand the relationship between radio/TV announcements and perception of CPP meeting effectiveness
- To enhance outreach to stakeholders, counties might consider the following strategies:
  - Increase the use of social media
  - Increase the use of announcements at meetings
- If resources permit, provide stipends/other financial incentives to encourage stakeholder participation as this seems to increase stakeholder's satisfaction in the CPP process, sense of wellness, and perception that the CPP process is consistent with MHSA philosophies.
- Offer childcare services to promote stakeholder participation during CPP activities. Data suggests the provision of childcare correlates with the following positive outcomes:
  - Stakeholders' perception of accessibility was enhanced.
  - Stakeholders' perception of safety and trust in sharing feedback was enhanced.
  - Stakeholders' perception that their opinions are respected by the CPP facilitators was enhanced.

Participant Input

- Establish clear ground rules for how stakeholders are expected to participate in strategy roundtables/strategizing sessions. For counties using strategy roundtables/strategizing sessions, data seems to indicate a decrease in stakeholder's perception that their opinions and culture were respected.
- Increase the use of surveys/questionnaires. Data suggests using surveys/questionnaires in the CPP process might increase stakeholder's perception of accessibility, contribution, and safety.
- Explore ways in which to make public hearings more useful. County informants and stakeholders generally reported public hearings were ineffective. In addition, stakeholders found the bureaucratic processes confusing.
- Further explore the use of suggestion boxes.
- Consider ways to make voting and prioritization activities more successful.

- Conduct further research exploring how to use translation/interpretation services in the most effective and culturally relevant manner. Approximately half of the counties utilize translation/interpretation services during the CPP process. Moreover, the majority of these counties find translation/interpretation services to be a successful strategy for encouraging stakeholder participation.

Training

- Refine expectations around stakeholder participation and revise participant trainings to match and communicate these expectations as a part of outreach efforts.
- Minimize the use of technical jargon to enhance stakeholders understanding of the material.
- Provide CPP activities and materials in languages other than English in order to increase accessibility and understanding of the CPP process.
- Expand support for external trainings as this could increase accessibility of the CPP process.
- For counties in the Bay Area, mental health departments might allocate more time for planning CPP activities with stakeholders. This could help stakeholders better understand their roles and expectations in the CPP process as well as provide them with enough information to effectively participate in CPP activities.

Evaluation

- Should the MHSOAC decide to implement a required evaluation component, it is recommended that the MHSOAC first formalize and standardize methods for counties to record participant attendance and demography, providing guidelines for how to use this information to improve future CPP processes.

Satisfaction with the CPP Process

- Aim to improve the structure of CPP meetings so that the planning process is more transparent, welcoming, safe, and meaningful.
- Increase efforts to include more consumers in leadership, planning processes, and policymaking.
- Encourage staff members who work in the mental health departments to participate in CPP processes.

Participant Impacts

- Activity facilitators should take care to make CPP activities accessible to participants—including establishing a safe environment free of stigma and providing adequate training so that participants know how and why they are participating
- Design CPP activities in alignment with MHSA principles. Factors to keep in mind during the planning process are adopting a recovery-oriented approach and being explicit about how participant input will be used to inform programming and service delivery.

Mental Health System Impacts

- Strive to include consumers and their family members in program planning, implementation, evaluation, and decision making. The inclusion of consumers and family members in higher-level planning has shown to be essential in building buy-in, trust, and utilization of the PMHS.
- Continue to involve consumers and their family members in all aspects of MHSA program development.
- Continue to require the representation from other health and human service providers in all aspects of MHSA program development.

Perceptions of the Broader Community Impacts

- Be proactive in developing a diverse stakeholder population. To further this goal, counties might consider building more opportunities for dialogue in a safe environment that fosters trust, understanding, and collaboration among the different constituencies. As a result, increased partnerships across stakeholder groups and sectors will help reduce stigma around mental health issues and accessing services.

Conclusion

Counties throughout California are conducting an immense variety and quantity of activities for their CPP processes. The vast amount of data collected from this evaluation serves as an indication of the dedication of counties to providing quality public mental health services and soliciting meaningful feedback from stakeholders via their CPP processes. Additionally, this evaluation received an enormous amount of information from stakeholders across the state, thus also demonstrating stakeholders' commitment to providing their insights and feedback on their counties' CPP processes and potential avenues for continued future improvements for all parties involved. While MHSA/CPP Coordinators largely felt more positive than stakeholders about their counties' CPP processes and the levels of engagement that they had been able to produce, both MHSA/CPP Coordinators and stakeholders were generally satisfied with their counties' current CPP processes, thus signifying that counties are currently on the right track with their CPP processes and the levels of engagement that they are generating amongst stakeholders.

This evaluation report provides a comprehensive examination of all of the data collected over the course of the evaluation of California's CPP processes, presenting all of the findings that could be determined from the evaluation research questions for which data was available (see attached document titled, "MHSA Community Program Planning Processes – Technical Evaluation Report (Supplemental Report)". Additionally, this report summarizes these results by specific CPP categories or themes and presents those summaries in the "Findings" section. Lastly, the "Discussion" offers a presentation of the crosscutting findings that were evident throughout the results and findings. Throughout this report, results and findings are presented at the statewide, CMHDA Region, and county size levels in order to provide multiple layers of analysis and more to draw out nuanced understandings of trends across the state. The layout of this evaluation report is intended to provide readers with detailed understandings of all of the evaluation's collected data, as well as synthesis and analysis of those results to identify common within- and across-theme findings that could serve to inform the identification of specific CPP activities and methods that were effective and potentially replicable across California.

Significance tests were conducted to examine counties' implementation of specific CPP activities and their associations with stakeholders' perceptions of a variety of outcome variables. CPP activities pertaining to CPP outreach efforts, incentives, trainings, or participant input strategies were tested against outcome variables (accessibility, consistency with MHSA philosophies, participant safety, participant training, perception of contribution, and respect of participant opinions) to find the statistically significant associations. In total, 32 significant positively or negatively correlated relationships were discovered between counties conduction of specific CPP activities and stakeholder perceptions. This evaluation report details these significant findings and provides potential areas for consideration in counties' future CPP processes.

In summary, the evaluation team recognized that it is important for counties and stakeholders to continue to identify those strategies that further promote CPP processes that were in alignment with the MHSA's goals and values. By being more cognizant of MHSA's overall goals and values in their CPP processes,

counties will yield more meaningful CPP participation by stakeholders and increased trust with the state's PMHS. Additionally, this evaluation also verified that there are indeed unique CMHDA regional and county size trends for CPP processes that counties should be cognizant of, and adapt their future CPP processes accordingly, in order to potentially maximize their CPP efforts and receive more meaningful feedback from stakeholders.

Next Steps

The findings from this evaluation, combined with best practices in community planning from other related content areas, will be used to identify promising CPP practices that can be applied throughout California. As previously noted, promising CPP practices will be identified for the State at-large by the following levels: statewide, by CMHDA region, and by county size. Promising CPP practices are those specific practices believed to be replicable in broader parts of the state, beyond just in one individual county, and will promote increased meaningful and effective CPP processes and participation by stakeholders. The promising CPP practices, to be identified in Summer 2014 by a selected group of county and stakeholder representatives, will be incorporated into future CPP training and technical assistance efforts for California's counties and stakeholders.

Suggestions for Future Trainings for CPP Participants

Stakeholders and counties made various suggestions related to trainings that would have been useful to CPP participants. A number of counties across the state included CPP training-related activities during some of their standing MHSA meetings. This allowed those counties to have a continual, dedicated audience of stakeholders who were invested in MHSA to be present for the dissemination of information about its CPP processes. This also negated having to set up different times to conduct CPP training activities/meetings. However, one challenge of this approach was that potential CPP participants who did not attend counties' MHSA meetings would not be included in the descriptions and trainings about CPP activities.

Stakeholders and counties were both concerned about training that would address language and comprehension barriers for participants. Conducting CPP trainings in Spanish, or languages other than English, would have promoted more participation from stakeholders for whom English is not their main language of communication. By being cognizant to the language needs of its stakeholder populations, counties can identify the types of services and accommodations that they could provide in order to encourage more expansive participation in its CPP processes.

It was also suggested that steps be taken to increase the likelihood that all stakeholders will be able to understand the information being provided at CPP trainings. Stakeholders suggested encouraging facilitators, providers, and CPP staff to use less jargon during its CPP trainings. This would allow stakeholders to better understand the CPP objectives and tasks.

Many counties handed out flyers and other printed/email materials describing the CPP process and activities. This was a method used by the counties to reach a wider audience of potential CPP participants while utilizing small amounts of resources, both in terms of staff time and the financial costs of convening meetings, to educate people about its CPP process.

One county suggested that using multi-media services to conduct CPP trainings and activities would be conducive to including more stakeholders from around the county. For example, webinars and radio broadcasting can serve as ways to train people about the counties' CPP processes.

NAMI was noted quite often as an organization that provided trainings to counties' stakeholders on how to participate in the CPP process. Stakeholders perceived NAMI in a positive light, often saying that they would like more NAMI-sponsored CPP trainings.

Appendices

Appendix 1: Evaluation Logic Model

See the next two pages for the Evaluation Logic Model.

Processes			Outcomes/Impacts
Inputs	Activities	Process Outcomes	Short term, intermediate, and long term outcomes & impacts
1. What resources do counties have to conduct CPP process?	**2. What CPP activities are Counties engaged in?**	**3. What does participation consist of? (Who? How much? How often? In what ways?)**	**4. How does participation affect participant wellness?** **5. How does CPP process affect the Mental Health system?** **6. How does CPP affect the broader community?**
Questions			Questions
Staff • What staffing is allocated to CPP processes? e.g., contractors, volunteers, trainers • What are the qualifica-tions of the MHSA-CPP staff? • To what extent are resources for the CPP process sufficient and sustain-able?	*Outreach and engagement* • What activities are used to outreach & engage stakeholders in the CPP process? • What types of communication are used to outreach and engage stakeholders to participate in the CPP process? E.g. flyers, phone calls, emails, other • Who are targeted in the outreach for CPP participation? • What unique or innovative outreach activities do counties employ to engage people in the CPP process? *Participation* • What are the barriers to CPP participation? How are they mitigated? • In what ways and to what extent do counties target un-served/ underserved/ inappropriately served populations for outreach and participation in the CPP process? *Promoting Access*	*Outreach and engagement* • Who/ how many stakeholders are outreached to for participation in the CPP process? • To what extent do counties outreach to groups who have not historically been involved in Mental Health planning or services? *Participation* • Who participates in the CPP process? i.e., demographics • Why do they decide to participate in the CPP process? • How many new people participate in the CPP process? • How long and with what frequency do people participate in CPP? • What are the barriers to participation in the CPP process? • What is the level partner organization participation? • Who does not participate? • If an individual's participation in the CPP process ceased, what are the reasons? • What activities are stakeholders participating in throughout the continuum of MHSA activities? Is there penetration into all functions of MHSA including program planning, implementation, evaluation, oversight and accountability?	**STAKEHOLDER** • To what degree does CPP participation affect participant wellness? e.g. education, vocation/employment, housing, self-sufficiency, reduction of negative outcomes • To what degree does CPP process participation affect stakeholder trust in MH system to provide services? **MH SYSTEM** • How has CPP participation affected regional & statewide advocacy? • How & to what degree does the CPP process influence planning of MH services, implementation of MH services & outcomes of people who receive MH services? • How does the CPP process affect county program budgets & resource allocation? *Services* • To what degree are MH services changed as a result of CPP process? Are they improved? Expanded? • To what extent does participant input throughout the CPP process impact the

	• To what extent is translation/ interpretation provided? In which languages? Is it consistently available throughout the CPP process? • What is being done to make stakeholder participation in the CPP process accessible? i.e transport, reimbursement • What are counties doing to increase access to meetings? i.e location, time, childcare • What do counties do to create CPP environments that are safe, free from stigma, discrimination and retaliation? *Training* • What training & education activities are counties providing to participants of the CPP process? *Participant Input* • What do counties do to collect input from participants of the CPP processes? • To what extent and how do counties seek input from consumers, families, and/ or underserved populations? • To what extent and in what ways does the county provide feedback and communication about how it integrates or does not integrate participant input from the CPP process? • How does the county integrate diverse, differing and/or conflicting CPP participant input? • What is the degree of transparency about decisions made as a result of CPP process? *CPP Process & Design* • How are adjustments to the CPP design made? How is participant input incorporated in the CPP process planning and design? • What is the relationship between LMHB & MHSA-CPP Committee? What is the relationship between Behavioral Health administration & MHSA-CPP Committee? • How do counties evaluate and improve their CPP process? *General* • Are counties employing any unique or innovative strategies to engage stakeholders in planning, implementing or evaluation services and supports? i.e consumer committees	*Access* • To what extent are consumers and family members engaged in every MHSA committee? • To what extent do CPP participants feel that the CPP environment was safe, free from stigma, discrimination and retaliation? • To what degree do CPP process participants feel that CPP process meetings and activities are accessible? *Training* • To what degree do CPP participants feel that they have the training needed to meaningfully participate? • To what degree do MHSA-CPP staff/contractors feel that they have the training to support the CPP process? *Participant Input* • To what degree do participants feel that they can contribute to program planning? • To what degree do participants feel that their opinions are respected? • To what degree are the minutes from CPP process meetings reflective of participatory input? • To what degree are public hearing comments documented in the Annual Update? *General Perceptions:* • What is the participant perception of the CPP process? • What is the MHSA coordinator's perception of the CPP process? • What are other stakeholders' perceptions of the CPP process?	planning, implementation and evaluation of MH services? • To what degree do services more effectively meet the needs of the community as a result of the CPP process? (culture, language, needs) • How has staffing of the MH system changed due to CPP process? (e.g: Are more consumers being hired?) • How has CPP process participation changed advocacy efforts? How has CPP process participation affected regional and statewide advocacy? • To what extent has the CPP process increased collaboration among public systems (e.g. probation, child welfare, etc.)? • What are the ways that CPP process has affected stigma in MH services system? • Does partner participation lead to improved services of partner organizations? **COMMUNITY AT LARGE** • Does CPP process influence voting & civic engagement? • To what extent does CPP affect stigma and community perception of services? • Does CPP process affect community's trust in MH service system? • How has CPP affected the community beyond the Mental Health system?

Appendix 2: Data Collection Instruments

See attached Appendix 2 document for all five data collection instruments as they were viewed in SurveyGizmo. In the attached Appendix 2, the data collection instruments are presented in the following order:

1. County Web-Based Data Request
2. Annual Update Document Review
3. Key Informant Interviews (notes entry)
4. Focus Groups (notes entry)
5. Stakeholder Survey (English version)

Appendix 3: Crosswalk between SurveyGizmo Data Collection Instruments Items and CPP Inventory Data Fields

NOTE: The items noted below are in the same order as in the SurveyGizmo printouts for each county. The code to the left of each item below signifies the SurveyGizmo output item identification number; the number before the decimal point corresponds to the section in the SurveyGizmo output, and the number after the decimal point corresponds to the specific item number in the SurveyGizmo output. The code to the right of each item below signifies the specific CPP Inventory data field that the item corresponds with.

County Web-Based Data Request

CPP FY 12/13 Annual Update

2.5	During what period did your county conduct its CPP activities for the development of the Annual Update for FY 12/13? Please check all that apply:	A-1
2.6	What best describes the frequency in which your county conducts its CPP process?	A-2
2.7	Within CPP planning for the FY 12/13 Annual Update, please specify what plans were being considered (please check all that apply):	A-3
2.8	For how long have you been involved in MHSA Community Program Planning (CPP) activities and processes in your county? Please specify the approximate number of months you have been involved in this process:	A-32
2.9	Are you involved in any other county program planning (i.e., planning done outside the scope of the Mental Health Services Act)?	A-33

CPP Staff Participation

3.10	How many staff Full Time Equivalents (FTEs) were used to facilitate the CPP process used to develop your 2012/13 Annual Update?	A-11
3.11	During the planning process for the FY 12/13 Annual Updates, did the county encourage or provide any training to staff responsible for or involved in the CPP process?	A-12
3.12	Has your county provided or encouraged any such training to staff responsible for or involved in the CPP process in the past (i.e., prior to the time when your county was preparing to complete stakeholder planning related to the Annual Update for FY 12/13)?	A-13

Total Stakeholder Involvement

4	Please enter the total number (unduplicated count) of individuals who participated in CPP activities for the development of the Annual Update for FY 12/13.	A-4

Total Stakeholder Involvement (demographics)

5	Age	A-6
5	Gender	A-7
5	Race/Ethnicity	A-5
5	Primary Spoken Language at Home	A-8
5	Stakeholder affiliation	A-10

Outreach

6.13 & 7	What types of CPP outreach activities did your county do to plan for the 2012/13 Annual Update?	B-1	A-14	A-15

Incentives Offered

8 & 9	During planning for the FY 12/13 Annual Update, which of the following incentives did your county offer to CPP participants?	B-2

Stakeholder Input

10 & 11	Which of the following activities aimed at collecting input from stakeholders did your county engage in during planning for the 2012/13 Annual Update?	B-3

Stakeholder Participation

12 & 13	Which of the following activities aimed at promoting stakeholder participation in planning, prioritizing and decision-making does the county engage in?	B-4

Training

14 & 15	For the purpose of planning for the 2012/13 Annual updates, in what ways were training and education provided to participants of the CPP process.	B-5

Evaluation

16 & 17	Please identify any ways in which your county evaluated or attempted to improve its CPP process.	B-6

Additional Questions

18.127	Related to planning for the FY 12/13 Annual Update and changes made to your county's services and systems based on this planning, did your county measure the impact of its local CPP process on any individual- or system-level outcomes (e.g., evaluation of potential improvements in the mental health or functioning of clients/family members served by the newly planned/implemented services; evaluation of service-delivery improvements that may have stemmed from changes made based on implemented plans)?	A-26
18.127	Please describe which outcomes your county evaluated:	A-27
18.127	Please describe the results of your evaluation:	A-28
18.128	Related to MHSA stakeholder planning that your county has completed at any time in the past and changes made to your county's services and systems based on this planning, did your county measure the impact of its local CPP process on any individual- or system-level outcomes (e.g., evaluation of potential improvements in the mental health or functioning of clients/family members served by the newly planned/implemented services; evaluation of service-delivery improvements that may have stemmed from changes made based on implemented plans)?	A-29
18.129	Please describe which outcomes your county evaluated:	A-30
18.130	Please describe the results of your evaluation:	A-31

MHSA Principles 1

19 & 20	Has your county's CPP process has changed since it was first used to develop plans for the Three Year Program and Expenditure Report (FY 05/06, 06/07, 07/08), with regard to the following?	A-16

MHSA Principles 2

21	How representative of your county's overall MHSA stakeholder planning process do you think the planning done for the development of the FY 2012/13 Annual Updates was?	A-25

Annual Update Document Review

Demographics of Participants

2.5	Age	A-6	
2.6	Gender	A-7	
2.7	Race/Ethnicity	A-5	
2.8	Consumer/Family Member	A-10	
2.9	Language - Non-English proficient	A-8	
2.10 & 2.11	Other Demographic categories described:	A-10	A-9
2.10 & 2.11	Stakeholder Affiliations:	A-10	A-9

Outreach

3.17	Outreach Activities - please describe	B-1

Stakeholder Planning, Strategizing & Evaluating (i.e., ongoing CPP engagement)

4.18	Outreach Activities - please describe	B-4

Stakeholder Input

5.19	Outreach Activities - please describe	B-3

Posting and Reporting

6.20	Was there a 30-day posting of the Annual Update?	A-17
6.21	If yes, where/how was the Annual Update distributed?	A-18
6.22	To what languages was the Annual Update translated into?	A-19

Public Hearing

7.23	Was there a public hearing of the Annual Update?	A-20
7.23	Was public health feedback incorporated into the final draft of the Annual Update?	A-21
7.23	Number of public hearing participants:	A-22
7.23	Number of comments received:	A-23
7.23	How were comments addressed?	A-24
7.23	What changes were made to the plan? (if applicable):	A-24

Key Informant Interview

Introduction

1.3	For how long and in what ways have you been involved in MHSA Community Program Planning (CPP) processes in this county?	A-32

CPP Staffing

2.4	How do you feel that the CPP process is adequately staffed to coordinate and manage the Community Program Planning Process and ensure that stakeholders have the opportunity to participate?	C-19

Outreach

3.5	Which outreach activities to stakeholders for participation in the CPP process were most effective and why? Please describe the activities and why you thought they were effective.	C-20
3.6	Which outreach activities were least effective and why? Please explain.	C-21

Stakeholder Participation

4.7	Are their certain stakeholder groups that participate more frequently than others? If so, who? (reference stakeholder groups)	C-25
4.8	Are their certain stakeholder groups that are underrepresented or do not participate in the CPP process? If so, why do you think this is?	C-26
4.9	What barriers to participation do you think that stakeholders in your county face? How do you address these barriers? Are there any barriers you feel you are unable to address?	C-27
4.10	What does the CPP staff or county do to ensure that the CPP process is consistent with the principles of MHSA? Please give specific examples to the following prompts:	C-33

CPP Process - Community Changes

5.11	What does the CPP staff or county do to create safe environments for the CPP process activities and meetings? (i.e., free from stigma, discrimination and retaliation)	C-34

5.12	How and to what degree has the CPP process affected trust and collaboration: • Among mental health service providers? • Between mental health providers and other stakeholders including health and human service providers? • Between consumers and family members?	D-3
5.13	To what extent does the CPP process in your county affect: • the public's perception of public mental health services? • the public's perception of people with mental illness? (i.e., stigma)	D-4

CPP Process - Policy & Advocacy Change

6.14	In what ways has the CPP process affected and/or changed the public mental health system and services? Please be specific.	D-5
6.15	Are CPP participants engaging in regional and statewide advocacy or planning related to mental health services? Is the county or the CPP process doing anything to support their regional or statewide engagement? If so, what?	D-6

CPP Process - Other Impacts

7.16	What other impacts do you perceive the CPP process to have on the community at large, particularly related to MHSA-defined outcomes?	D-7

Satisfaction With & Changes to CPP Process

8.17	Overall, how satisfied are you with the CPP process in your county? Please explain.	D-8
8.18	Given the resources you have, what would you do differently in future CPP processes?	D-9

Focus Group

Questions for Individuals from Unserved/Underserved Populations without Prior CPP Participation Experience

2.3	To your knowledge, how does the county reach out and invite stakeholders from unserved/underserved populations to participate in the CPP process?	C-23
2.4	What are the barriers/challenges that prevent or restrict individuals from unserved/underserved populations from participating in CPP processes?	C-24

Outreach

3.5	How did you find out about the Community Program Planning process?	C-22
3.6	To your knowledge, how else does the county reach out and invite stakeholders to participate in the CPP process?	C-23
3.7	Are there any barriers/challenges that prevent or restrict people from participating in CPP processes?	C-24

Community Program Planning Activities

4.8	What types of Community Program Planning activities do you participate in and how often? Which activities do you like the most? Why?	C-28
4.8	What types of Community Program Planning activities do you participate in and how often? Which activities do you least appreciate? Why?	C-29
4.9	Did the mental health department provide you with training or educational opportunities to better prepare you to participate in CPP processes?	C-30
4.10	Are there certain stakeholder groups that participate more frequently than others? If so, who? (reference stakeholder groups)?	C-25
4.11	Are their certain stakeholder groups that are underrepresented or do not participate in the CPP process? Why do you think this is (reference stakeholder groups)?	C-26
4.12	How do County Mental Health Department staff members communicate with you and other participants about the CPP process?	C-31

4.13	Do you feel that decisions made regarding your input are transparent? For example, do you receive an explanation on how staff integrates or does not integrate participant input?	C-32
4.14	To what extent do people feel safe and supported participating in CPP?	D-2

Outcomes and Impact

5.15	How has the CPP process impacted or changed the public mental health system and/or mental health services?	D-5
5.16	Does your participation in the CPP process affect your opinion of the mental health department and your trust in the mental health system? How so?	D-2
5.17	How has participating in CPP affected your own wellness and/or recovery, if at all?	D-1
5.18	Has the CPP process affected how the public perceives mental health services and people who have mental health illnesses?	D-4
5.19	Has the CPP process affected relationships between the mental health department and government agencies or community based organizations? How and to what extent?	D-3
5.20	What other impacts, if any, do you think that the CPP process has had?	D-7

Overall Perception

6.21	Overall, to what degree are you satisfied with the CPP processes and why?	D-8
6.22	With regards to the CPP processes, what would you do differently? What are your recommendations for the future?	D-9

Stakeholders Survey

1	Which California county do you live in?	C-1
2	Have you ever participated in the MHSA Community Program Planning process?	C-10
3	Did you participate in Community Program Planning activities during the last fiscal year (July 2012- June 2013)?	C-11
4	For how long have you participated in the MHSA Community Program Planning process?	C-12
5	Do you plan to participate in the future?	C-14
6	How frequently did you participate in MHSA Community Program Planning activities or meetings	C-13
7	Why did you decide to participate in the MHSA Community Program Planning process? (Check all that apply.)	C-15
8	Which of the following MHSA/ Community Program Planning activities did you participate in within the last year? (Check all that apply.)	B-7
9	In the past year, how have you received information about the MHSA Community Program Planning process in your county? (Check all that apply.)	B-8
10	Which of the following incentives does your county offer MHSA Community Program Planning participants? (Check all that apply.)	B-10
11	What has made it difficult for you to participate in the MHSA Community Program Planning process? (Check all that apply.)	C-16
12	Please rate how much you agree with the following statements about the MHSA Community Program Planning (CPP) process in your county:	C-9
13	What did you like most about the MHSA Community Program Planning process in your county?	D-10
14	What did you like least about the MHSA Community Program Planning process in your county?	D-11
15	How could the MHSA Community Program Planning process be improved?	D-9
16	Did you stop participating in the 2012-2013 MHSA Community Program Planning process before it was over?	C-18
17	Why did you stop participating in the MHSA Community Program Planning process?	C-18
18	What would encourage you to participate in the MHSA Community Program Planning process again?	C-35

19	What would be the best way for the county to inform you about the MHSA Community Program Planning process? (Check all that apply.)	B-9
20	Which of the following incentives would encourage you to participate in the MHSA Community Program Planning process? (Check all that apply.)	B-11
21	What barriers would prevent you from participating in the MHSA Community Program Planning process in your county? (Check all that apply.)	C-17
22	Please check this box if you do not wish to answer demographic questions	C-2
25	Please indicate you age range	C-4
26	Please indicate your gender	C-5
27	Please indicate if you identify as LGBT	C-8
28	Please indicate you race/ethnicity:	C-3
29	Please indicate the language you speak at home:	C-7
30	Please indicate your affiliation with the MHSA CPP process. (Check all that apply.)	C-6

Appendix 4: Qualitative Data Themes

The table below lists the various themes in which the evaluation team's qualitative data were organized by, as well as the specific data collection instruments (Key Informant Interview and/or Stakeholder Focus Group) from which qualitative data could be found for each theme.

Table 18. Qualitative Data Themes

Themes / Categories	Key Informant Interview Data Source	Focus Group Data Source
CPP outreach activities - Most effective	KII	
CPP outreach activities - Least effective	KII	
CPP outreach activities - Received by stakeholders		FG
General outreach thoughts		FG
Barriers to CPP participation		FG
Stakeholder groups - Frequent participation	KII	FG
Stakeholder groups - Underrepresented	KII	FG
Barriers to CPP participation	KII	
CPP activities - Liked most	KII	FG
CPP activities - Liked least		FG
MHD training activities		FG
MHD communication is informative		FG
Decisions with stakeholder input are transparent		FG
Consistent with MHSA principles - CPP process	KII	
Steps to create safe environments	KII	FG
Impact on participant empowerment, hope, etc.		FG
Impact on participant trust/collaboration with MHD		FG
Impact on trust/collaboration between providers	KII	FG
Impact on community perception of MH stigma	KII	FG
Impact on MH policy, planning, etc.	KII	FG
Other impacts of CPP	KII	FG
Overall satisfaction of county's CPP processes	KII	FG
Opportunities for improvement	KII	FG

Appendix 5: Qualitative Data Codes

The tables below list the qualitative data codes that the evaluation team used throughout its qualitative data analyses.

Table 19. Qualitative Data Codes for CPP Outreach and Informational Activities

Code	Category
O-A	Post flyers/ posters/ brochures
O-B	Phone calls/ invitations by mental health dept. staff
O-C	Emails to list-serve
O-D	Radio/ TV announcements
O-E	Print announcements (e.g., newspaper)
O-F	Social media (e.g., Twitter, Facebook)
O-G	Announcement at meetings
O-H	Word-of-mouth/Personal contact/Referral
O-N	None
O-O	Other (specify)
O-S	Comments about services provision

Table 20. Qualitative Data Codes for Incentives for CPP Participation

Code	Category
Inc-A	Transportation to meetings
Inc-B	Transportation vouchers
Inc-C	Meals at meetings
Inc-D	Multiple meeting times (e.g., evening and daytime)
Inc-E	Stipends/Other financial incentives
Inc-F	Childcare
Inc-G	Continuing Education Credits/Certificates
Inc-H	Translation/Interpretation services
Inc-I	Meetings in languages other than English
Inc-N	None
Inc-O	Other (specify)
Inc-S	Comments about services provision

Table 21. Qualitative Data Codes for CPP Stakeholder Input Activities

Code	Category
I-A	Survey/questionnaires
I-B	Focus Groups
I-C	Town hall/community meetings to gather input
I-D	Public hearings
I-E	Key informant interviews
I-F	Suggestion boxes
I-N	None
I-O	Other (specify)
I-S	Comments about services provision

Table 22. Qualitative Data Codes for CPP Stakeholder Participation Activities

Code	Category
P-A	Stakeholder Steering Committee/Stakeholder Planning Committees
P-B	Strategy roundtables/strategizing sessions
P-C	Voting or prioritization activities
P-D	Community meetings and town hall meetings to plan, prioritize or make decisions
P-E	Public campaign
P-F	Advocacy group
P-G	Mental health board/advisory board
P-H	Informal social activity/community event
P-N	None
P-O	Other (specify)
P-S	Comments about services provision

Table 23. Qualitative Data Codes for Training and Education for CPP Participants

Code	Category
T-A	Produce and distribute CPP educational materials
T-B	Offer professional development or continuing education credits
T-C	County-specific trainings on participation in the local stakeholder planning process
T-D	Support for participants to attend trainings not sponsored by the county
T-M	Need more training activities.
T-N	None
T-O	Other (specify)
T-S	Comments about services provision

Table 24. Qualitative Data Codes for Creating Safe Environments for CPP Participation

Code	Category
S-A	Inclusive/neutral locations/environments
S-B	Safe locations/environments
S-C	Setting-up agreements/rules beforehand
S-D	Open participation to variety of stakeholders
S-E	Setting-up agreements/rules beforehand
S-F	Creating alternative forms of communication
S-G	Create vision statement
S-H	Organizing activities that allow for socializing & camaraderie
S-I	Anonymity
S-J	Well-trained, friendly MHD staff
S-I	Anonymity
S-O	Other (specify)
S-S	Comments about services provision

Table 25. Qualitative Data Codes for Barriers to CPP Participation

Code	Category
B-A	Transportation (including geography, size, rural)
B-B	Money
B-C	Outreach (including promotion and education of CPP)
B-D	Language & Cultural Competence
B-E	Accessibility (Meeting times, location, inviting)
B-F	Community Stigma (including protecting anonymity)
B-G	Childcare / work
B-H	Impact (not results; input not seen as used)
B-O	Other (specify)
B-N	None
B-S	Service provision

Table 26. Qualitative Data Codes for Outreach to Underrepresented/Underserved Communities

Code	Category
U-A	Cultural brokers/community navigators
U-B	Agencies/community orgs working with ethnic communities
U-C	Tribal groups
U-D	Faith-based groups/Places of worship
U-E	MHSA Ethnic Service Manager
U-O	Other (specify)
U-N	None
U-S	Service provision

Table 27. Qualitative Data Codes for Stakeholder Groups/Affiliations

Code	Category
G-A	Children and Family Services
G-B	Community-based/non-profit mental health service provider
G-C	Community based organization (non-MH)
G-D	Consumer/client
G-E	County mental health department staff
G-F	Family member
G-G	Hospital/health care provider
G-H	K-12 education provider
G-I	Law enforcement/Justice system
G-J	Senior Services
G-K	Substance abuse service provider
G-L	Veteran Services
G-M	Mental health advisory/board members
G-N	Racial/Ethnic group
G-P	Veterans
G-O	Other (specify)
G-Q	None
G-S	Service provision

Appendix 6: Results from Stakeholder Survey Significance Testing

Table 28. t-Test Analysis for Stakeholder Survey Variables Correlated with CPP Outreach Activities – Posting Flyers/Posters/Brochures

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Outcome Variables							
CPP Meeting Effectiveness	No	132	4.27	.71	-.344	491	.731
	Yes	361	4.29	.79			
Recovery Orientation	No	142	4.03	.98	.027	492	.979
	Yes	352	4.03	.98			
Participant Safety	No	147	4.03	1.05	-1.073	516	.284
	Yes	371	4.14	1.00			
Participant Training	No	147	3.88	1.00	-.011	516	.991
	Yes	371	3.88	1.06			
Perception of Contributions	No	148	3.91	1.24	-.685	504	.494
	Yes	358	3.99	1.11			
Respect of Participant Opinions and Culture	No	136	4.17	.90	-.234	488	.815
	Yes	354	4.19	.92			

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Impact Variables							
Participant Satisfaction in CPP Process	No	147	4.07	1.05	-.287	513	.774
	Yes	368	4.1	1.07			
Increased Participant Trust in PMHS	No	151	3.74	1.14	.148	519	.883
	Yes	370	3.72	1.13			
Improved Participant Wellness	No	146	3.48	1.10	-.639	510	.523
	Yes	366	3.55	1.06			

**p < .05, **p < .01, ***p < .001*

Table 29. t-Test Analysis for Stakeholder Survey Variables Correlated with CPP Outreach Activities – Phone Calls/Invitations by Mental Health Department Staff

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Outcome Variables							
CPP Meeting Effectiveness	No	107	4.29	.76	.036	491	.971
	Yes	386	4.29	.77			
Recovery Orientation	No	117	4.07	.94	.531	492	.595
	Yes	377	4.01	.99			
Participant Safety	No	120	4.17	.95	.697	516	.486
	Yes	398	4.09	1.04			
Participant Training	No	119	3.83	1.05	-.554	516	.580
	Yes	399	3.89	1.04			
Perception of Contributions	No	120	3.93	1.12	-.453	504	.651
	Yes	386	3.98	1.15			
Respect of Participant Opinions and Culture	No	111	4.20	.81	.237	488	.813
	Yes	379	4.18	.94			

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Impact Variables							
Participant Satisfaction in CPP Process	No	120	4.07	.99	-.266	513	.790
	Yes	395	4.10	1.09			
Increased Participant Trust in PMHS	No	123	3.79	1.10	.727	519	.467
	Yes	398	3.70	1.15			
Improved Participant Wellness	No	120	3.57	1.08	.460	510	.646
	Yes	392	3.52	1.07			

**p < .05, **p < .01, ***p < .001*

Table 30. t-Test Analysis for Stakeholder Survey Variables Correlated with CPP Outreach Activities – Emails to List-Servs

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Outcome Variables							
CPP Meeting Effectiveness	No	49	4.42	.58	1.227	491	.221
	Yes	444	4.27	.79			
Recovery Orientation	No	56	4.11	.97	.656	492	.512
	Yes	438	4.02	.98			
Participant Safety	No	57	4.25	.81	1.069	516	.286
	Yes	461	4.09	1.04			
Participant Training	No	60	3.80	1.16	-.619	516	.536
	Yes	458	3.89	1.03			
Perception of Contributions	No	59	4.03	1.14	.481	504	.631
	Yes	447	3.96	1.15			
Respect of Participant Opinions and Culture	No	54	4.29	.68	.875	488	.382
	Yes	436	4.17	.94			

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Impact Variables							
Participant Satisfaction in CPP Process	No	56	4.25	1.03	1.198	513	.232
	Yes	459	4.07	1.07			
Increased Participant Trust in PMHS	No	61	3.90	1.03	1.306	519	.192
	Yes	460	3.70	1.15			
Improved Participant Wellness	No	58	3.78	1.08	1.882	510	.060
	Yes	454	3.50	1.07			

**p < .05, **p < .01, ***p < .001*

Table 31. t-Test Analysis for Stakeholder Survey Variables Correlated with CPP Outreach Activities – Radio/TV Announcements

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Outcome Variables							
CPP Meeting Effectiveness	No	467	4.30	.76	1.966	491	.050*
	Yes	26	4.00	.81			
Recovery Orientation	No	466	4.05	.97	1.740	492	.083
	Yes	28	3.71	1.15			
Participant Safety	No	489	4.12	1.03	.600	516	.548
	Yes	29	4.00	.85			
Participant Training	No	490	3.89	1.04	1.418	516	.157
	Yes	28	3.61	1.13			
Perception of Contributions	No	477	3.98	1.15	1.006	504	.315
	Yes	29	3.76	1.09			
Respect of Participant Opinions and Culture	No	463	4.20	.91	1.740	488	.083
	Yes	27	3.89	.84			

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Impact Variables							
Participant Satisfaction in CPP Process	No	487	4.10	1.05	1.188	513	.235
	Yes	28	3.86	1.35			
Increased Participant Trust in PMHS	No	492	3.74	1.13	1.686	519	.092
	Yes	29	3.38	1.18			
Improved Participant Wellness	No	483	3.53	1.07	.052	510	.958
	Yes	29	3.52	1.18			

**p < .05, **p < .01, ***p < .001*

Table 32. t-Test Analysis for Stakeholder Survey Variables Correlated with CPP Outreach Activities – Print Announcements

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Outcome Variables							
CPP Meeting Effectiveness	No	237	4.23	.79	-1.698	491	.090
	Yes	256	4.34	.75			
Recovery Orientation	No	240	4.05	1.02	.430	492	.667
	Yes	254	4.01	.94			
Participant Safety	No	249	4.06	1.02	-1.074	516	.283
	Yes	269	4.16	1.01			
Participant Training	No	249	3.88	1.04	-.060	516	.952
	Yes	269	3.88	1.04			
Perception of Contributions	No	245	3.91	1.14	-.992	504	.322
	Yes	261	4.02	1.15			
Respect of Participant Opinions and Culture	No	236	4.14	.93	-1.151	488	.250
	Yes	254	4.23	.89			

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Impact Variables							
Participant Satisfaction in CPP Process	No	246	4.09	1.03	-.081	513	.936
	Yes	269	4.09	1.10			
Increased Participant Trust in PMHS	No	251	3.73	1.14	.029	519	.977
	Yes	270	3.72	1.13			
Improved Participant Wellness	No	247	3.57	1.08	.888	510	.375
	Yes	265	3.49	1.07			

**p < .05, **p < .01, ***p < .001*

Table 33. t-Test Analysis for Stakeholder Survey Variables Correlated with CPP Outreach Activities – Social Media

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Outcome Variables							
CPP Meeting Effectiveness	No	448	4.28	.76	-.964	491	.335
	Yes	45	4.39	.82			
Recovery Orientation	No	449	4.00	.97	-1.570	492	.117
	Yes	45	4.24	1.05			
Participant Safety	No	471	4.08	1.03	-2.243	516	.025*
	Yes	47	4.43	.85			
Participant Training	No	470	3.85	1.04	-1.578	516	.115
	Yes	48	4.10	1.06			
Perception of Contributions	No	458	3.93	1.16	-2.478	504	.014*
	Yes	48	4.08	.91			
Respect of Participant Opinions and Culture	No	443	4.17	.92	-1.403	488	.161
	Yes	47	4.36	.79			
	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Impact Variables							
Participant Satisfaction in CPP Process	No	470	4.06	1.07	-1.761	513	.079
	Yes	45	4.36	.98			
Increased Participant Trust in PMHS	No	474	3.69	1.14	-2.439	519	.015*
	Yes	47	4.11	1.05			
Improved Participant Wellness	No	464	3.49	1.14	-2.662	510	.008**
	Yes	48	3.92	1.05			

**p < .05, **p < .01, ***p < .001*

Table 34. t-Test Analysis for Stakeholder Survey Variables Correlated with CPP Outreach Activities – Announcements at Meetings

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Outcome Variables							
CPP Meeting Effectiveness	No	30	4.20	.83	-.643	491	.521
	Yes	463	4.29	.76			
Recovery Orientation	No	31	3.94	1.00	-.533	492	.594
	Yes	463	4.03	.98			
Participant Safety	No	33	3.82	1.13	-1.710	516	.088
	Yes	485	4.13	1.00			
Participant Training	No	33	3.91	.95	.175	516	.861
	Yes	485	3.88	1.05			
Perception of Contributions	No	32	3.53	1.63	-2.229	504	.026*
	Yes	474	4.00	1.10			
Respect of Participant Opinions and Culture	No	31	4.21	.81	.158	488	.875
	Yes	459	4.18	.92			

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Impact Variables							
Participant Satisfaction in CPP Process	No	31	3.94	1.00	-1.174	513	.241
	Yes	463	4.03	.98			
Increased Participant Trust in PMHS	No	34	3.18	1.31	-2.932	519	.004**
	Yes	487	3.76	1.11			
Improved Participant Wellness	No	33	3.33	1.36	-1.077	510	.282
	Yes	479	3.54	1.05			

**p < .05, **p < .01, ***p < .001*

Table 35. t-Test Analysis for Stakeholder Survey Variables Correlated with CPP Incentives – Transportation to Meetings

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Outcome Variables							
CPP Meeting Effectiveness	No	291	4.23	.82	-1.868	491	.062
	Yes	202	4.36	.68			
Recovery Orientation	No	292	4.06	1.00	.870	492	.384
	Yes	202	3.98	.95			
Participant Safety	No	309	4.05	1.08	-1.679	516	.094
	Yes	209	4.20	.91			
Participant Training	No	308	3.88	1.07	-.046	516	.963
	Yes	210	3.88	1.00			
Perception of Contributions	No	300	3.93	1.14	-.784	504	.434
	Yes	206	4.01	1.15			
Respect of Participant Opinions and Culture	No	291	4.15	.98	-.984	488	.325
	Yes	199	4.23	.80			

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Impact Variables							
Participant Satisfaction in CPP Process	No	303	4.0	1.09	-.594	513	.553
	Yes	212	4.12	1.02			
Increased Participant Trust in PMHS	No	309	3.70	1.12	-.676	519	.499
	Yes	212	3.76	1.09			
Improved Participant Wellness	No	305	3.48	1.11	-1.249	510	.212
	Yes	207	3.60	1.01			

**p < .05, **p < .01, ***p < .001*

Table 36. t-Test Analysis for Stakeholder Survey Variables Correlated with CPP Incentives – Transportation Vouchers

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Outcome Variables							
CPP Meeting Effectiveness	No	404	4.30	.74	.850	491	.396
	Yes	89	4.22	.87			
Recovery Orientation	No	402	4.02	.98	-.068	492	.946
	Yes	92	4.03	1.00			
Participant Safety	No	422	4.14	.99	1.625	516	.105
	Yes	96	3.96	1.12			
Participant Training	No	423	3.88	1.03	.049	516	.961
	Yes	95	3.87	1.11			
Perception of Contributions	No	412	4.00	1.12	.982	504	.326
	Yes	94	3.86	1.23			
Respect of Participant Opinions and Culture	No	399	4.21	.87	1.44	488	.149
	Yes	91	4.06	1.05			

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Impact Variables							
Participant Satisfaction in CPP Process	No	419	4.10	1.04	.592	513	.554
	Yes	96	4.03	1.18			
Increased Participant Trust in PMHS	No	428	3.77	1.11	1.851	519	.065
	Yes	93	3.53	1.22			
Improved Participant Wellness	No	418	3.56	1.05	1.449	510	.148
	Yes	94	3.38	1.16			

**p < .05, **p < .01, ***p < .001*

Table 37. t-Test Analysis for Stakeholder Survey Variables Correlated with CPP Incentives – Meals at Meetings

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Outcome Variables							
CPP Meeting Effectiveness	No	142	4.23	.78	-1.141	491	.255
	Yes	351	4.31	.76			
Recovery Orientation	No	148	4.14	.93	1.719	492	.086
	Yes	346	3.98	1.00			
Participant Safety	No	154	4.11	1.03	.005	516	.996
	Yes	364	4.11	1.01			
Participant Training	No	154	3.84	1.07	-.578	516	.563
	Yes	364	3.90	1.03			
Perception of Contributions	No	151	3.92	1.11	-.587	504	.557
	Yes	355	3.99	1.16			
Respect of Participant Opinions and Culture	No	145	4.21	.90	.350	488	.727
	Yes	345	4.18	.92			

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Impact Variables							
Participant Satisfaction in CPP Process	No	150	4.08	1.05	-.127	513	.899
	Yes	365	4.09	1.07			
Increased Participant Trust in PMHS	No	157	3.75	1.15	.370	519	.712
	Yes	364	3.71	1.13			
Improved Participant Wellness	No	153	3.53	1.06	.029	510	.977
	Yes	359	3.53	1.08			

**p < .05, **p < .01, ***p < .001*

Table 38. t-Test Analysis for Stakeholder Survey Variables Correlated with CPP Incentives – Multiple Meeting Times

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Outcome Variables							
CPP Meeting Effectiveness	No	297	4.26	.77	-.840	491	.401
	Yes	196	4.32	.76			
Recovery Orientation	No	295	4.05	.93	.584	492	.560
	Yes	199	4.0	1.05			
Participant Safety	No	309	4.11	1.02	.000	516	1.000
	Yes	209	4.11	1.01			
Participant Training	No	309	3.89	1.03	.222	516	.825
	Yes	209	3.87	1.07			
Perception of Contributions	No	297	3.94	1.12	-.632	504	.528
	Yes	209	4.00	1.18			
Respect of Participant Opinions and Culture	No	292	4.20	.89	.512	488	.609
	Yes	198	4.16	.94			

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Impact Variables							
Participant Satisfaction in CPP Process	No	307	4.10	1.02	.217	513	.828
	Yes	208	4.08	1.12			
Increased Participant Trust in PMHS	No	311	3.73	1.14	.075	519	.940
	Yes	210	3.72	1.13			
Improved Participant Wellness	No	307	3.51	1.08	-.328	510	.743
	Yes	205	3.55	1.05			

**p < .05, **p < .01, ***p < .001*

Table 39. t-Test Analysis for Stakeholder Survey Variables Correlated with CPP Incentives – Stipends/Other Financial Incentives

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Outcome Variables							
CPP Meeting Effectiveness	No	264	4.27	.77	-.611	491	.542
	Yes	229	1.31	.76			
Recovery Orientation	No	265	3.92	.99	-2.593	492	.010*
	Yes	229	4.15	.96			
Participant Safety	No	281	4.06	1.05	-1.123	516	.262
	Yes	237	4.16	.98			
Participant Training	No	277	3.80	1.07	-1.805	516	.072
	Yes	241	3.97	1.01			
Perception of Contributions	No	274	3.92	1.17	-1.075	504	.283
	Yes	232	4.03	1.12			
Respect of Participant Opinions and Culture	No	265	4.15	.88	-1.040	488	.299
	Yes	225	4.23	.95			

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Impact Variables							
Participant Satisfaction in CPP Process	No	278	4.00	1.08	-2.154	513	.032*
	Yes	237	4.20	1.04			
Increased Participant Trust in PMHS	No	285	3.65	1.14	-1.729	519	.084
	Yes	236	3.82	1.13			
Improved Participant Wellness	No	275	3.35	1.04	-4.208	510	.000***
	Yes	237	3.74	1.07			

**p < .05, **p < .01, ***p < .001*

Table 40. t-Test Analysis for Stakeholder Survey Variables Correlated with CPP Incentives – Childcare

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Outcome Variables							
CPP Meeting Effectiveness	No	458	4.27	.78	-2.126	491	.036*
	Yes	35	4.55	.54			
Recovery Orientation	No	461	4.01	1.0	-1.129	492	.260
	Yes	33	4.21	.70			
Participant Safety	No	484	4.07	1.03	-3.040	516	.002**
	Yes	34	4.62	.50			
Participant Training	No	483	3.86	1.05	-1.726	516	0.85
	Yes	35	4.17	.82			
Perception of Contributions	No	473	3.94	1.15	-1.909	504	.057
	Yes	33	4.33	.96			
Respect of Participant Opinions and Culture	No	458	4.16	.92	-2.542	488	.011*
	Yes	32	4.58	.60			

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Impact Variables							
Participant Satisfaction in CPP Process	No	480	4.07	1.08	-1.462	513	.144
	Yes	35	4.34	.77			
Increased Participant Trust in PMHS	No	486	3.69	1.14	-2.275	519	.023*
	Yes	35	4.14	.97			
Improved Participant Wellness	No	479	3.50	1.08	-1.955	510	.051
	Yes	33	3.88	.93			

**p < .05, **p < .01, ***p < .001*

Table 41. t-Test Analysis for Stakeholder Survey Variables Correlated with CPP Incentives – Continuing Education Credits/Certificates

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Outcome Variables							
CPP Meeting Effectiveness	No	490	4.29	.77	-.606	491	.544
	Yes	3	4.56	.51			
Recovery Orientation	No	492	4.03	.98	.761	492	.447
	Yes	2	3.50	.71			
Participant Safety	No	516	4.11	1.02	-.544	516	.587
	Yes	2	4.50	.71			
Participant Training	No	515	3.88	1.04	-.203	516	.840
	Yes	3	4.0	1.73			
Perception of Contributions	No	504	3.97	1.15	-.042	504	.967
	Yes	2	4.00	.00			
Respect of Participant Opinions and Culture	No	488	4.18	.91	-.102	488	.919
	Yes	2	4.25	.35			

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Impact Variables							
Participant Satisfaction in CPP Process	No	512	4.09	1.07	-.398	513	.691
	Yes	3	4.33	.56			
Increased Participant Trust in PMHS	No	518	3.72	1.14	.087	519	.931
	Yes	3	3.67	.58			
Improved Participant Wellness	No	510	3.53	1.07	.036	510	.971
	Yes	2	3.50	.71			

**p < .05, **p < .01, ***p < .001*

Table 42. t-Test Analysis for Stakeholder Survey Variables Correlated with CPP Incentives – Translation/Interpretation Services

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Outcome Variables							
CPP Meeting Effectiveness	No	201	4.36	.72	1.864	491	.063
	Yes	292	4.23	.80			
Recovery Orientation	No	199	4.04	1.05	.259	492	.796
	Yes	295	4.02	.93			
Participant Safety	No	209	4.19	.99	1.413	516	.158
	Yes	309	4.06	1.03			
Participant Training	No	210	3.97	1.0	1.595	516	.111
	Yes	308	3.82	1.07			
Perception of Contributions	No	204	4.04	1.17	1.255	504	.210
	Yes	302	3.91	1.13			
Respect of Participant Opinions and Culture	No	199	4.25	.92	1.288	488	.198
	Yes	291	4.14	.90			

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Impact Variables							
Participant Satisfaction in CPP Process	No	206	4.14	1.07	.811	513	.418
	Yes	309	4.06	1.06			
Increased Participant Trust in PMHS	No	211	3.80	1.14	1.207	519	.228
	Yes	310	3.67	1.12			
Improved Participant Wellness	No	203	3.67	1.09	2.541	510	.011*
	Yes	309	3.43	1.05			

**p < .05, **p < .01, ***p < .001*

Table 43. t-Test Analysis for Stakeholder Survey Variables Correlated with CPP Incentives –Meetings in Languages Other than English

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Outcome Variables							
CPP Meeting Effectiveness	No	361	4.32	.75	1.672	491	.095
	Yes	132	4.19	.80			
Recovery Orientation	No	366	4.04	.98	.563	492	.574
	Yes	128	3.98	.98			
Participant Safety	No	382	4.12	1.02	.193	516	.847
	Yes	136	4.10	1.02			
Participant Training	No	381	3.96	1.05	.797	516	.426
	Yes	137	3.98	1.02			
Perception of Contributions	No	376	3.96	1.17	-.210	504	.834
	Yes	130	3.98	1.08			
Respect of Participant Opinions and Culture	No	363	4.19	.91	.052	488	.959
	Yes	127	4.18	.90			

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Impact Variables							
Participant Satisfaction in CPP Process	No	379	4.09	1.07	.202	513	.840
	Yes	136	4.07	1.07			
Increased Participant Trust in PMHS	No	384	3.71	1.14	-.339	519	.735
	Yes	137	3.75	1.11			
Improved Participant Wellness	No	376	3.52	1.07	-.306	510	.759
	Yes	136	3.55	1.02			

**p < .05, **p < .01, ***p < .001*

Table 44. t-Test Analysis for Stakeholder Survey Variables Correlated with CPP Trainings – Produce and Distribute CPP Educational Materials

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Outcome Variables							
CPP Meeting Effectiveness	No	281	4.26	.80	-.877	468	.431
	Yes	189	4.32	.72			
Recovery Orientation	No	281	4.01	.95	-.225	470	.822
	Yes	191	4.03	1.04			
Participant Safety	No	295	4.13	1.0	.304	492	.761
	Yes	199	4.10	1.04			
Participant Training	No	297	3.85	1.04	-.484	492	.629
	Yes	197	3.90	1.06			
Perception of Contributions	No	287	3.93	1.15	-1.164	481	.245
	Yes	196	4.05	1.08			
Respect of Participant Opinions and Culture	No	280	4.19	.89	.303	466	.762
	Yes	188	4.16	.95			

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Impact Variables							
Participant Satisfaction in CPP Process	No	293	4.07	1.05	-.298	489	.766
	Yes	198	4.10	1.09			
Increased Participant Trust in PMHS	No	300	3.74	1.12	.169	495	.866
	Yes	197	3.73	1.13			
Improved Participant Wellness	No	294	3.56	1.05	1.107	486	.269
	Yes	194	3.45	1.10			

**p < .05, **p < .01, ***p < .001*

Table 45. t-Test Analysis for Stakeholder Survey Variables Correlated with CPP Trainings – Offer Professional Development or Continuing Education Credits

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Outcome Variables							
CPP Meeting Effectiveness	No	454	4.27	.78	-2.471	468	.014*
	Yes	16	4.75	.31			
Recovery Orientation	No	456	4.01	.98	-.956	470	.339
	Yes	16	4.25	1.00			
Participant Safety	No	477	4.11	1.01	-1.218	492	.224
	Yes	17	4.41	1.06			
Participant Training	No	477	3.86	1.05	-.754	492	.451
	Yes	17	4.06	1.09			
Perception of Contributions	No	466	3.95	1.12	-2.518	481	.012*
	Yes	17	4.65	1.00			
Respect of Participant Opinions and Culture	No	542	4.17	.91	-1.282	466	.200
	Yes	16	4.47	1.04			

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Impact Variables							
Participant Satisfaction in CPP Process	No	474	4.07	1.07	-1.290	489	.198
	Yes	17	4.41	1.06			
Increased Participant Trust in PMHS	No	480	3.72	1.12	-1.643	495	.101
	Yes	17	4.18	1.13			
Improved Participant Wellness	No	472	3.51	1.07	-.659	486	.510
	Yes	16	3.69	1.08			

**p < .05, **p < .01, ***p < .001*

Table 46. t-Test Analysis for Stakeholder Survey Variables Correlated with CPP Participant Input Activities – Voting or Prioritization Activities

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Outcome Variables							
CPP Meeting Effectiveness	No	182	4.30	.72	.288	491	.774
	Yes	311	4.28	.79			
Recovery Orientation	No	186	4.13	.88	1.816	492	.070
	Yes	308	3.96	1.03			
Participant Safety	No	188	4.14	.96	.568	516	.570
	Yes	330	4.09	1.05			
Participant Training	No	194	3.84	1.05	-.645	516	.519
	Yes	324	3.90	1.04			
Perception of Contributions	No	187	3.96	1.16	-.138	504	.890
	Yes	319	3.97	1.14			
Respect of Participant Opinions and Culture	No	180	4.26	.822	1.417	488	.157
	Yes	310	4.14	.96			

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Impact Variables							
Participant Satisfaction in CPP Process	No	188	4.11	1.07	.362	513	.718
	Yes	327	1.08	1.06			
Increased Participant Trust in PMHS	No	194	3.81	1.11	1.330	519	.184
	Yes	327	3.67	1.15			
Improved Participant Wellness	No	193	3.74	1.07	3.463	510	.001**
	Yes	319	3.40	1.05			

**p < .05, **p < .01, ***p < .001*

Table 47. t-Test Analysis for Stakeholder Survey Variables Correlated with CPP Trainings – County-Specific Trainings on Participation In the Local Stakeholder Planning Process

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Outcome Variables							
CPP Meeting Effectiveness	No	271	4.27	.82	-.355	468	.723
	Yes	199	4.30	.69			
Recovery Orientation	No	281	4.06	.97	1.016	470	.310
	Yes	191	3.96	1.01			
Participant Safety	No	286	4.13	1.04	.397	492	.692
	Yes	208	4.10	.97			
Participant Training	No	289	3.85	1.08	-.484	492	.629
	Yes	205	3.90	1.00			
Perception of Contributions	No	285	3.95	1.15	-.669	481	.504
	Yes	198	4.02	1.08			
Respect of Participant Opinions and Culture	No	273	4.19	.93	.226	466	.821
	Yes	195	4.17	.90			

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Impact Variables							
Participant Satisfaction in CPP Process	No	285	4.07	1.11	-.410	489	.682
	Yes	206	4.11	1.01			
Increased Participant Trust in PMHS	No	291	3.77	1.15	.865	495	.387
	Yes	206	3.68	1.10			
Improved Participant Wellness	No	289	3.57	1.10	1.325	486	.186
	Yes	199	3.44	1.01			

**p < .05, **p < .01, ***p < .001*

Table 48. t-Test Analysis for Stakeholder Survey Variables Correlated with CPP Trainings – Support for Participants to Attend Trainings Not Sponsored By the County

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Outcome Variables							
CPP Meeting Effectiveness	No	365	4.25	.79	-1.981	468	.048*
	Yes	105	4.42	.68			
Recovery Orientation	No	366	4.03	.97	.563	470	.574
	Yes	106	3.97	1.02			
Participant Safety	No	383	4.13	1.00	.322	492	.748
	Yes	111	4.09	1.07			
Participant Training	No	385	3.85	1.05	-.944	492	.346
	Yes	109	3.95	1.05			
Perception of Contributions	No	373	3.75	1.12	-.996	481	.320
	Yes	110	4.07	1.11			
Respect of Participant Opinions and Culture	No	361	4.19	.90	.519	466	.604
	Yes	107	4.14	.96			

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Impact Variables							
Participant Satisfaction in CPP Process	No	380	4.08	1.08	.027	489	.978
	Yes	111	4.08	1.04			
Increased Participant Trust in PMHS	No	387	3.76	1.12	.960	495	.337
	Yes	110	3.65	1.15			
Improved Participant Wellness	No	381	3.56	1.06	1.748	486	.081
	Yes	107	3.36	1.08			

**p < .05, **p < .01, ***p < .001*

Table 49. t-Test Analysis for Stakeholder Survey Variables Correlated with CPP Participant Input Activities – Surveys/Questionnaires

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Outcome Variables							
CPP Meeting Effectiveness	No	200	4.01	1.14	-2.293	7491	.022*
	Yes	315	4.14	1.01			
Recovery Orientation	No	193	4.03	.97	-.007	492	.994
	Yes	301	4.03	.99			
Participant Safety	No	201	3.99	1.11	-2.240	516	.026*
	Yes	317	4.19	.94			
Participant Training	No	203	3.82	1.10	-1.063	615	.288
	Yes	315	3.92	1.00			
Perception of Contributions	No	195	3.84	1.20	-2.036	504	.042*
	Yes	311	4.45	1.10			
Respect of Participant Opinions and Culture	No	192	4.13	1.00	-1.114	488	.266
	Yes	298	4.22	.85			

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Impact Variables							
Participant Satisfaction in CPP Process	No	200	4.01	1.14	-1.349	513	.178
	Yes	315	4.14	1.01			
Increased Participant Trust in PMHS	No	199	3.62	1.20	-1.673	519	.095
	Yes	322	3.79	1.09			
Improved Participant Wellness	No	199	3.45	1.15	-1.266	510	.206
	Yes	313	3.58	1.01			

**p < .05, **p < .01, ***p < .001*

Table 50. t-Test Analysis for Stakeholder Survey Variables Correlated with CPP Participant Input Activities – Focus Groups

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Outcome Variables							
CPP Meeting Effectiveness	No	288	4.24	.78	-1.640	491	.102
	Yes	205	4.35	.74			
Recovery Orientation	No	298	4.01	.92	-.361	492	.719
	Yes	196	4.05	1.07			
Participant Safety	No	309	4.06	1.01	-1.325	516	.186
	Yes	209	4.18	1.02			
Participant Training	No	308	3.84	1.04	-.991	516	.322
	Yes	210	3.93	1.04			
Perception of Contributions	No	303	3.90	1.14	-1.652	504	.099
	Yes	203	4.07	1.15			
Respect of Participant Opinions and Culture	No	289	4.15	.90	-.895	488	.971
	Yes	201	4.23	.93			

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Impact Variables							
Participant Satisfaction in CPP Process	No	308	4.05	1.04	-1.057	513	.291
	Yes	207	4.115	1.10			
Increased Participant Trust in PMHS	No	309	3.71	1.12	-.440	519	.660
	Yes	212	3.75	1.16			
Improved Participant Wellness	No	307	3.48	1.09	-1.256	510	.210
	Yes	205	3.60	1.05			

**p < .05, **p < .01, ***p < .001*

Table 51. t-Test Analysis for Stakeholder Survey Variables Correlated with CPP Participant Input Activities – Town Halls/Community Meetings to Gather Input

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Outcome Variables							
CPP Meeting Effectiveness	No	203	4.25	.804	-.953	491	.341
	Yes	290	4.32	.74			
Recovery Orientation	No	214	4.02	.99	-.151	492	.880
	Yes	280	4.03	.97			
Participant Safety	No	220	4.09	1.05	-.456	516	.649
	Yes	298	4.13	.99			
Participant Training	No	222	3.86	1.05	-.426	516	.671
	Yes	296	3.90	1.04			
Perception of Contributions	No	220	3.96	1.15	-.048	504	.962
	Yes	286	3.97	1.15			
Respect of Participant Opinions and Culture	No	207	4.15	.95	-.776	488	.438
	Yes	283	4.21	.88			

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Impact Variables							
Participant Satisfaction in CPP Process	No	218	4.10	1.10	.128	513	.898
	Yes	297	4.08	1.04			
Increased Participant Trust in PMHS	No	222	3.79	1.14	1.201	519	.230
	Yes	299	3.67	1.13			
Improved Participant Wellness	No	220	3.55	1.08	.332	510	.740
	Yes	292	3.51	1.07			

**p < .05, **p < .01, ***p < .001*

Table 52. t-Test Analysis for Stakeholder Survey Variables Correlated with CPP Participant Input Activities – Public Hearings

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Outcome Variables							
CPP Meeting Effectiveness	No	36	4.57	.65	2.338	491	.020*
	Yes	457	4.26	.77			
Recovery Orientation	No	39	4.33	.93	2.047	492	.041*
	Yes	455	4.00	.98			
Participant Safety	No	40	4.48	.68	2.378	516	.018*
	Yes	478	4.08	1.03			
Participant Training	No	40	4.20	.97	2.038	516	.042*
	Yes	478	3.85	1.04			
Perception of Contributions	No	41	4.29	.90	1.908	504	.057
	Yes	465	3.94	1.16			
Respect of Participant Opinions and Culture	No	39	4.51	.61	2.356	488	.019*
	Yes	451	4.16	.93			

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Impact Variables							
Participant Satisfaction in CPP Process	No	38	4.37	1.03	1.683	513	.093
	Yes	477	4.07	1.07			
Increased Participant Trust in PMHS	No	40	4.20	.91	2.784	519	.006**
	Yes	481	3.68	1.14			
Improved Participant Wellness	No	38	4.08	1.02	3.334	510	.001**
	Yes	474	3.48	1.06			

**p < .05, **p < .01, ***p < .001*

Table 53. t-Test Analysis for Stakeholder Survey Variables Correlated with CPP Participant Input Activities – Key Informant Interviews

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Outcome Variables							
CPP Meeting Effectiveness	No	365	4.27	.81	-.787	491	.432
	Yes	128	4.33	.65			
Recovery Orientation	No	370	4.04	.97	.663	492	.507
	Yes	124	3.98	1.01			
Participant Safety	No	386	4.06	1.05	-1.739	516	.083
	Yes	132	4.24	.88			
Participant Training	No	389	3.87	1.07	-.359	516	.719
	Yes	129	3.91	.96			
Perception of Contributions	No	380	3.94	1.16	-.918	504	.359
	Yes	126	4.05	1.12			
Respect of Participant Opinions and Culture	No	365	4.17	.94	-.673	488	.502
	Yes	125	4.23	.81			

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Impact Variables							
Participant Satisfaction in CPP Process	No	383	4.08	1.09	-.209	513	.834
	Yes	132	4.11	.98			
Increased Participant Trust in PMHS	No	390	3.74	1.13	.516	519	.606
	Yes	131	3.68	1.14			
Improved Participant Wellness	No	383	3.51	1.09	-.568	510	.571
	Yes	129	3.57	1.03			

**p < .05, **p < .01, ***p < .001*

Table 54. t-Test Analysis for Stakeholder Survey Variables Correlated with CPP Participant Input Activities – Suggestion Boxes

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Outcome Variables							
CPP Meeting Effectiveness	No	435	4.29	.77	.606	491	.544
	Yes	58	4.23	.75			
Recovery Orientation	No	438	4.07	.95	.230	516	.816
	Yes	56	3.71	1.16			
Participant Safety	No	457	4.11	1.02	2.547	492	.011*
	Yes	61	4.08	.97			
Participant Training	No	460	3.89	1.04	1.063	516	.288
	Yes	58	3.74	1.05			
Perception of Contributions	No	447	3.97	1.14	.365	504	.716
	Yes	59	3.91	1.19			
Respect of Participant Opinions and Culture	No	432	4.21	.90	1.725	488	.085
	Yes	58	3.99	.97			

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Impact Variables							
Participant Satisfaction in CPP Process	No	455	4.11	1.06	1.209	513	.227
	Yes	60	3.93	1.10			
Increased Participant Trust in PMHS	No	461	3.77	1.13	2.361	519	.019*
	Yes	60	3.40	1.11			
Improved Participant Wellness	No	454	3.56	1.07	1.905	510	.057
	Yes	58	3.28	1.02			

**p < .05, **p < .01, ***p < .001*

Table 55. t-Test Analysis for Stakeholder Survey Variables Correlated with CPP Participant Input Activities – Stakeholder Steering Committee/Stakeholder Planning Committee

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Outcome Variables							
CPP Meeting Effectiveness	No	118	4.21	.77	-1.225	491	.221
	Yes	375	4.31	.77			
Recovery Orientation	No	127	3.94	.99	-1.193	492	.233
	Yes	367	4.06	.97			
Participant Safety	No	130	4.06	1.02	-.629	516	.530
	Yes	388	4.13	1.02			
Participant Training	No	131	3.78	1.03	-1.268	516	.205
	Yes	387	3.91	1.04			
Perception of Contributions	No	131	3.89	1.11	-.939	504	.348
	Yes	375	3.99	1.16			
Respect of Participant Opinions and Culture	No	121	4.12	.84	-.903	488	.367
	Yes	369	4.21	.93			

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Impact Variables							
Participant Satisfaction in CPP Process	No	129	4.04	1.08	-.623	513	.534
	Yes	386	4.11	1.06			
Increased Participant Trust in PMHS	No	135	3.80	1.06	.910	519	.363
	Yes	386	3.70	1.16			
Improved Participant Wellness	No	133	3.59	1.04	.834	510	.405
	Yes	379	3.50	1.08			

**p < .05, **p < .01, ***p < .001*

Table 56. t-Test Analysis for Stakeholder Survey Variables Correlated with CPP Participant Input Activities – Strategy Roundtables/Strategizing Sessions

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Outcome Variables							
CPP Meeting Effectiveness	No	295	4.32	.73	1.065	491	.288
	Yes	198	4.24	.82			
Recovery Orientation	No	295	4.05	.92	.678	492	.498
	Yes	199	3.99	1.05			
Participant Safety	No	305	4.14	.99	.830	516	.407
	Yes	213	4.07	1.04			
Participant Training	No	309	3.87	1.05	-.208	516	.836
	Yes	209	3.89	1.04			
Perception of Contributions	No	298	3.99	1.11	.474	504	.636
	Yes	208	3.94	1.20			
Respect of Participant Opinions and Culture	No	292	4.25	.82	2.087	488	.037*
	Yes	198	4.08	1.02			

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Impact Variables							
Participant Satisfaction in CPP Process	No	305	4.11	1.07	.485	513	.628
	Yes	210	4.06	1.06			
Increased Participant Trust in PMHS	No	310	3.78	1.12	1.39	519	.164
	Yes	211	3.64	1.16			
Improved Participant Wellness	No	308	3.55	1.09	.554	510	.580
	Yes	204	3.50	1.04			

**p < .05, **p < .01, ***p < .001*

Table 57. t-Test Analysis for Stakeholder Survey Variables Correlated with CPP Participant Input Activities – Voting or Prioritization Activities

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Outcome Variables							
CPP Meeting Effectiveness	No	182	4.30	.72	.288	491	.774
	Yes	311	4.28	.79			
Recovery Orientation	No	186	4.13	.88	1.816	492	.070
	Yes	308	3.96	1.03			
Participant Safety	No	188	4.14	.96	.568	516	.570
	Yes	330	4.09	1.05			
Participant Training	No	194	3.84	1.05	-.645	516	.519
	Yes	324	3.90	1.04			
Perception of Contributions	No	187	3.96	1.16	-.138	504	.890
	Yes	319	3.97	1.13			
Respect of Participant Opinions and Culture	No	180	4.26	.82	1.417	488	.157
	Yes	310	4.14	.96			

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Impact Variables							
Participant Satisfaction in CPP Process	No	188	4.11	1.07	.362	513	.718
	Yes	327	4.08	1.06			
Increased Participant Trust in PMHS	No	194	3.81	1.11	1.33	519	.184
	Yes	327	3.67	1.15			
Improved Participant Wellness	No	193	3.74	1.07	3.46	510	.001**
	Yes	319	3.40	1.05			

**p < .05, **p < .01, ***p < .001*

Table 58. t-Test Analysis for Stakeholder Survey Variables Correlated with CPP Participant Input Activities – Community Meetings and Town Hall Meetings to Plan, Prioritize, or Make Decisions

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Outcome Variables							
CPP Meeting Effectiveness	No	279	4.26	.79	-.928	491	.354
	Yes	214	4.32	.74			
Recovery Orientation	No	279	4.03	.99	-.032	492	.975
	Yes	215	4.03	.97			
Participant Safety	No	288	4.07	1.05	-1.019	516	.309
	Yes	230	4.16	.96			
Participant Training	No	295	3.82	1.08	-1.545	516	.123
	Yes	223	3.96	.99			
Perception of Contributions	No	281	3.94	1.13	-.590	504	.555
	Yes	225	4.0	1.16			
Respect of Participant Opinions and Culture	No	276	4.20	.93	.352	488	.725
	Yes	214	4.17	.89			

	Yes/No	*N*	*Mean*	*SD*	*t*	*df*	*Sig*
Impact Variables							
Participant Satisfaction in CPP Process	No	288	4.06	1.14	-.811	513	.418
	Yes	227	4.13	.96			
Increased Participant Trust in PMHS	No	292	3.74	1.14	.444	519	.657
	Yes	229	3.70	1.13			
Improved Participant Wellness	No	289	3.54	1.12	.299	510	.765
	Yes	223	3.51	1.01			

**p < .05, **p < .01, ***p < .001*

Appendix 7: List of RDA's Deliverables

The following list includes the approved deliverables that Resource Development Associates has submitted to date. These deliverables are posted on the California Mental Health Services Accountability and Oversight Commission's website at: http://www.mhsoac.ca.gov/Evaluations/default.aspx.

RDA's Evaluation Deliverables (through July 2014):

- Deliverable #1: Report of Proposed Research Design and Data Collection Training Plan
- Deliverable #2: Proposed Data Analytic Plan
- Deliverable #3: Summary of Consultation Provided to Client Contractors re: CPP Process Inventory
- Deliverable #4: Report of Other Public Community Planning Processes

Appendix 8: Supplementary Report – Results by Research Question

See attached Appendix 8 document for the supplementary report describing key findings for each research question. This supplementary report was produced from an integrated analysis across data collection tools and data sources as well as the specific analyses from each data collection tool for each research question.

MHSA CPP: County Web-Based Data Request

Introduction

Page description:

Background

The Client Stakeholder Project (CSP) is requesting your assistance in completing this Web-Based Data Request as part of the statewide evaluation of MHSA Community Program Planning (CPP) processes, which is sponsored by the Mental Health Oversight and Accountability Commission (MHSOAC). The goal of this evaluation is to measure the impact and effectiveness of CPP processes in all of California's 58 counties and two municipalities. The evaluation will inventory current CPP activities and characteristics, and will also seek to identify promising CPP practices, which will be incorporated into curriculum and trainings taught to others throughout the State.

The length of time that it will take to complete this Web-Based Data Request will vary based on the size of your county and how readily available information about your local stakeholder planning process is to you. Our focus is on planning activities that took place in your county in order to complete the FY 2012/2013 Annual Update, although we will also ask about planning processes that took place prior to that time.

In order to reduce the time required to enter information for the Web-Based Data Request, we suggest that you collect the following documents/information/materials beforehand, if they are available. We understand that you may not have all of these materials:

- CPP activity participant counts and demographic information
- Outreach materials (e.g., flyers, brochures)
- Training and meeting materials
- County specific CPP policy and procedure manuals
- Evaluations of CPP activities

Some questions in this Web-Based Data Request ask that you provide either estimates or exact numbers of participants. When asked, you will have the opportunity to say whether your response is an estimate or an exact measure. Also, you are able to start the Web-Based Data Request, stop, and return at any time – please follow the instructions given on the bottom of the screen by Survey Gizmo. Thank you for completing this Web-Based Data Request. We very much appreciate your time and effort. If you have any questions, please contact Cyndi Eppler (ceppler@peersnet.org; 510-832-7337 ext. 204) and Tawny Porter (tporter@peersnet.org; 510-832-7337 ext. 226).

1. County or Municipality: *

2. Your Name: *

3. Phone Number: *

4. Email: *

CPP FY 12/13 Annual Update

Page description:

5. During what period did your county conduct its CPP activities for the development of the Annual Update for FY 12/13? Please check all that apply:

- ☐ Prior to July 1, 2011
- ☐ July 1, 2011 – September 30, 2011
- ☐ October 1, 2011 – December 31, 2011
- ☐ January 1, 2012 – March 30, 2012
- ☐ April 1, 2012 – June 30, 2012

6. What best describes the frequency in which your county conducts its CPP process?

- ○ Weekly
- ○ Monthly
- ○ Bi-monthly
- ○ Semi-annually
- ○ Annually
- ○ Other _____

7. Within CPP planning for the FY 12/13 Annual Update, please specify what plans were being considered (please check all that apply):

- ☐ Addition of programs/services
- ☐ Deletion of programs/services
- ☐ Revisions to the service delivery system
- ☐ Changes to target populations, including un/underserved communities or groups
- ☐ Budgetary changes
- ☐ Staffing changes
- ☐ Changes related to Community Services and Supports component
- ☐ Changes related to Prevention and Early Intervention component
- ☐ Changes related to Workforce and Education component
- ☐ Changes related to Capital Facilities and Technological Needs
- ☐ Changes related to other MHSA components not listed here
- ☐ Changes related to participation in statewide PEI projects funded through CalMHSA
- ☐ Changes related to the MHSA stakeholder planning (CPP) process
- ☐ Other _____
- ☐ No major revisions to our mental health services or systems were being considered at that time

8. For how long have you been involved in MHSA Community Program Planning (CPP) activities and processes in your county? Please specify the approximate number of **months** you have been involved in this process:

_____

9. Are you involved in any other county program planning (i.e., planning done outside the scope of the Mental Health Services Act)?

- Yes
- No

CPP Staff Participation

Page description:

10. How many staff Full Time Equivalents (FTEs) were used to facilitate the CPP process used to develop your 2012/13 Annual Update?

For example, if one staff works approximately half time on the CPP process, indicate .5 FTE; if three staff work 10 hours each week on the CPP process, please indicate .75 FTE.

11. During the planning process for the FY 12/13 Annual Updates, did the county encourage or provide any training to staff responsible for or involved in the CPP process?

- Yes
- No

- Yes
- No

Total Stakeholder Involvement

Page description:

13. Please enter the ***total number*** ***(unduplicated count)*** of individuals who participated in CPP activities for the development of the Annual Update for FY 12/13.

14. Please indicate whether the reported count is actual, estimated, or not available.

- Actual
- Estimated
- Count is not available

15. **Comments:** *(if applicable)*

Total Stakeholder Involvement (demographics)

Page description:

Total Stakeholder Involvement

Please fill out for all unduplicated stakeholders who participated in CPP activities:

LOGIC Show/hide trigger exists.

16. Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Age demographic** information is:

- Actual
- Estimated
- Information is not available

LOGIC Dynamically shown if "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Age demographic** information is:" = Actual or "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Age demographic** information is:" = Estimated

17. CPP **Age demographic** information is in:

- Counts
- Percentages

LOGIC Dynamically shown if "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Age demographic** information is:" = Actual or "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Age demographic** information is:" = Estimated

18. **Age**

- [ ] Under 18
- [ ] 18 - 25
- [ ] 26 - 59
- [ ] 60 or older

Total : 0

LOGIC Show/hide trigger exists.

19. Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Gender demographic** information is:

- ○ Actual
- ○ Estimated
- ○ Information is not available

LOGIC Dynamically shown if "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Gender demographic** information is:" = Actual or "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Gender demographic** information is:" = Estimated

20. CPP **Gender demographic** information is in:

- ○ Counts
- ○ Percentages

LOGIC Dynamically shown if "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Gender demographic** information is:" = Actual or "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Gender demographic** information is:" = Estimated

21. **Gender**

- [ ] Female
- [ ] Male
- [ ] Transgender/other

Total : 0

LOGIC Show/hide trigger exists.

22. Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Race/Ethnicity demographic** information is:

- ○ Actual
- ○ Estimated
- ○ Information is not available

LOGIC Dynamically shown if "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Race/Ethnicity demographic** information is:" = Actual or "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Race/Ethnicity demographic** information is:" = Estimated

23. CPP **Race/Ethnicity demographic** information is in:

- ○ Counts
- ○ Percentages

LOGIC Dynamically shown if "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Race/Ethnicity demographic** information is:" = Actual or "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Race/Ethnicity demographic** information is:" = Estimated

24. **Race/Ethnicity**

- [ ] Tribal/Native American
- [ ] Latino/Hispanic
- [ ] Asian Pacific Islander
- [ ] Black/African American
- [ ] White/Caucasian
- [ ] Mixed Race
- [ ] Other

Total : 0

LOGIC Dynamically shown if "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Race/Ethnicity demographic** information is:" = Actual or "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Race/Ethnicity demographic** information is:" = Estimated
Mixed Race - Please specify

LOGIC Dynamically shown if "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Race/Ethnicity demographic** information is:" = Actual or "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Race/Ethnicity demographic** information is:" = Estimated
Other - Please specify

LOGIC Show/hide trigger exists.
25. Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Primary Spoken Language demographic** information is:

- Actual
- Estimated
- Information is not available

LOGIC Dynamically shown if "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Primary Spoken Language demographic** information is:" = Actual or "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Primary Spoken Language demographic** information is:" = Estimated

26. CPP **Primary Spoken Language demographic** information is in:

- ○ Counts
- ○ Percentages

LOGIC Dynamically shown if "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Primary Spoken Language demographic** information is:" = Actual or "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Primary Spoken Language demographic** information is:" = Estimated

27. **Primary Spoken Language at Home**

[ ] English

[ ] Other

Total : 0

LOGIC Dynamically shown if "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Primary Spoken Language demographic** information is:" = Actual or "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Primary Spoken Language demographic** information is:" = Estimated

Other - Please specify

[ ]

LOGIC Show/hide trigger exists.

28. Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **stakeholder affiliation** information is:

- Actual
- Estimated
- Information is not available

LOGIC Dynamically shown if "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **stakeholder affiliation** information is:" = Actual or "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **stakeholder affiliation** information is:" = Estimated

29. CPP **stakeholder affiliation** information is in:

- Counts
- Percentages

LOGIC Dynamically shown if "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **stakeholder affiliation** information is:" = Actual or "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **stakeholder affiliation** information is:" = Estimated

30. **Stakeholder affiliation**

- [ ] Mental health client/consumer
- [ ] Family member of a mental health consumer
- [ ] County mental health department staff
- [ ] Substance abuse service provider
- [ ] Community-based/non-profit mental health service provider
- [ ] Community based organization (not mental health service provider)
- [ ] Children and families services
- [ ] K-12 education provider
- [ ] Law enforcement
- [ ] Veteran services
- [ ] Senior services
- [ ] Hospital/Health care provider
- [ ] Advocate
- [ ] Other

Total : 0

LOGIC Dynamically shown if "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **stakeholder affiliation** information is:" = Actual or "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **stakeholder affiliation** information is:" = Estimated
Other - Please specify

31. **Comments:** *(if applicable)*

Outreach

Page description:

32. What types of CPP outreach activities did your county do to plan for the 2012/13 Annual Update?

Please select the activities that your county engaged in and provide details about them in the subsequent sections. Please note that this is not a complete list and inclusion of an activity does not imply that it is a requirement of the MHSA under Title 9 §3300.

- ☐ Post flyers/ posters/ brochures
- ☐ Phone calls/ invitations by Mental Health Department staff
- ☐ Emails to list-serve
- ☐ Radio/ TV announcements
- ☐ Print announcements (i.e., newspaper)
- ☐ Social media (i.e., Twitter, Facebook)
- ☐ Announcement at meetings
- ☐ Other
- ☐ Other
- ☐ Other
- ☐ Other
- ☐ Other

Outreach (specific responses)

Page description:

CPP Outreach Activity -

Please answer each of the below questions for this outreach activity, if information is available.

33. Please describe the activity:

34. # of items distributed, given or broadcasted (please provide your best estimate if you do not have an exact #):

35. Frequency of distribution (i.e., how many times did activity occur; e.g., daily, once per week, once per month):

36. Was this method used to outreach to clients with SMI, SED, or family members of SMI/SED populations?

- Yes
- No

37. Was this method used to outreach to un/underserved populations and family members of un/underserved populations?

- Yes
- No

38. How successful or useful do you think this activity was in helping your county meet MHSA goals?

- ○ Highly Successful
- ○ Successful
- ○ Neutral
- ○ Unsuccessful
- ○ Highly Unsuccessful

Incentives Offered

Page description:

39. During planning for the FY 12/13 Annual Update, which of the following incentives did your county offer to CPP participants? Please note that the items below are not mandated under the MHSA but are only examples of how counties may accommodate and encourage participation in the community planning process.

On the following pages, you will be asked to provide information about each of the incentives that your county offers.

- ☐ Transportation to meetings
- ☐ Transportation vouchers
- ☐ Meals at meetings
- ☐ Multiple meeting times (e.g., evening and daytime)
- ☐ Stipends/ Other financial incentives
- ☐ Childcare
- ☐ Continuing Education Credits/ Certificates
- ☐ Translation/ Interpretation services
- ☐ Meetings in languages other than English
- ☐ Other Incentive
- ☐ Other Incentive
- ☐ Other Incentive
- ☐ Other Incentive
- ☐ Other Incentive
- ☐ None—our county did not offer any incentives to stakeholders

Incentives Offered (specific responses)

Page description:

CPP Incentives Offered -

Please answer the following questions about this type of incentive offered.

40. How many were offered?

41. How much was offered?

42. Other comments about this type of incentive:

43. How successful/useful was this incentive to accommodating and/or encouraging stakeholder participation?

- ○ Highly Successful
- ○ Successful
- ○ Neutral
- ○ Unsuccessful
- ○ Highly Unsuccessful

Stakeholder Input

Page description:

44. Which of the following activities aimed at **collecting input from stakeholders** did your county engage in during planning for the 2012/13 Annual Update?

Please select the activities that your county engaged in and provide details about them in the subsequent sections. Please note that these items are not mandated under the MHSA but are only examples of how counties can accommodate and encourage participation in the community planning process.

- ☐ Survey/Questionnaires
- ☐ Focus groups
- ☐ Town hall/community meetings to gather input
- ☐ Public hearings
- ☐ Key informant interview
- ☐ Suggestion boxes
- ☐ Other
- ☐ Other
- ☐ Other
- ☐ Other
- ☐ Other

Stakeholder Input (specific responses)

Page description:

Stakeholder Input -

Please answer each of the below questions for the stakeholder input activity, if information is available.

45. Please describe the activity:

46. Total # of unduplicated participants not including county staff or representatives (please provide your best estimate if you do not have an exact #):

47. Frequency of activity (i.e., how many times did activity occur; e.g., daily, once per week, once per month):

LOGIC Show/hide trigger exists.

48. Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Age demographic** information is:

- Actual
- Estimated
- Information is not available

LOGIC Dynamically shown if "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Age demographic** information is:" = Actual or "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Age demographic** information is:" = Estimated

49. CPP **Age demographic** information is in:

- ○ Counts
- ○ Percentages

LOGIC Dynamically shown if "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Age demographic** information is:" = Actual or "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Age demographic** information is:" = Estimated

50. **Age**

- [ ] Under 18
- [ ] 18 - 25
- [ ] 26 - 59
- [ ] 60 or older

Total : 0

LOGIC Show/hide trigger exists.

51. Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Gender demographic** information is:

- ○ Actual
- ○ Estimated
- ○ Information is not available

LOGIC Dynamically shown if "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Gender demographic** information is:" = Actual or "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Gender demographic** information is:" = Estimated

52. CPP **Gender demographic** information is in:

- ○ Counts
- ○ Percentages

LOGIC Dynamically shown if "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Gender demographic** information is:" = Actual or "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Gender demographic** information is:" = Estimated

53. **Gender**

- [ ] Female
- [ ] Male
- [ ] Transgender/other

Total : 0

LOGIC Show/hide trigger exists.

54. Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Race/Ethnicity demographic** information is:

- Actual
- Estimated
- Information is not available

LOGIC Dynamically shown if "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Race/Ethnicity demographic** information is:" = Actual or "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Race/Ethnicity demographic** information is:" = Estimated

55. CPP **Race/Ethnicity demographic** information is in:

- Counts
- Percentages

LOGIC Dynamically shown if "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Race/Ethnicity demographic** information is:" = Actual or "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Race/Ethnicity demographic** information is:" = Estimated

56. **Race/Ethnicity**

- [ ] Tribal/Native American
- [ ] Latino/Hispanic
- [ ] Asian Pacific Islander
- [ ] Black/African American
- [ ] White/Caucasian
- [ ] Mixed Race
- [ ] Other

Total : 0

LOGIC Dynamically shown if "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Race/Ethnicity demographic** information is:" = Actual or "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Race/Ethnicity demographic** information is:" = Estimated

Mixed Race - Please specify

LOGIC Dynamically shown if "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Race/Ethnicity demographic** information is:" = Actual or "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Race/Ethnicity demographic** information is:" = Estimated
Other - Please specify

LOGIC Show/hide trigger exists.
57. Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Primary Spoken Language demographic** information is:

- Actual
- Estimated
- Information is not available

LOGIC Dynamically shown if "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Primary Spoken Language demographic** information is:" = Actual or "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Primary Spoken Language demographic** information is:" = Estimated
58. CPP **Primary Spoken Language demographic** information is in:

- Counts
- Percentages

LOGIC Dynamically shown if "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Primary Spoken Language demographic** information is:" = Actual or "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Primary Spoken Language demographic** information is:" = Estimated

59. **Primary Spoken Language at Home**

- [ ] English
- [ ] Other

Total : 0

LOGIC Dynamically shown if "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Primary Spoken Language demographic** information is:" = Actual or "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Primary Spoken Language demographic** information is:" = Estimated

Other - Please specify

LOGIC Show/hide trigger exists.

60. Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **stakeholder affiliation** information is:

- ○ Actual
- ○ Estimated
- ○ Information is not available

LOGIC Dynamically shown if "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **stakeholder affiliation** information is:" = Actual or "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **stakeholder affiliation** information is:" = Estimated

61. CPP **stakeholder affiliation** information is in:

- ○ Counts
- ○ Percentages

LOGIC Dynamically shown if "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **stakeholder affiliation** information is:" = Actual or "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **stakeholder affiliation** information is:" = Estimated or "CPP **stakeholder affiliation** information is:" = Actual or "CPP **stakeholder affiliation** information is:" = Estimated

62. **Stakeholder affiliation**

- [ ] Mental health client/consumer
- [ ] Family member of a mental health consumer
- [ ] County mental health department staff
- [ ] Substance abuse service provider
- [ ] Community-based/non-profit mental health service provider
- [ ] Community based organization (not mental health service provider)
- [ ] Children and families services
- [ ] K-12 education provider
- [ ] Law enforcement
- [ ] Veteran services
- [ ] Senior services
- [ ] Hospital/Health care provider
- [ ] Advocate
- [ ] Other

Total : 0

LOGIC Dynamically shown if "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **stakeholder affiliation** information is:" = Actual or "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **stakeholder affiliation** information is:" = Estimated or "CPP **stakeholder affiliation** information is:" = Actual or "CPP **stakeholder affiliation** information is:" = Estimated
Other - Please specify

63. Was input recorded and distributed?

- Yes
- No

64. How was input used to inform the development of the 2012/13 Annual Updates?

65. How effective do you think this activity was?

- Highly Effective
- Effective
- Neutral
- Ineffective
- Highly Ineffective

Stakeholder Participation

Page description:

66. Which of the following activities aimed at **promoting stakeholder participation** in planning, prioritizing and decision-making does the county engage in?

Please select the activities that your county engaged in and provide details about them in the subsequent sections. Please note that these items are not mandated under the MHSA but are only examples of how counties can accommodate and encourage participation in the community planning process.

- ☐ Stakeholder Steering Committee/Stakeholder planning committee
- ☐ Strategy roundtables/strategizing session
- ☐ Voting or prioritization activities
- ☐ Community meetings and town hall meetings to plan, prioritize or make decisions
- ☐ Other
- ☐ Other
- ☐ Other
- ☐ Other
- ☐ Other

Stakeholder Participation (specific responses)

Page description:

Stakeholder Participation -

Please answer each of the below questions for the stakeholder participation promotion activity, if information is available.

67. Please describe the activity:

68. Total # of unduplicated participants not including county staff or representatives (please provide your best estimate if you do not have an exact #):

69. Frequency of activity (i.e., how many times did activity occur; e.g., daily, once per week, once per month):

LOGIC Show/hide trigger exists.

70. Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Age demographic** information is:

- Actual
- Estimated
- Information is not available

LOGIC Dynamically shown if "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Age demographic** information is:" = Actual or "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Age demographic** information is:" = Estimated

71. CPP **Age demographic** information is in:

- ○ Counts
- ○ Percentages

LOGIC Dynamically shown if "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Age demographic** information is:" = Actual or "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Age demographic** information is:" = Estimated

72. **Age**

- [ ] Under 18
- [ ] 18 - 25
- [ ] 26 - 59
- [ ] 60 or older

Total : 0

LOGIC Show/hide trigger exists.

73. Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Gender demographic** information is:

- ○ Actual
- ○ Estimated
- ○ Information is not available

LOGIC Dynamically shown if "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Gender demographic** information is:" = Actual or "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Gender demographic** information is:" = Estimated

74. CPP **Gender demographic** information is in:

- ○ Counts
- ○ Percentages

LOGIC Dynamically shown if "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Gender demographic** information is:" = Actual or "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Gender demographic** information is:" = Estimated

75. **Gender**

- [ ] Female
- [ ] Male
- [ ] Transgender/other

Total : 0

LOGIC Show/hide trigger exists.

76. Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Race/Ethnicity demographic** information is:

- ○ Actual
- ○ Estimated
- ○ Information is not available

LOGIC Dynamically shown if "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Race/Ethnicity demographic** information is:" = Actual or "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Race/Ethnicity demographic** information is:" = Estimated

77. CPP **Race/Ethnicity demographic** information is in:

- ○ Counts
- ○ Percentages

LOGIC Dynamically shown if "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Race/Ethnicity demographic** information is:" = Actual or "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Race/Ethnicity demographic** information is:" = Estimated

78. **Race/Ethnicity**

- [ ] Tribal/Native American
- [ ] Latino/Hispanic
- [ ] Asian Pacific Islander
- [ ] Black/African American
- [ ] White/Caucasian
- [ ] Mixed Race
- [ ] Other

Total : 0

LOGIC Dynamically shown if "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Race/Ethnicity demographic** information is:" = Actual or "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Race/Ethnicity demographic** information is:" = Estimated

Mixed Race - Please specify

LOGIC Dynamically shown if "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Race/Ethnicity demographic** information is:" = Actual or "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Race/Ethnicity demographic** information is:" = Estimated
Other - Please specify

LOGIC Show/hide trigger exists.
79. Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Primary Spoken Language demographic** information is:

- Actual
- Estimated
- Information is not available

LOGIC Dynamically shown if "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Primary Spoken Language demographic** information is:" = Actual or "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Primary Spoken Language demographic** information is:" = Estimated
80. CPP **Primary Spoken Language demographic** information is in:

- Counts
- Percentages

LOGIC Dynamically shown if "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Primary Spoken Language demographic** information is:" = Actual or "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Primary Spoken Language demographic** information is:" = Estimated

81. **Primary Spoken Language at Home**

- [ ] English
- [ ] Other

Total : 0

LOGIC Dynamically shown if "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Primary Spoken Language demographic** information is:" = Actual or "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **Primary Spoken Language demographic** information is:" = Estimated

Other - Please specify

LOGIC Show/hide trigger exists.

82. Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **stakeholder affiliation** information is:

- ○ Actual
- ○ Estimated
- ○ Information is not available

LOGIC Dynamically shown if "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **stakeholder affiliation** information is:" = Actual or "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **stakeholder affiliation** information is:" = Estimated

83. CPP **stakeholder affiliation** information is in:

- ○ Counts
- ○ Percentages

LOGIC Dynamically shown if "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **stakeholder affiliation** information is:" = Actual or "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **stakeholder affiliation** information is:" = Estimated

84. **Stakeholder affiliation**

- [ ] Mental health client/consumer
- [ ] Family member of a mental health consumer
- [ ] County mental health department staff
- [ ] Substance abuse service provider
- [ ] Community-based/non-profit mental health service provider
- [ ] Community based organization (not mental health service provider)
- [ ] Children and families services
- [ ] K-12 education provider
- [ ] Law enforcement
- [ ] Veteran services
- [ ] Senior services
- [ ] Hospital/Health care provider
- [ ] Advocate
- [ ] Other

Total : 0

LOGIC Dynamically shown if "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **stakeholder affiliation** information is:" = Actual or "Please indicate whether reported breakdown information is actual, estimated, or not available.

CPP **stakeholder affiliation** information is:" = Estimated
Other - Please specify

Training

Page description:

85. For the purpose of planning for the 2012/13 Annual updates, in what ways were training and education provided to participants of the CPP process.

Please select the activities that your county engaged in and provide details about them in the subsequent sections. Please note that these items are not mandated under the MHSA but are only examples of how counties can meet the minimum requirements of the CPP as described in the MHSA.

Produce and distribute CPP educational materials

Offer professional development or continuing education credits

County specific trainings on participation in the local stakeholder planning process

Support for participants to attend training not sponsored by the county

Other

Other

Other

Other

Other

Training (specific responses)

Page description:

Training and Education -

Please answer each of the below questions for the training and education activity, if information is available.

86. Please describe the activity:

87. Total # of unduplicated participants not including county staff or representatives (please provide your best estimate if you do not have an exact #):

88. Frequency of training:

89. How successful do you think this training activity/method was in helping to teach stakeholders about participation in the local stakeholder planning process?

- ○ Highly Successful
- ○ Successful
- ○ Neutral
- ○ Unsuccessful
- ○ Highly Unsuccessful

Evaluation

Page description:

90. Please identify any ways in which your county evaluated or attempted to improve its CPP process.

Please select the activities that your county engaged in and provide details about them in the subsequent sections. Please note that these items are not mandated under the MHSA but are only examples of how counties can meet the minimum requirements of the CPP as described in the MHSA.

- ☐ Participant satisfaction surveys
- ☐ Collection of participation data, including number of participants and demographic information
- ☐ Discussion/ focus groups to evaluate process
- ☐ Other
- ☐ Other
- ☐ Other
- ☐ Other
- ☐ Other

Evaluation (specific responses)

Page description:

Evaluation -

Please answer each of the below questions for the evaluation activity, if information is available.

91. Please describe the activity:

92. Total # of unduplicated participants not including county staff or representatives (please provide your best estimate if you do not have an exact #):

93. Frequency of evaluation:

94. Were the results of this activity used to inform / improve future stakeholder planning processes in your county?

- ○ Yes
- ○ No

Additional Questions

Page description:

LOGIC Show/hide trigger exists.

95. Related to planning for the **FY 12/13 Annual Update** and changes made to your county's services and systems based on this planning, did your county measure the impact of its local CPP process on any individual- or system-level outcomes (e.g., evaluation of potential improvements in the mental health or functioning of clients/family members served by the newly planned/implemented services; evaluation of service-delivery improvements that may have stemmed from changes made based on implemented plans)?

- ○ Yes
- ○ No

LOGIC Dynamically shown if "

Related to planning for the **FY 12/13 Annual Update** and changes made to your county's services and systems based on this planning, did your county measure the impact of its local CPP process on any individual- or system-level outcomes (e.g., evaluation of potential improvements in the mental health or functioning of clients/family members served by the newly planned/implemented services; evaluation of service-delivery improvements that may have stemmed from changes made based on implemented plans)?

" = Yes

96. Please describe which outcomes your county evaluated:

LOGIC Dynamically shown if "

Related to planning for the **FY 12/13 Annual Update** and changes made to your county's services and systems based on this planning, did your county measure the impact of its local CPP process on any individual- or system-level outcomes (e.g., evaluation of potential improvements in the mental health or functioning of clients/family members served by the newly planned/implemented services; evaluation of service-delivery improvements that may have stemmed from changes made based on implemented plans)?

" = Yes

97. Please describe the results of your evaluation:

LOGIC Show/hide trigger exists.

98. Related to MHSA stakeholder planning that your county has completed **at any time in the past** and changes made to your county's services and systems based on this planning, did your county measure the impact of its local CPP process on any individual- or system-level outcomes (e.g., evaluation of potential improvements in the mental health or functioning of clients/family members served by the newly planned/implemented services; evaluation of service-delivery improvements that may have stemmed from changes made based on implemented plans)?

- ○ Yes
- ○ No

LOGIC Dynamically shown if "

Related to MHSA stakeholder planning that your county has completed **at any time in the past** and changes made to your county's services and systems based on this planning, did your county measure the impact of its local CPP process on any individual- or system-level outcomes (e.g., evaluation of potential improvements in the mental health or functioning of clients/family members served by the newly planned/implemented services; evaluation of service-delivery improvements that may have stemmed from changes made based on implemented plans)?

" = Yes

99. Please describe which outcomes your county evaluated:

LOGIC Dynamically shown if "

Related to MHSA stakeholder planning that your county has completed **at any time in the past** and changes made to your county's services and systems based on this planning, did your county measure the impact of its local CPP process on any individual- or system-level outcomes (e.g., evaluation of potential improvements in the mental health or functioning of clients/family members served by the newly planned/implemented services; evaluation of service-delivery improvements that may have stemmed from changes made based on implemented plans)?

" = Yes

100. Please describe the results of your evaluation:

MHSA Principles 1

Page description:

101. Has your county's CPP process changed since it was first used to develop plans for the Three Year Program and Expenditure Report (FY 05/06, 06/07, 07/08), with regard to the following?

- ☐ Strategies used to encourage stakeholder involvement
- ☐ The degree to which your CPP process was comprehensive and representative
- ☐ Responsibility and roles of staff to implement the CPP process
- ☐ The training provided to ensure full participation of stakeholders and staff in the local planning process
- ☐ The focus of the planning (e.g., programs, services, systems, MHSA components)
- ☐ Other areas that changed:
- ☐ Other areas that changed:
- ☐ Other areas that changed:
- ☐ Other areas that changed:

MHSA Principles 1 (specific responses)

Page description:

CPP Process Changes -

Please answer each of the below questions for the CPP process(es) that changed in your county.

- ○ Major change
- ○ Some change

103. Please provide examples of how these items have changed over the years:

MHSA Principles 2

Page description:

104. How representative of your county's overall MHSA stakeholder planning process do you think the planning done for the development of the FY 2012/13 Annual Updates was?

- ○ Highly Representative
- ○ Somewhat Representative
- ○ Neither Representative or Unrepresentative
- ○ Somewhat Unrepresentative
- ○ Highly Unrepresentative

CPP Process Documentation

Page description:

105. **CPP Process Documentation:**

If there are any documents or materials that you believe exemplify the activities your county engaged in as part of its local stakeholder planning process (e.g., county staff participation, outreach, training, stakeholder input/participation, evaluation), please feel free to upload them here or email them to Cyndi Eppler (ceppler@peersnet.org).

(NOTE: This online submission format is capable of a maximum of 10 files, 25 megabytes each.)

Browse... Choose File No file selected Upload

Almost done!

Page description:

You are almost done!

If you would like to review and/or change any of your responses, please click the 'Back' button below. **When you are satisfied with your responses, please click the 'Submit' button below to complete this survey.**

Thank You!

Thank you for your participation!

MHSA CPP: FY2012/13 Annual Update Document Review

Background Information

Page description:
NOTE: If the county's Annual Update does not have the information requested here, please enter "N/A". Please do not leave any fields blank in this instrument.

1. County: *

2. Name of reviewer: *

LOGIC Show/hide trigger exists.
3. Was the 2012/2013 Annual Update available on the county's MHSA website or anywhere else?

- Yes
- No

LOGIC Dynamically shown if "Was the 2012/2013 Annual Update available on the county's MHSA website or anywhere else?" = Yes or "Was the 2012/2013 Annual Update available on the county's MHSA website or anywhere else?" = Yes
4. Total participants in FY 2012-/13 CPP process:

Page exit logic: No Annual Update available for the county --> Skip to Other Thoughts at the end of instrument.
IF: Question "Was the 2012/2013 Annual Update available on the county's MHSA website or anywhere else?" #3 contains any ("No") **THEN:** Jump to page 9 - Other Thoughts

Demographics of Participants

Page description:
Please enter counts or percentages below. If entering percentages, please include "%" sign.

5. Age

- [ ] Transition Age Youth (ages 16-24)
- [ ] Adult
- [ ] Older Adult
- [ ] Declined to state
- [ ] Unknown

Total : 0

6. Gender

- [ ] Male
- [ ] Female
- [ ] Other/Declined
- [ ] Unknown

Total : 0

7. Race/Ethnicity

- [ ] Tribal/Native American
- [ ] Asian Pacific Islander
- [ ] White/Caucasian
- [ ] Latino/Hispanic
- [ ] Black/African American
- [ ] Mixed/Other
- [ ] Unknown/Declined

Total : 0

8. Consumer/Family Member

- [ ] Consumer
- [ ] Family Member

Total : 0

9. Language - Non-English proficient

LOGIC Show/hide trigger exists.

10. Other Demographic categories described: Please indicate name of demographic and percentages (when available):

- ☐ Other 1 _____
- ☐ Other 2 _____
- ☐ Other 3 _____
- ☐ Other 4 _____
- ☐ Other 5 _____
- ☐ Other 6 _____

LOGIC Dynamically shown if "Other Demographic categories described: Please indicate name of demographic and percentages (when available):" = Other 1

11. Other 1 - Count/Percentage

_____

LOGIC Dynamically shown if "Other Demographic categories described: Please indicate name of demographic and percentages (when available):" = Other 2

12. Other 2 - Count/Percentage

_____

LOGIC Dynamically shown if "Other Demographic categories described: Please indicate name of demographic and percentages (when available):" = Other 3

13. Other 3 - Count/Percentage

_____

LOGIC Dynamically shown if "Other Demographic categories described: Please indicate name of demographic and percentages (when available):" = Other 4

14. Other 4 - Count/Percentage

LOGIC Dynamically shown if "Other Demographic categories described: Please indicate name of demographic and percentages (when available):" = Other 5

15. Other 5 - Count/Percentage

LOGIC Dynamically shown if "Other Demographic categories described: Please indicate name of demographic and percentages (when available):" = Other 6

16. Other 6 - Count/Percentage

17. **Stakeholder Affiliations:**

Please identify the various types of stakeholder groups that are represented amongst the county's CPP participating population.

- ☐ Mental health client/consumer
- ☐ Family member of a mental health consumer
- ☐ County mental health department staff
- ☐ Substance abuse service provider
- ☐ Community-based/non-profit mental health service provider
- ☐ Community based organization (not mental health service provider)
- ☐ Children and families services
- ☐ K-12 education provider
- ☐ Law enforcement
- ☐ Veteran services
- ☐ Senior services
- ☐ Hospital/Health care provider
- ☐ Advocate
- ☐ Other (please list all other categories of stakeholders)

Outreach

Page description:

18. Outreach Activities - please describe

	YES / NO (Please enter 'Yes' or 'No')	DESCRIPTION OF ACTIVITY (i.e. flyers about participating in Annual Stakeholder meeting, posted in English & Spanish)	# OF PEOPLE RECEIVING ACTIVITY (i.e. 35 flyers posted)	LOCATION (i.e. Wellness center, library)	TARGET POPULATION (i.e., consumers, family members, Spanish speaking population)
Flyers					
Emails/Letters					
Phone calls					
Social media					
Radio/TV/News					
Other					
Other					

Stakeholder Planning, Strategizing & Evaluating (i.e., ongoing CPP engagement)

Page description:

19. Outreach Activities - please describe

	YES / NO (Please enter 'Yes' or 'No')	DESCRIPTION OF ACTIVITY	# OF MEETINGS/YEAR	TOTAL # OF PARTICIPANTS	DEM P PO
Planning council/Steering committee meeting(s)					
Other					
Other					

Stakeholder Input

Page description:

20. Outreach Activities - please describe

	YES / NO (Please enter 'Yes' or 'No')	DESCRIPTION OF ACTIVITY	# OF ACTIVITY(S)	TOTAL # OF PARTICIPANTS	DEM F PC
Focus group					
Other					
Key informant interview					
Survey/Questionnaire					
Town hall/Community meeting					

Posting and Reporting

Page description:

LOGIC Show/hide trigger exists.

21. Was there a 30-day posting of the Annual Update?

- Yes
- No
- Unknown

LOGIC Dynamically shown if "Was there a 30-day posting of the Annual Update?" = Yes

22. If yes, where/how was the Annual Update distributed?

LOGIC Dynamically shown if "Was there a 30-day posting of the Annual Update?" = Yes

23. To what languages was the Annual Update translated into?

Public Hearing

Page description:

LOGIC Show/hide trigger exists.

24. Was there a public hearing of the Annual Update?

- Yes
- No
- Unknown

LOGIC Show/hide trigger exists. Dynamically shown if "Was there a public hearing of the Annual Update?" = Yes

25. Was public health feedback incorporated into the final draft of the Annual Update?

- ○ Yes
- ○ No
- ○ Unknown
- ○ No Substantive Comments

LOGIC Dynamically shown if "Was public health feedback incorporated into the final draft of the Annual Update?" = Yes

26. Number of public hearing participants:

LOGIC Dynamically shown if "Was public health feedback incorporated into the final draft of the Annual Update?" = Yes

27. Number of comments received:

LOGIC Dynamically shown if "Was public health feedback incorporated into the final draft of the Annual Update?" = Yes

28. How were comments addressed?

LOGIC Dynamically shown if "Was public health feedback incorporated into the final draft of the Annual Update?" = Yes

29. What changes were made to the plan? (if applicable):

Additional Question

Page description:

30. What was unique/innovative about the Annual Update (if applicable)?

Other Thoughts

Page description:

31. Other thoughts about the Annual Update:

Thank You!

Thank you for taking our survey. Your response is very important to us.

MHSA CPP: Key Informant Interviews (Notes Entry)

Introduction

Page description:
INSTRUCTIONS TO REGIONAL PARTNERS:

Please review and synthesize your key informant interview notes into the items in the interview protocol. Please enter your synthesized notes into this online form.

1. (For Regional Partner) **Your Name**: *

2. **County Name**: *

3. In what ways have you been involved in MHSA Community Program Planning (CPP) processes in this county?

CPP Staffing

Page description:

4. To what degree do you feel that the CPP process is adequately staffed to coordinate and manage the Community Program Planning Process and to ensure that stakeholders have the opportunity to participate? Please explain.

Outreach

Page description:

5. Consider the outreach activities your county did to inform and encourage participation in the CPP process…

a. Which outreach activities were most effective and why? Please describe the activities and why you thought they were effective.

6. b. Which outreach activities were least effective and why? Please explain.

Stakeholder Participation

Page description:

7. Are their certain stakeholder groups that participate more frequently than others? If so, who? (reference stakeholder groups)

8. Are their certain stakeholder groups that are underrepresented or do not participate in the CPP process? If so, why do you think this is?

9. What barriers to participation do you think that stakeholders in your county face? How do you address these barriers? Are there any barriers you feel you are unable to address?

10. What does the CPP staff or county do to ensure that the CPP process is consistent with the principles of MHSA? Please give specific examples to the following prompts:

• Cultural competency (i.e., ability to interact effectively with people of different cultures and socio-economic backgrounds)
• Community collaboration
• Integrated service experience
• Family and client driven
• Recovery oriented (i.e., wellness, recovery and resiliency)

11. Which CPP activities that your county facilitated do you feel were most effective and why? Please describe the activities and why you thought they were effective.

CPP Process - Community Changes

Page description:

12. What does the CPP staff or county do to create safe environments for the CPP process activities and meetings? (i.e., free from stigma, discrimination and retaliation)

13. How and to what degree has the CPP process affected trust and collaboration:

• Among mental health service providers?
• Between mental health providers and other stakeholders including health and human service providers?
• Between consumers and family members?

Please give specific examples.

14. To what extent does the CPP process in your county affect:

• the public's perception of public mental health services?
• the public's perception of people with mental illness? (i.e., stigma)

Please provide specific examples.

CPP Process - Program & Policy Change

Page description:

15. In what ways has the CPP process affected and/or changed the public mental health system and services? Please be specific. Prompts: plans, policy, budget, resource allocation, staffing decisions, quality improvement

CPP Process - Other Impacts

Page description:

16. What other impacts do you perceive the CPP process to have on the community at large, particularly related to MHSA-defined outcomes?

Satisfaction With & Changes to CPP Process

Page description:

17. Overall, how satisfied are you with the CPP process in your county? Please explain.

Changes to CPP Process

Page description:

18. Given the resources you have, what could be done to improve the CPP process in your county? In other words, what might you do differently in future CPP processes?

Interviewer's Summary Thoughts

Page description:
After each key informant interview, please write down your summary thoughts pertaining to each interview. Please structure your summary thoughts under the following topics:

19. Successful aspects of the interview (i.e. interview strategies used, logistics, etc.):

20. Points of improvement (i.e. interview strategies used, logistics, etc.):

21. Other comments about the interview:

Thank You!

Thank you for taking our survey. Your response is very important to us.

MHSA CPP: Focus Groups (Notes Entry)

Introduction

Page description:
INSTRUCTIONS TO REGIONAL PARTNERS:

Please review and synthesize your focus group notes into the items in the focus group protocol. Please enter your synthesized notes into this online form.

1. (For Regional Partner) **Your Name**: *

2. **County Name**: *

Questions for Individuals from Unserved/Underserved Populations without Prior CPP Participation Experience

Page description:
NOTE TO FOCUS GROUP FACILITATOR: For those individuals from unserved/underserved populations without prior CPP participation experience who attend the focus group, please ask them the following questions:

3. To your knowledge, how does the county reach out and invite stakeholders from unserved/underserved populations to participate in the CPP process?

4. What are the barriers/challenges that prevent or restrict individuals from unserved/underserved populations from participating in CPP processes?

Outreach

Page description:

5. How did you find out about the Community Program Planning process?

6. To your knowledge, how else does the county reach out and invite stakeholders to participate in the CPP process? [Prompts: flyers; emails; phone call; or referral from friend?]

i) To your knowledge, does the county make a special effort to reach out to any specific stakeholder group? (reference stakeholder groups)

ii) Are meetings locations/times accessible? How so? How not?

7. Are there any barriers/challenges that prevent or restrict people from participating in CPP processes?

i) What is the mental health department doing to make the CPP meetings more accessible and inviting?

Community Program Planning Activities

Page description:

8. What types of Community Program Planning activities do you participate in and how often? [Prompt: public hearings, CPP planning meetings, town hall meeting]

i) Which activities do you like the most? Why?

ii) Which activities do you least appreciate? Why?

9. Did the mental health department provide you with training or educational opportunities to better prepare you to participate in CPP processes?

i) If so, to what extent do you feel that the training you received helped you to meaningfully participate?

10. Are there certain stakeholder groups that participate more frequently than others? If so, who? (reference stakeholder groups)?

11. Are their certain stakeholder groups that are underrepresented or do not participate in the CPP process? Why do you think this is (reference stakeholder groups)?

12. How do County Mental Health Department staff members communicate with you and other participants about the CPP process?

i) Is communication from County Mental Health Department staff sufficient to make you feel informed about the process? Please explain.

13. Do you feel that decisions made regarding your input are transparent? For example, do you receive an explanation on how staff integrates or does not integrate participant input?

i) To what extent do you feel that all CPP participants' opinions are respected? Please explain.

14. To what extent do people feel safe and supported participating in CPP? [Prompt: free from stigma, discrimination, retaliation.]

a) What do CPP facilitators do to ensure that people feel safe and supported? [Prompt: communication agreements, building trust, dealing with differing perspectives]

b) Do you feel that county staff are prepared to lead and facilitate the CPP process?

c) Is the CPP process consistent with the principles of MHSA?
i) Recovery Vision (i.e., wellness, recovery and resiliency)
ii) Cultural competency (i.e., ability to interact effectively with people of different cultures and socio-economic backgrounds)
iii) Community collaborations
iv) Integrated service experiences
v) Family and client-driven

Outcomes and Impact

Page description:

15. How has the CPP process impacted or changed the public mental health system and/or mental health services? [Prompt: plans, policy, budgets, resource allocation, staffing decisions, quality improvement] Please provide specific or concrete examples.

16. Does your participation in the CPP process affect your opinion of the mental health department and your trust in the mental health system? How so?

17. How has participating in CPP affected your own well-being and/or recovery, if at all?

18. Has the CPP process affected how the public perceives mental health services and people who have mental health illnesses?

19. Has the CPP process affected relationships between the mental health department and government agencies or community based organizations? How and to what extent?

20. What other impacts, if any, do you think that the CPP process has had?

Overall Perception

Page description:

21. Overall, to what degree are you satisfied with the CPP processes and why?

22. With regards to the CPP processes, what would you do differently? What are your recommendations for the future?

Written Responses - Data Entry

Page description:

23. **NOTE TO REGIONAL PARTNERS:**

If you collected written responses from any of your focus group participants, please enter those compiled responses here.

Focus Group Leader's Summary Thoughts

Page description:
After each focus group, please write down your summary thoughts pertaining to each focus group. Please structure your summary thoughts under the following topics:

24. Successful aspects of the focus group (i.e. facilitation strategies used, logistics, participants makeup, etc.)

25. Points of improvement (i.e. facilitation strategies used, logistics, participants makeup, etc.)

26. Other comments about the focus group

Participant Information

Page description:

Focus Group Participant Demographic Form

Please add-up all of the focus group participant demographic forms and report the total counts below.

NOTE: The Focus Group Participant Demographic Form is optional for focus group participants to complete.

27. Number of focus group participants:

28. Number of participants declining to answer demographics questions:

29. **Age Range**:

Please enter the total counts for each category.

Under 18	
18-25	
26-59	
60 or older	

30. **Race/Ethnicity**:

Please enter the total counts for each category. If participants noted "Mixed Race" or "Other", please also include the specific designations that they write down for those categories.

Tribal/Native American	
Latino/Hispanic	
Asian Pacific Islander	
Black/African American	
White/Caucasian	
Mixed Race	
Other	

31. **Stakeholder Affiliation**:

Please enter the total counts for each category. If participants noted "Other", please also include the specific designations that they write down for that category.

Mental health client/consumer	
Family member of a mental health consumer	
County mental health department staff	
Substance abuse service provider	
Community-based/non-profit mental health service provider	
Community based organization (not mental health service provider)	
Children and families services	
K-12 education provider	
Law enforcement	
Veteran services	
Senior services	
Hospital/ Health care provider	
Advocate	
Other	

32. **Gender**:

Please enter the total counts for each category.

Female	
Male	
Transgender/Other	

33. **Identify as LGBT**:

Please enter the total counts for each category.

Yes	
No	

34. **Primary Language Spoken at Home**:

Please enter the total counts for each category. If participants noted "Other", please also include the specific designations that they write down for this category.

English	
Other	

35. **OUTREACH EFFORTS & ADDITIONAL NOTES**:

Please describe the outreach efforts you took to recruit participants for this focus group. Please provide any additional notes about the focus group that you would like to share.

Thank You!

Thank you for taking our survey. Your response is very important to us.

MHSA CPP: Stakeholder Survey

Introduction

Page description:

Background

California's Mental Health Services Act (MHSA) was passed in 2004 and requires that each county's mental health department involve a broad range of community stakeholders in "mental health policy, program planning and implementation, monitoring, quality improvement, evaluation and budgeting" (WIC, § 5845-5848). Stakeholders should reflect the diversity of the county and include "adults and seniors with severe mental illness, families of children, adults, and seniors with severe mental illness, providers of services, law enforcement agencies, education, social services agencies, veterans, representatives from veterans organizations, providers of alcohol and drug services, health care organizations, and other important interests" (WIC, § 5845-5848).

The State of California is interested to hear from stakeholders such as you, about your knowledge and experience with MHSA Community Program Planning processes. Prior participation in the Community Program Planning process is not necessary to respond to this survey. Your answers will help us identify the most effective and useful MHSA Community Program Planning activities so that they may be shared with and taught to others throughout the state.

This survey is confidential and anonymous. It will take about *10 minutes* to complete. If you have any questions about this survey or the evaluation, or if you would like help completing the survey, please contact Cyndi Eppler (ceppler@peersnet.org; 510-832-7337 ext. 204) and Tawny Porter (tporter@peersnet.org; 510-832-7337 ext. 226).

1. Which California county do you live in? *

Alameda
Alpine
Amador
City of Berkeley
Butte
Calaveras
Colusa
Contra Costa
Del Norte
El Dorado
Fresno
Glenn
Humboldt
Imperial
Inyo
Kern
Kings
Lake
Lassen
Los Angeles
Madera
Marin
Mariposa
Mendocino
Merced
Modoc
Mono
Monterey
Napa
Nevada
Orange
Placer
Plumas
Riverside
Sacramento
San Benito
San Bernardino
San Diego
San Francisco
San Joaquin
San Luis Obispo
San Mateo
Santa Barbara
Santa Clara
Santa Cruz
Shasta
Sierra

Siskiyou
Solano
Sonoma
Stanislaus
Sutter
Tehama
Tri-City Region
Trinity
Tulare
Tuolumne
Ventura
Yolo
Yuba

2. Have you ever participated in the MHSA Community Program Planning process? *

- Yes
- No

Page exit logic: no-jump to page 7
IF: Question "Have you ever participated in the MHSA Community Program Planning process?" #2 contains any ("No") **THEN:** Jump to page 7 - Never Participated

2012-2013 CPP Participation

Page description:

3. Did you participate in Community Program Planning activities during the last fiscal year (July 2012- June 2013)? *

- Yes
- No
- Don't know

Page exit logic: Stopped participating
IF: Question "Did you participate in Community Program Planning activities during the last fiscal year (July 2012- June 2013)?" #3 contains any ("No","Don't know") **THEN:** Jump to page 6 - Stopped Participating

Current Participants

Page description:

4. For how long have you participated in the MHSA Community Program Planning process?

- ☐ Less than 1 year
- ☐ 1 year - 3 years
- ☐ More than 3 years
- ☐ Don't know

5. Do you plan to participate in the future?

- ☐ Yes
- ☐ No. If no, why not? _____

6. How frequently did you participate in MHSA Community Program Planning activities or meetings?

- ☐ Once per year
- ☐ Less than once per month, but more than once per year
- ☐ One to two times per month
- ☐ Three or more times per month
- ☐ Other _____
- ☐ Don't know

7. Why did you decide to participate in the MHSA Community Program Planning process? (Check all that apply.)

- ☐ Interested in mental health advocacy
- ☐ Wanted to contribute to my community
- ☐ Has impact on my business or community development plans
- ☐ Thought it would help me personally/ thought it would improve my mental health
- ☐ Thought it would help a family member
- ☐ Thought it would help me better understand what services and supports are available
- ☐ Thought it would provide me with training and education
- ☐ Other _____
- ☐ Don't know

8. Which of the following MHSA/ Community Program Planning activities did you participate in within the last year? (Check all that apply.)

- ☐ Attended a MHSA town hall or community meeting
- ☐ Participated on a MHSA program planning committee or other ongoing MHSA committee
- ☐ Participated in a MHSA focus group
- ☐ Filled out a MHSA survey/ questionnaire
- ☐ Attended a public hearing organized by the local Mental Health Board
- ☐ Other _____
- ☐ Don't know

9. In the past year, how have you received information about the MHSA Community Program Planning process in your county? (Check all that apply.)

- ☐ Flyers/ poster/ brochures
- ☐ Phone calls
- ☐ Emails
- ☐ Radio/ TV announcement
- ☐ Facebook/ Twitter/ Social Media messages
- ☐ Newspaper announcement
- ☐ Referral from friend or family member
- ☐ Referral from Mental Health Department
- ☐ Referral from other service provider. Which service provider? _____
- ☐ Other _____
- ☐ None. I have never received any communication about MHSA Community Program Planning
- ☐ Don't know

10. Which of the following incentives does your county offer MHSA Community Program Planning participants? (Check all that apply.)

- ☐ Transportation to meetings
- ☐ Transportation vouchers
- ☐ Meals at meetings
- ☐ Multiple meeting times (e.g. evening and day time)
- ☐ Stipend/ Other financial incentive
- ☐ Childcare
- ☐ Continuing Education Credits/ Certificates
- ☐ Translation/ Interpretation services
- ☐ None
- ☐ Other _____
- ☐ Don't know

11. What has made it difficult for you to participate in the MHSA Community Program Planning process? (Check all that apply.)

- ☐ Meeting location is inaccessible
- ☐ Meeting time is inconvenient
- ☐ Language barriers
- ☐ Not enough knowledge/training to meaningfully participate
- ☐ Unsafe/ unfriendly environment at MHSA Community Program Planning meetings
- ☐ Stigma about mental illness
- ☐ Other _____
- ☐ None/ No barriers
- ☐ Don't know

Likert Questions - Current & Past Participants

Page description:

12. Please rate how much you agree with the following statements about the MHSA Community Program Planning (CPP) process in your county:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't know
MHSA CPP meetings were well organized	○	○	○	○	○	○
MHSA CPP facilitators were well-prepared to lead meetings/activities	○	○	○	○	○	○
I received enough training/info to meaningfully participate	○	○	○	○	○	○
Stakeholder input was taken into account for planning mental health services in the county	○	○	○	○	○	○
Participating in MHSA CPP increased my trust in the mental health system	○	○	○	○	○	○
Participating in the MHSA CPP process improved my sense of wellbeing	○	○	○	○	○	○
I felt safe participating in the MHSA CPP process	○	○	○	○	○	○
My opinions were respected and listened to	○	○	○	○	○	○
The MHSA CPP meetings were in a language that I speak/ understand	○	○	○	○	○	○
The MHSA CPP facilitators respected my culture	○	○	○	○	○	○
The CPP process was recovery-oriented	○	○	○	○	○	○
Overall, I found the MHSA CPP process to be valuable	○	○	○	○	○	○

Qualitative Questions - Current & Past Participants

Page description:

13. What did you like most about the MHSA Community Program Planning process in your county?

14. What did you like least about the MHSA Community Program Planning process in your county?

15. How could the MHSA Community Program Planning process be improved?

16. Did you stop participating in the 2012-2013 MHSA Community Program Planning process before it was over?

- Yes
- No
- Don't know

Page exit logic: Stopped participating in the middle of the 2012-2013 CPP process
IF: Question "Did you stop participating in the 2012-2013 MHSA Community Program Planning process before it was over?" #16 contains any ("No","Don't know") **THEN:** Jump to page 8 - Demographics Information

Stopped Participating

Page description:

17. Why did you stop participating in the MHSA Community Program Planning process?

18. What would encourage you to participate in the MHSA Community Program Planning process again?

Page exit logic: Stopped participating-> demographics
IF: TRUE **THEN:** Jump to page 8 - Demographics Information

Never Participated

Page description:

19. What would be the best way for the county to inform you about the MHSA Community Program Planning process? (Check all that apply.)

- ☐ Flyers/posters/brochures
- ☐ Phone Calls
- ☐ Emails
- ☐ Radio/ TV announcement
- ☐ Facebook/ Twitter/ Social Media messages
- ☐ Newspaper announcement
- ☐ Referral from friend or family member
- ☐ Referral from Mental Health Department
- ☐ Referral from other service provider. Which service provider? _____
- ☐ Other _____
- ☐ Don't know

20. Which of the following incentives would encourage you to participate in the MHSA Community Program Planning process? (Check all that apply.)

- ☐ Transportation to meetings
- ☐ Transportation vouchers
- ☐ Meals at meetings
- ☐ Multiple meeting times (e.g. evening and day time)
- ☐ Stipend/ other financial incentive
- ☐ Childcare
- ☐ Continuing Education Credits/Certificates
- ☐ Translation/Interpretation services
- ☐ None
- ☐ Other _____
- ☐ Don't know

21. What barriers would prevent you from participating in the MHSA Community Program Planning process in your county? (Check all that apply.)

- ☐ Meeting location is not accessible
- ☐ Meeting time is not convenient
- ☐ Language barrier
- ☐ Not enough knowledge/training
- ☐ Meetings feel unsafe or unfriendly
- ☐ Stigma about mental illness
- ☐ Other _____
- ☐ Don't know

Demographics Information

Page description:

22. Please check this box if you do not wish to answer demographic questions

- ☐ I do not wish to answer demographic questions

23. Which California county do you live in? *

Alameda
Alpine
Amador
Butte
Calaveras
Colusa
Contra Costa
Del Norte
El Dorado
Fresno
Glenn
Humboldt
Imperial
Inyo
Kern
Kings
Lake
Lassen
Los Angeles
Madera
Marin
Mariposa
Mendocino
Merced
Modoc
Mono
Monterey
Napa
Nevada
Orange
Placer
Plumas
Riverside
Sacramento
San Benito
San Bernardino
San Diego
San Francisco
San Joaquin
San Luis Obispo
San Mateo
Santa Barbara
Santa Clara
Santa Cruz
Shasta
Sierra
Siskiyou

Solano
Sonoma
Stanislaus
Sutter
Tehama
Trinity
Tulare
Tuolumne
Ventura
Yolo
Yuba

24. The city of Berkeley and the Tri-City region have their own mental health departments. Please check the following boxes if you receive or provide services in:

- [ ] City of Berkeley
- [ ] Tri-City Region

25. Please indicate you age range

- ○ Under 18
- ○ 18-25
- ○ 26-59
- ○ 60 or older

26. Please indicate your gender

- ○ Female
- ○ Male
- ○ Transgender/other

27. Please indicate if you identify as LGBT

- ○ Yes
- ○ No

28. Please indicate you race/ethnicity:

- ○ Tribal/ Native American
- ○ Latino/ Hispanic
- ○ Asian Pacific Islander
- ○ Black/ African American
- ○ White/ Caucasian
- ○ Mixed Race: _____
- ○ Other: _____

29. Please indicate the language you speak at home:

- ☐ English
- ☐ Other _____

30. Please indicate your affiliation with the MHSA CPP process. (Check all that apply.)

- ☐ Mental health client/ consumer
- ☐ Family member of a mental health consumer
- ☐ County Mental Health Department staff
- ☐ Substance abuse service provider
- ☐ Community-based/non-profit mental health service provider
- ☐ Community based organization (not mental health service provider)
- ☐ Children and families services
- ☐ K-12 education provider
- ☐ Law enforcement
- ☐ Veteran services
- ☐ Senior services
- ☐ Hospital/ Health care provider
- ☐ Advocate
- ☐ Other _____

ADMIN ONLY: Paper-based Surveys

Page description:
FOR ADMINISTRATIVE PURPOSES ONLY:

Please answer this question only if you are an administrator.

31. Was this Stakeholder survey originally done via paper?

- ○ Yes
- ○ No

Thank You!

Thank you for completing the survey. Your input is very much appreciated. If you would like more information about how you can participate in the Community Program Planning process in your county, please contact Cyndi Eppler at (510) 832-7337 ext. 204.

MHSA Community Program Planning Processes – Supplemental Report (Appendix 8)

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

Project/Agreement #12MHSOAC009

August 6, 2014

Prepared by:

Resource Development Associates

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Introduction

The purpose of this supplemental report is to provide an in-depth look at the analyses that supported the formulation of findings and conclusions identified in the technical evaluation report. As such, readers should refer to this guide in the event that they would like a more detailed understanding of the analyses or response to a specific research question.

This supplemental report highlights the results from each of the 42 research questions as identified in RDA's report titled, "Deliverable 1: Report of Proposed Research Design and Data Collection Training Plan." Each section will identify the general topic area that the research questions will address, including the following:

- **Inputs:** What resources do counties have to conduct CPP processes?
- **Activities:** What CPP activities do counties engage in?
- **Process Outcomes:** Who, how many, and how often are stakeholders involved in the CPP process? Are stakeholders satisfied with the process?
- **Impacts:** How does the CPP process affect participants, the mental health system, and the broader community?
- **Stakeholders Who Did Not Participate in the CPP Process:** What activities would encourage individuals to participate in the CPP process? What are the barriers that prevent individuals from participating in the CPP process?

Each of these topic areas are further divided (as appropriate) based on the following nine designations. These include: 1) Inputs, 2) Outreach, 3) Participant Input, 4) Training, 5) Evaluation, 6) Stakeholder Perceptions and Satisfaction, 7) Participant Impacts, 8) Mental Health System Impacts, and 9) Perceptions of the Broader Community Impact. Each of these designations is presented within each general topic area, as appropriate.

Within each topic area and designation, each research question is listed individually and is structured in the following way:

- **Result:** This section consolidates results across all the data sources in order to distill key findings from the data analysis. Analysis was performed at the statewide, CMHDA region, and county size level. As such, each results section presents key findings at these three analytical units. Overall, this section is intended to function as a snapshot of the *Rationale* section (see below). This snapshot provides readers with a quick summary of the major findings without going into levels of detail that may not be as useful for all readers of this report.

- **Rationale:** This section complements its respective Result section by presenting the data analysis from each relevant data sources. In other words, the rationale section thoroughly interprets the data used to address each research question. Charts, tables, and quotes serve as supporting

evidence to validate the results arrived at for each research question. Data was analyzed at the statewide, CMHDA region, and county size levels.

Analytical Units

All research questions were addressed according to three primary analytical units: 1) statewide, 2) CMHDA region, and 3) county size. In addition to analyzing the data at the statewide level, the evaluation team used the other two units of analysis for the following reasons:

- **CMHDA**: California is a vast state where wide variation characterizes these five geographic regions of the state. As a result, geography and demographics are important factors in the planning and delivery of services. Despite these broad differences, a certain degree of similarities can be assumed to exist within these five geographic regions. To gain a better understanding of the results relevant to each specific region, data was analyzed according to CMHDA regions. These regions are as follows: 1) Superior, 2) Northern, 3) Central, 4) Los Angeles, and 5) Southern.

- **County Size**: The evaluation team also recognized that considerable variation occurs *within* CMHDA regions. As such, this evaluation's data was also analyzed by county size. Once again, the evaluation team considered what would be most beneficial to understand CPP processes. County size is an important consideration in the planning and delivery of mental health services because levels of resources may vary according to county size.

Notations are used in this report to denote the data sources that specific results came from. The following five symbols are used throughout the remainder of this report:

$^{\mu}$ = *SOURCE*: Annual Update Document Review

$^{\beta}$ = *SOURCE*: County Key Informant Interviews

$^{\phi}$ = *SOURCE*: County Web-Based Data Request

$^{\Delta}$ = *SOURCE*: Stakeholder Focus Groups

$^{\delta}$ = *SOURCE*: Stakeholder Survey

Results

This supplemental report is divided into the following five sections: 1) Inputs, 2) Activities, 3) Process Outcomes, 4) Impacts, and 5) Stakeholders Who Did Not Participate in the CPP Process. Each of the 42 research questions fall under one of these five general research domains.

Inputs

The following section identifies those inputs that impact resources available to counties in order to conduct CPP processes. This section identifies the number of Full Time Equivalent positions or units (FTEs) that each county designates for the CPP process and the type of training provided to county staff.

IN-01: Does the county designate positions or units responsible for the CPP process? If so, how many Full Time Equivalents (FTEs)?

Results

Statewide: All counties reported designating at least 0.03 FTEs and at most 7.5 FTEs for the CPP Process, with a statewide average of 1.84 FTEs.

CMHDA Region: On average, the Los Angeles region reported the greatest number of FTEs responsible for its CPP process (4.0 FTEs), followed by the Southern region (3.03 FTEs), the Bay Area region (2.06 FTEs), the Central region (1.50 FTEs), and the Superior region (0.98 FTEs). On average, all CMHDA Regions reported that at least 1.0 FTE position or unit was responsible for each of their counties' CPP processes.

County Size: On average, large counties reported the greatest number of FTEs responsible for their CPP processes (3.58 FTEs), followed by medium counties (1.91 FTEs) and small counties (0.96 FTEs).

Statewide

Rationale: At the statewide level, counties (n = 50) reported designating an average of 1.84 FTEs, ranging from a minimum of 0.03 FTEs to a maximum of 7.5 FTEs.[Φ] Fifty-nine percent (59%, n = 50) of counties indicated that they felt the CPP process was adequately or more than adequately staffed to coordinate and manage their CPP processes, while 41% of counties indicated that they felt their CPP processes were not adequately staffed to coordinate and manage their CPP efforts.[Φ]

By CMHDA Region

Rationale: Further analysis of the data by CMHDA Region revealed that on average, as shown in Table 1, the Los Angeles region reported the greatest number of FTEs responsible for its CPP process (4.0 FTEs). This was followed by the Southern region (3.03 FTEs), the Bay Area region (2.06 FTEs), the Central region (1.50 FTEs), and the Superior region (0.98 FTEs). On average, all CMHDA Regions reported at least 1.0 FTE position or unit was responsible for their counties' CPP processes.

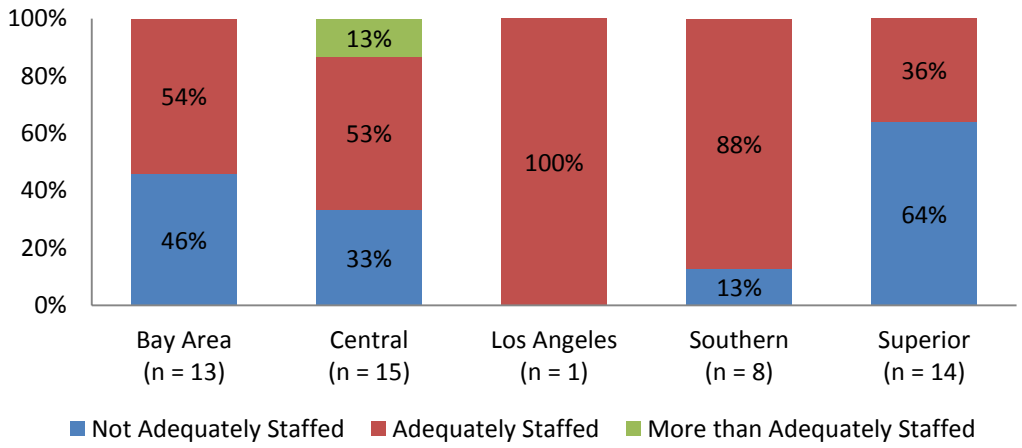
Table 1: Number of Full Time Equivalents (FTEs) Responsible for the CPP Process, by CMHDA Region ϕ

	Bay Area (*n* 13)	Central (*n* 14)	Los Angeles (*n* 1)	Southern (*n* 9)	Superior (*n* 13)
Average	2.06	1.50	4.00	3.03	0.98
Minimum	0.10	0.05	4.00	0.25	0.03
Maximum	5.50	7.50	4.00	5.00	4.00

ϕ*SOURCE:* County Web-Based Data Request

Counties were asked to indicate whether they felt there was adequate staffing to coordinate and manage their CPP processes, as shown in Figure 1. The Los Angeles region reported that its CPP process was adequately staffed (*n* = 1), followed by 88% of the Southern region (*n* = 8), 66% of the Central region (*n* = 15), 54% of the Bay Area region (*n* = 13), and 36% of the Superior region (*n* = 14).

Figure 1: Degree of Staffing Adequacy to Coordinate and Manage CPP Process, by CMHDA Region β



β *SOURCE:* County Key Informant Interview

By County Size

Rationale: Further analysis of the data by county size reveals that on average, as shown in Table 2, large counties reported the greatest number of FTEs responsible for their CPP processes (3.58 FTEs). This was followed by medium counties (1.91 FTEs) and small counties (0.96 FTEs). On average, across all county sizes, there was at least 1.0 FTE position or unit responsible for counties' CPP processes.

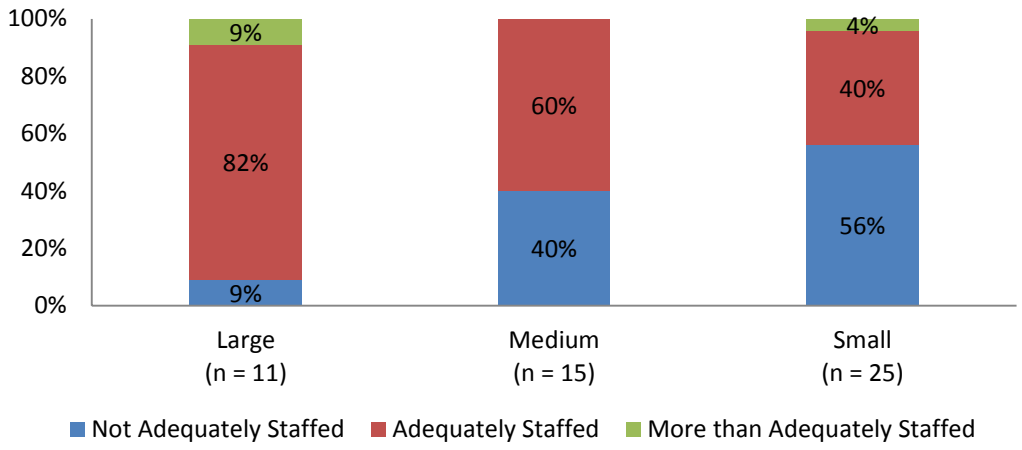
Table 2: Number of Full Time Equivalents (FTEs) Responsible for the CPP Process, by County Size ϕ

	Large (*n* 12)	Medium (*n* 13)	Small (*n* 25)
Average	3.58	1.91	0.96
Minimum	1.25	0.25	0.03
Maximum	7.50	5.00	5.00

ϕ *SOURCE:* County Web-Based Data Request

Counties were asked to indicate whether they felt there was adequate staffing to coordinate and manage their CPP processes, as shown in Figure 2. Overall, 91% of large counties reported that their CPP processes were adequately or more than adequately staffed (*n* = 11), followed by 60% of medium counties (*n* = 15) and 44% of small counties (*n* = 25).

Figure 2: Degree of Staffing Adequacy to Coordinate and Manage CPP Process, by County Size [β]



[β] *SOURCE:* County Key Informant Interview

IN-02: Is training provided to county staff responsible for managing the CPP process? If so, what types of training?

Results

Statewide: During the planning process for the FY 12/13 Annual Update, 61% of respondents indicated that their counties encouraged or provided training to staff responsible for or involved in their CPP processes; 81% of respondents indicated that the county had provided or encouraged training in the past. Data regarding the types of trainings provided to county staff was not available.

CMHDA Region: At least 50% of all counties in each CMHDA Region reported that their counties encouraged or provided training to staff responsible for managing their CPP processes during the FY 12/13 Annual Update; whereas at least 69% of all counties in each CMHDA Region reported that the county had encouraged or provided such trainings in the past.

County Size: At least 48% of all counties in each county size category reported that their counties encouraged or provided training to staff responsible for managing the CPP process during the FY 12/13 Annual Update; whereas, at least 70% of all counties in each county size category reported that their counties encouraged or provided such trainings in the past. Both large and medium counties reported higher rates of training to staff compared with small counties.

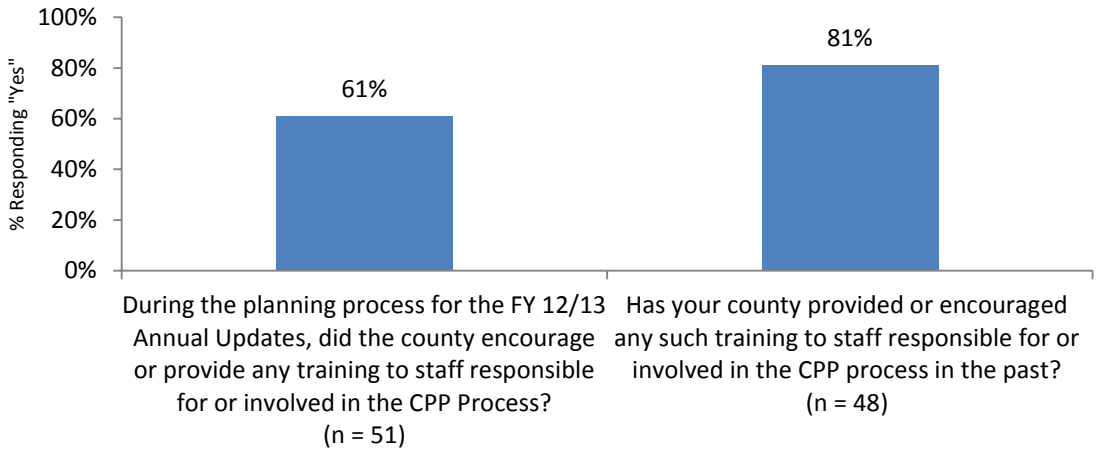
Statewide

Rationale: At the statewide level, 61% of counties (*n* = 51) indicated that their counties had encouraged or provided training to staff during their planning processes for the FY 12/13 Annual Update and 81% of

counties (*n* = 48) indicated that their counties had encouraged or provided some sort of training in the past (see

Figure 3). Data regarding the types of trainings provided to county staff was not available.

Figure 3: Training Provided to County Staff Responsible for Managing CPP Process, Statewide ϕ

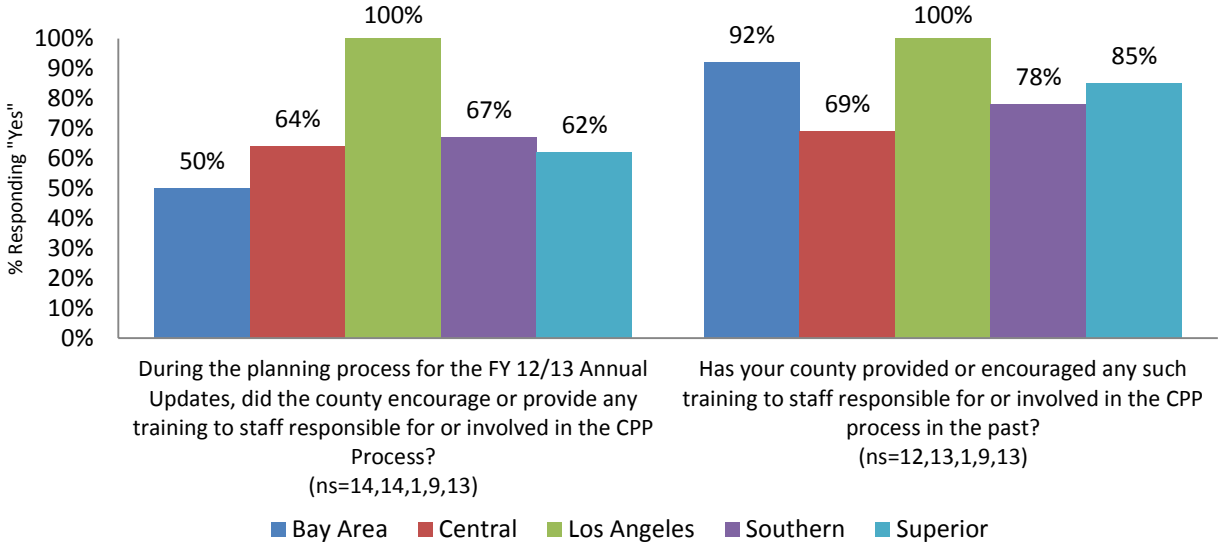


ϕ*SOURCE:* County Web-Based Data Request

CMHDA Region

Rationale: As shown in, the Los Angeles region (100%, *n* = 1) reported the greatest percentage of encouraging or providing training to staff responsible for or involved in their CPP processes during the planning for their Annual Updates, followed by the Southern region (67%, *n* = 9), the Central region (64%, *n* = 14), the Superior region (62%, *n* = 13), and the Bay Area region (50%, *n* = 14).

Figure 4: Training Provided to County Staff Responsible for Managing CPP Process, by CMHDA Region ϕ



ϕ*SOURCE:* County Web-Based Data Request

Comparatively, also shown in

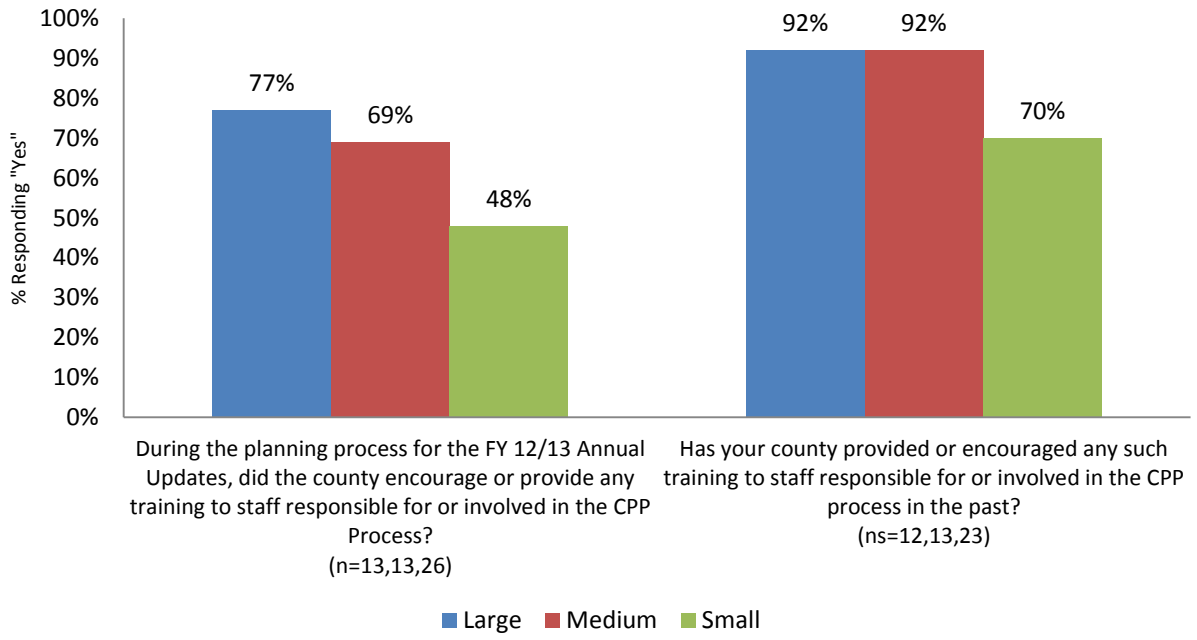
Figure 4, the Los Angeles region (100%, *n* = 1) reported the greatest percentage of counties encouraging or providing training to staff responsible for or involved in their CPP processes in the past, followed by the Bay Area region (92%, *n* = 12), the Superior region (85%, *n* =13), the Southern region (78%, *n* = 9), and the Central region (69%, *n* = 13).

County Size

Rationale: Generally speaking, as shown in

Figure 5, 77% of large counties (*n* = 13) reported that their counties encouraged or provided training to staff managing the CPP process during their planning processes for their FY 12/13 Annual Updates, compared with 69% of medium counties (*n* =13) and 48% of small counties (*n* = 26).

Figure 5: Staff Training Encouraged or Provided During the FY 12/13 Annual Update, by County Size ϕ



ϕ*SOURCE:* County Web-Based Data Request

Comparatively, also shown in

Figure 5, 92% of both large and medium counties (*n* = 12 and *n* =13, respectively) reported that their counties encouraged or provided training to staff managing their CPP processes in the past, compared with 70% of small counties (*n* = 23).

Activities – Outreach

This section first discusses the activities used by counties to outreach to and engage stakeholders overall, specifically those activities that aim to solicit feedback from participants and activities that intend to reduce barriers to attending CPP activities. Then, this section discusses the activities used by counties to outreach to consumers diagnosed with serious mental illness (SMI) and/or serious emotional disturbance (SED) and their family members, and if so how. Finally, this section discusses the activities used by counties to outreach to unserved and underserved populations.

AC-01A: What activities are used by the county to outreach to and engage stakeholders? (Describes the activities and getting people to want to attend or give input.)

Results

Statewide: At the statewide level, counties reported that in order to inform stakeholders about CPP activities they most frequently used: 1) announcements at meetings, 2) emails to listservs, 3) flyers/brochures posted, and 4) phone calls/invites by mental health department staff. Furthermore, to encourage participation from specific populations such as ethnic minority groups, counties discussed partnering with cultural brokers and ethnic community-based organizations/agencies in order to build trust and rapport in the communities over time. Counties found these strategies to be more effective than having county staff come into communities for discrete CPP activities.

Overall, counties perceived these CPP outreach activities to be highly successful, with stakeholders largely supporting this result. Stakeholders reported that they primarily found out about CPP activities through announcements at meetings, email, flyers/posters/brochures, and referrals from the Mental Health department. However, word of mouth emerged as an additional method during the stakeholder focus group. At the statewide level, stakeholders reported they found out about CPP activities primarily through a family member, friend, a mental health or human services provider (e.g. psychiatrist, case manager), or a connection in the community.

However, according to data collected from the Annual Update Document Review, the majority of counties reported using radio/TV/news announcements (47%, n = 49) as one of their key outreach activities. In contrast, data collected from the County Web-Based Data Request indicated that radio/TV announcements were the least used CPP outreach activity; stakeholders supported this result, reporting they were least likely to find out about CPP activities through radio/TV announcements.

Stakeholders reported the most common incentive that counties provided to encourage participation at CPP activities was providing meals at meetings; the least common activity was childcare services.

CMHDA Region: No significant differences were noted when analyzed by CMHDA Regions.

County Size: No significant differences were noted when analyzed by county size.

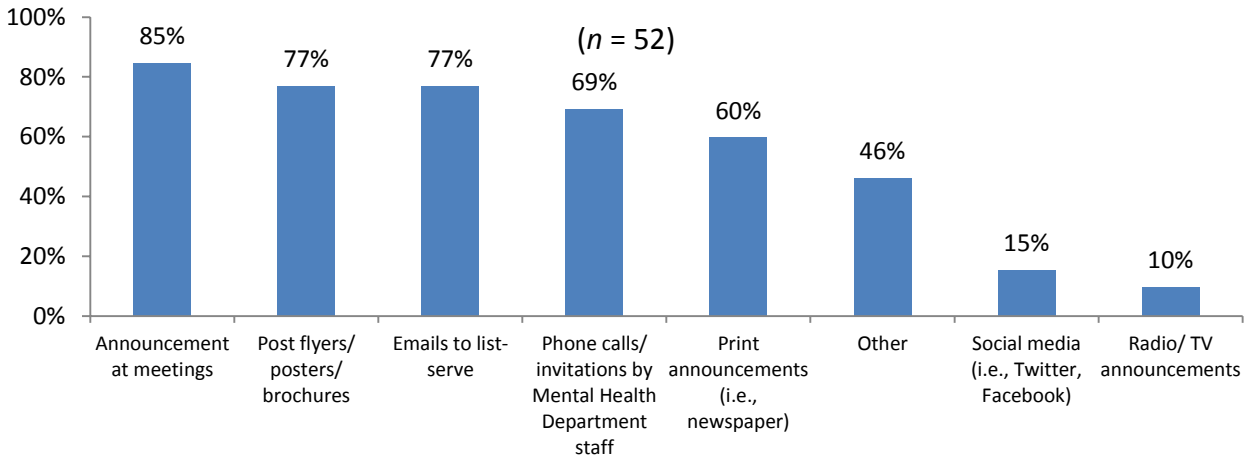
Statewide

Rationale: In order to understand what counties do to collect input from participants, the evaluation team analyzed statewide data from the County Web-Based Data Request, Annual Update Document Review, County Key Informant Interviews, Stakeholder Focus Groups, and Stakeholder Surveys.

Counties were asked to identify those outreach activities used to encourage stakeholder participation in CPP activities, and to rate how successful those outreach activities were in meeting MHSA goals. Counties reported that the most popular CPP outreach activities were announcements at meetings (85%), emails to listservs (77%), posted flyers/brochures (77%), and phone calls/invitations by mental health department staff *(*69%). Social media (15%) and radio/TV announcements (10%) were the least cited CPP outreach activities (see

Figure 6).

Figure 6: Outreach Activities Conducted for the 2012/13 Annual Update, Statewide ϕ

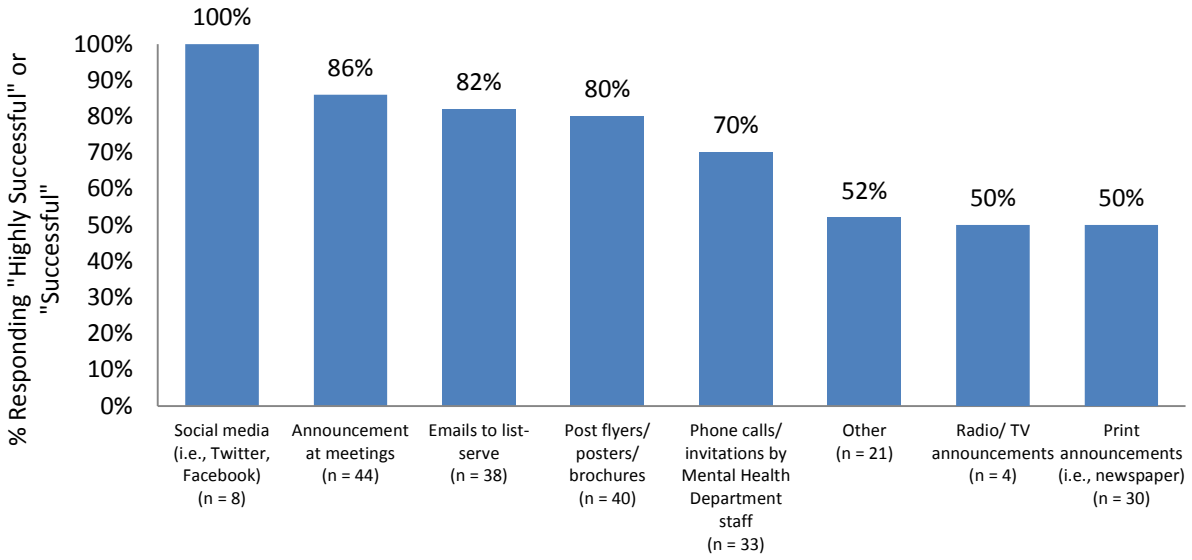


ϕ *SOURCE:* County Web-Based Data Request

Counties were asked to indicate the perceived success rate of each outreach activity, as shown in

Figure 7. While social media was the least popular outreach activity, all eight respondents who listed social media regarded it as a highly successful outreach activity. Overall, county informants' perceptions of the success rate for each outreach activity corresponded with the most frequently used outreach activity. In other words, county informants perceived announcements at meetings, emails to listservs, flyers/brochures, and phone calls by mental health department staff to be highly successful ways to inform stakeholders for participation in CPP activities.

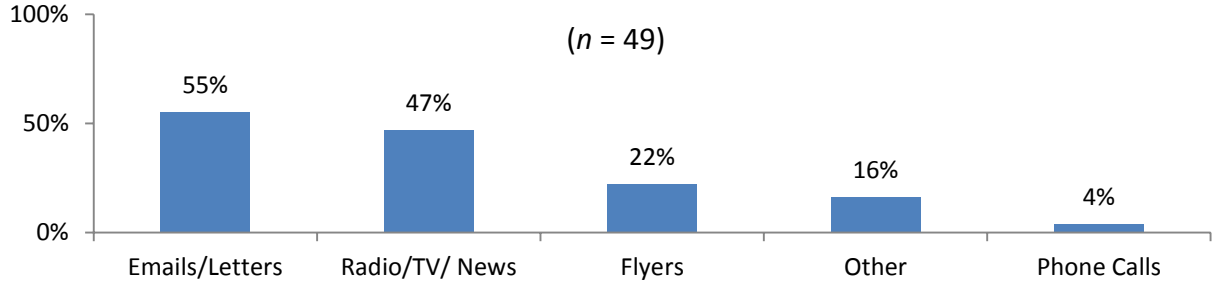
Figure 7: Perceived Success of Outreach Activity, Statewide [ϕ]



[ϕ] *SOURCE*: County Web-Based Data Request

However, data from the Annual Update Document Review revealed that counties reported engaging in different outreach activities than were reported in the County Web-Based Data Request, as shown in Figure 8. Just over half of counties (55%, *n* = 49) reported using emails/letters to inform stakeholders of CPP activities Additionally, radio/TV/news announcements were the second most popular CPP outreach activity used by counties (47%, *n = 49*), while phone calls by mental health department staff were the least frequently used CPP outreach activity (4%, *n* = 49). Other outreach activities included public announcements, notices in newsletters, county websites, and podcasts as well as face-to-face outreach.

Figure 8: Outreach Activities Conducted in FY 2012-2013, Statewide [μ]



[μ]*SOURCE:* Annual Update Document Review

Similarly, stakeholders were asked to identify how they found out about CPP activities (see Table 3) and their responses mirrored those provided by counties. That is, at the statewide level, stakeholders learned about CPP activities most commonly through: 1) email (78%, *n* = 590), 2) flyers (49%, *n* = 590), and 3) referral from a mental health department staff (38%, *n* = 590). A personal referral through a friend or family (13%, *n* = 590) and radio/TV announcements (3%, *n* = 590) were the two least common ways that stakeholders reported hearing about CPP activities.

Table 3: Methods by which Stakeholders Received Information about MHSA CPP, Statewide [δ]

	Most Common	2nd	3rd	4th	5th	Least Common
Statewide (n=590)	Email 78%	Flyers 49%	Referral from Mental Health Dept. 38%	Phone 17%	Referral from Friend/Family 13%	Radio/TV 3%

[δ] *SOURCE*: Stakeholder Survey

Stakeholders were also asked to indicate the type of incentives that counties provided in order to encourage stakeholder participation, as shown in

Table 4. Stakeholders reported the most common incentive as providing meals at meetings (39%, *n* = 585), while the least common incentive was childcare (4%; *n* = 585).

Table 4: Types of Activities Used to Engage Participants in Meetings, Statewide [δ]

	Most Common	2nd	3rd	4th	5th	Least Common
Statewide (n=585)	Meals at meetings 39%	Don't know 23%	Multiple meetings times 23%	Translation/ Interpretation 22%	Transportation to meetings 21%	Childcare 4%

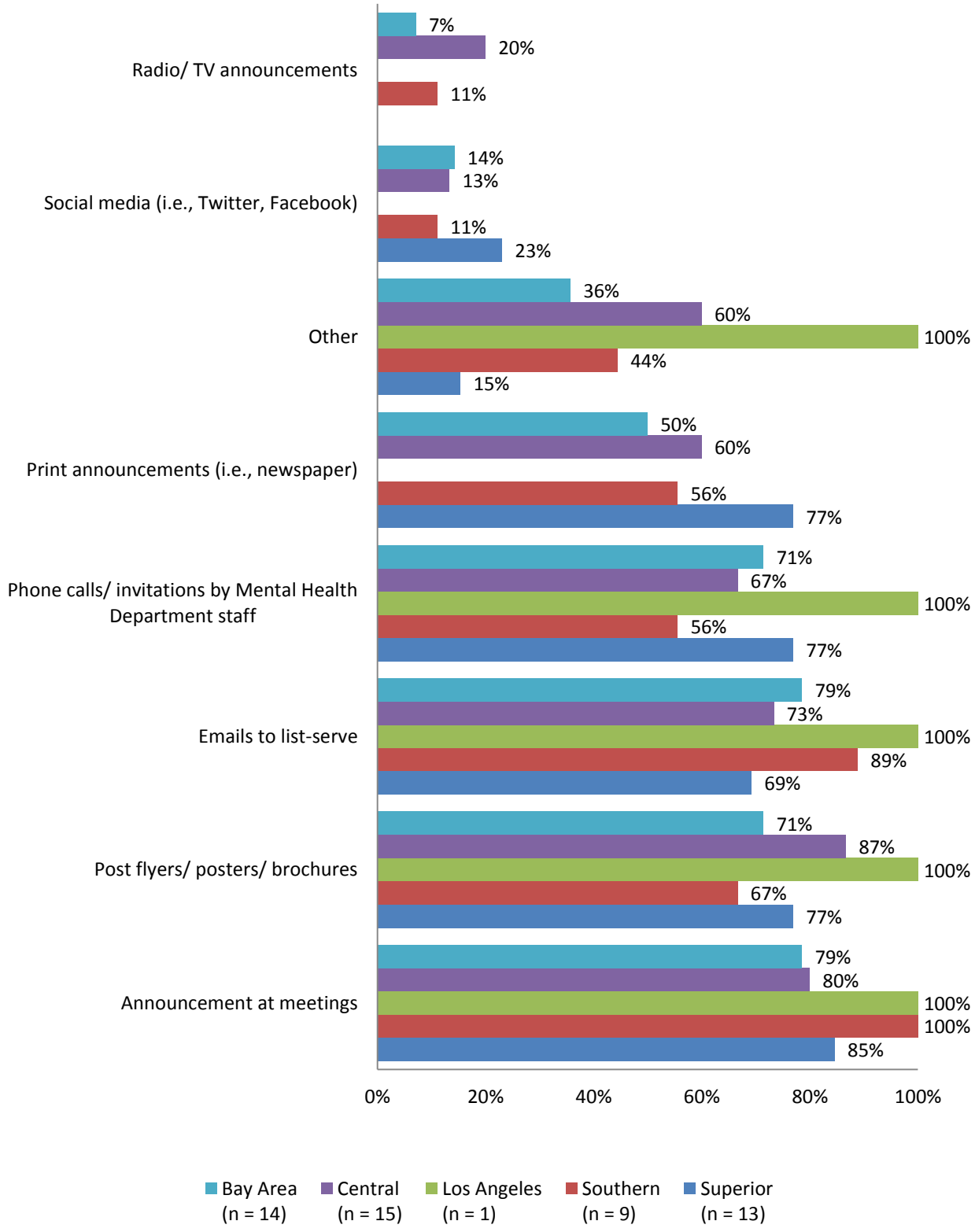
[δ] *SOURCE*: Stakeholder Survey

CMHDA Region

Rationale: For outreach activities during the 2012/13 Annual Update, all CMHDA Regions most commonly used: 1) announcements at meetings, 2) emails to listservs, 3) flyers/posters/brochures, and 4) phone call/invite by the mental health department. However, a significant proportion of the Central, Southern, and Superior regions also cited using print media (e.g., newspaper), while social media and radio/TV announcements were the least commonly used outreach activities across all CMHDA Regions (see

Figure 9).

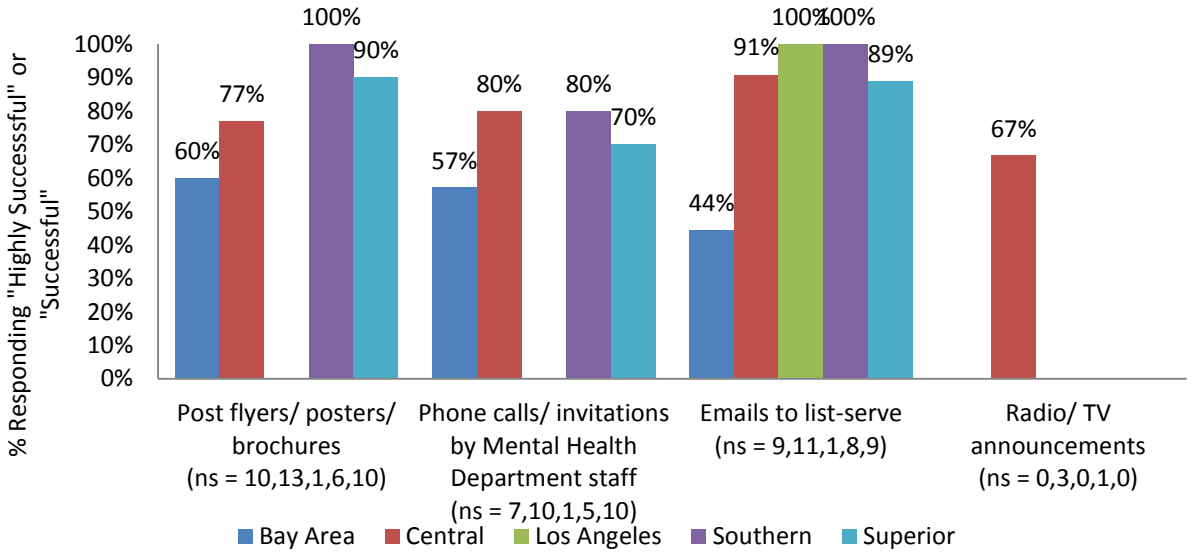
Figure 9: Outreach Activities Conducted for the 2012/13 Annual Update, by CMHDA Region ϕ



ϕ *SOURCE*: County Web-Based Data Request

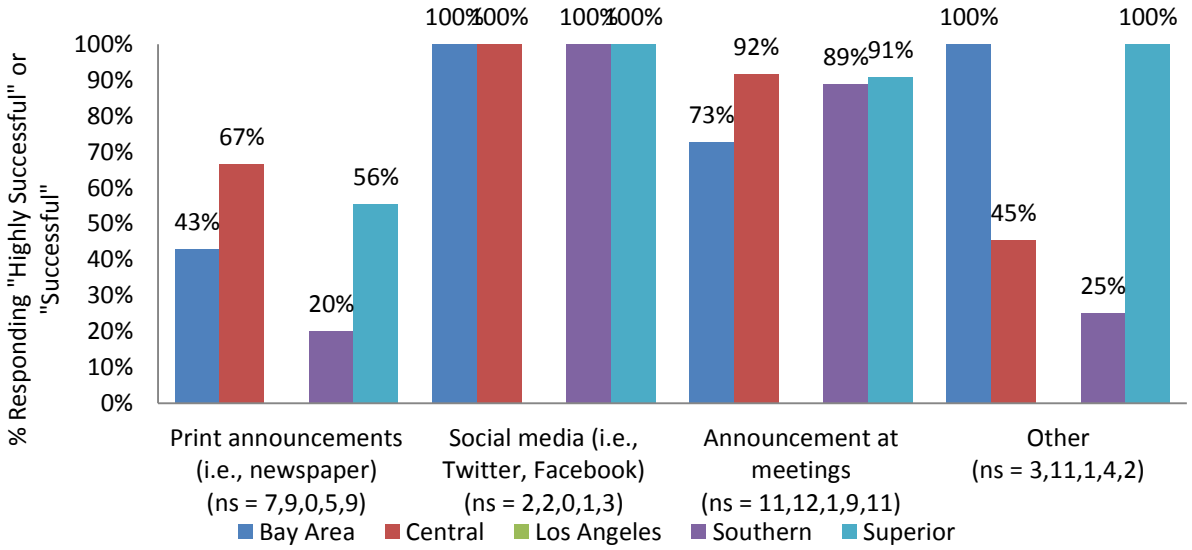
When asked to rate how successful they perceived the various outreach activities, all CMHDA Regions reported emails to listservs and announcements at meetings to be successful or highly successful, as shown in Figure 10 and Figure 11. However, the Bay Area region was the exception; 44% of respondents regarded emails to listservs as successful. Finally, despite low usage, all respondents indicated social media to be highly successful. This indicates that while social media is not a popular outreach activity, when it *is* used, counties find it to be highly successful in publicizing events.

Figure 10: Perceived Success of Outreach Activity, by CMHDA Region (1 of 2) ϕ



ϕ *SOURCE:* County Web-Based Data Request

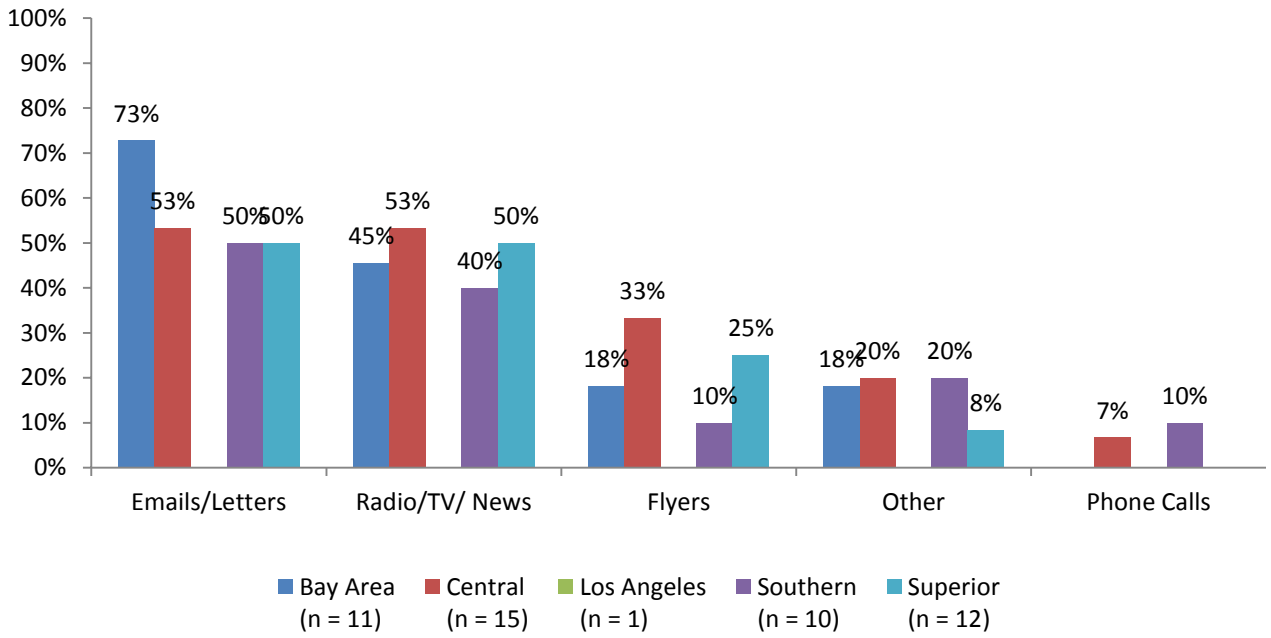
Figure 11: Perceived Success of Outreach Activity, by CMHDA Region (2 of 2) ϕ



ϕ *SOURCE:* County Web-Based Data Request

According to the Annual Update Document Review, counties reported the primary outreach activities in FY 2012-2013 were email/letter invites and radio/TV/news announcements (see Figure 12). Compared to other CMHDA Regions, a significant portion of the Bay Area region reported using email/letters (73%; *n* = 11), while all regions used phone calls less frequently. These findings contradict results from the County Web-Based Data Request, which showed announcements at meetings, emails to listservs, flyers/posters/brochures, and phone calls/invitations by the mental health department to be the most frequent types of outreach activity. However, there is one exception. The Annual Update Document Review demonstrated that counties from the Central region uses flyers/posters/brochures more frequently than other regions (33%, *n = 15*) and data from the County Web-Based Data Request supports this result. Relative to other CMHDA Regions, the Central region reported flyers/posters/brochures as the most popular outreach activity (see Figure 12).

Figure 12: Outreach Activities County Informants Conducted in FY 2012-2013, by CMHDA Region [µ]



[µ] *SOURCE:* Annual Update Document Review

Across CMHDA Regions, data from the Stakeholder Survey largely reflected data from County Web-Based Data Request. That is, stakeholders reported that the most common methods by which they found out about CPP activities were through emails, flyers/posters, and referrals from Mental Health Department staff. The least common CPP outreach activity was radio/TV announcements. Central region stakeholders differed and instead cited newspaper ads (17%; *n* = 132) as the fourth most common CPP outreach activity, whereas the other four CMHDA Regions cited phone calls as the fourth most common CPP outreach activity (see Table 5).

Table 5: Methods by which Stakeholders Received Information about CPP Activities, by CMHDA Region [δ]

	Most Common	2nd	3rd	4th	5th	Least Common
Statewide (n=590)	Email 78%	Flyers 49%	Referral from Mental Health Dept. 38%	Phone 17%	Referral from Friend/Family 13%	Radio/TV 3%
Bay Area (n=111)	Email 83%	Flyers 43%	Referral from Mental Health Dept. 31%	Phone 20%	Referral from Friend/Family 16%	Radio/TV 1%
Central (n=132)	Email 73%	Referral from Mental Health Dept. 46%	Flyers 42%	Newspaper 17%	Referral from Friend/Family 14%	Radio/TV 0%
Los Angeles (n=34)	Emails 62%	Flyers 59%	Referral from Mental Health Dept. 29%	Referral from Other Service 18%	Phone 15%	Newspaper, Radio/TV & Social Media 0%
Southern (n=185)	Emails 85%	Flyers 52%	Referral from Mental Health Dept. 38%	Phone 14%	Referral from Other Service 12%	Social Media 4%
Superior (n=128)	Email 70%	Flyers 52%	Referral from Mental Health Dept. 38%	Phone 21%	Referral from Friend/Family 16%	Radio/TV 2%

[δ] *SOURCE:* Stakeholder Survey

Counties primarily relied on providing meals at CPP meetings to encourage stakeholder participation (see

Table 6). Counties in the Central region differed; Central region stakeholders (31%, *n* = 132) cited holding multiple meetings at various times as the primary method for increasing stakeholder participation. In varying frequencies CMHDA Regions also commonly provided incentives such as translation/interpretation services, multiple meetings at different times, and transportation to meetings. Counties across CMHDA Regions least commonly cited providing childcare services to engage stakeholders in CPP activities.

Table 6: Types of Incentives Offered to Participants, by CMHDA Region [δ]

	Most Common	2nd	3rd	4th	5th	Least Common
Statewide (n=585)	Meals at meetings 39%	Don't know 23%	Multiple meeting times 23%	Translation/ Interpretation 22%	Transportation to meetings 21%	Childcare 4%
Bay Area (n=111)	Meals at meetings 40%	Stipend/ Financial 30%	Don't know 26%	Multiple meeting times 25%	Transportation to meetings 20%	Childcare 5%
Central (n=132)	Multiple meeting times 31%	Meals at meetings 28%	Translation/ Interpretation 27%	Transportation to meetings 24%	Stipend/ Financial 23%	Childcare 5%
Los Angeles (n=34)	Meals at meetings 53%	Translation/ Interpretation 35%	Stipend/ Financial 24%	Transportation vouchers 21%	Transportation to meetings 18%	Childcare, Continuing Edu. Credits, & None 9%
Southern (n=185)	Meals at meetings 35%	Don't know 30%	Translation/ Interpretation 28%	Multiple meeting times 21%	Transportation to meetings 17%	Childcare 3%
Superior (n=128)	Meals at meetings 50%	Transportation to meetings 27%	Don't know 19%	Multiple meeting times 17%	Stipend/ Financial 17%	Childcare 5%

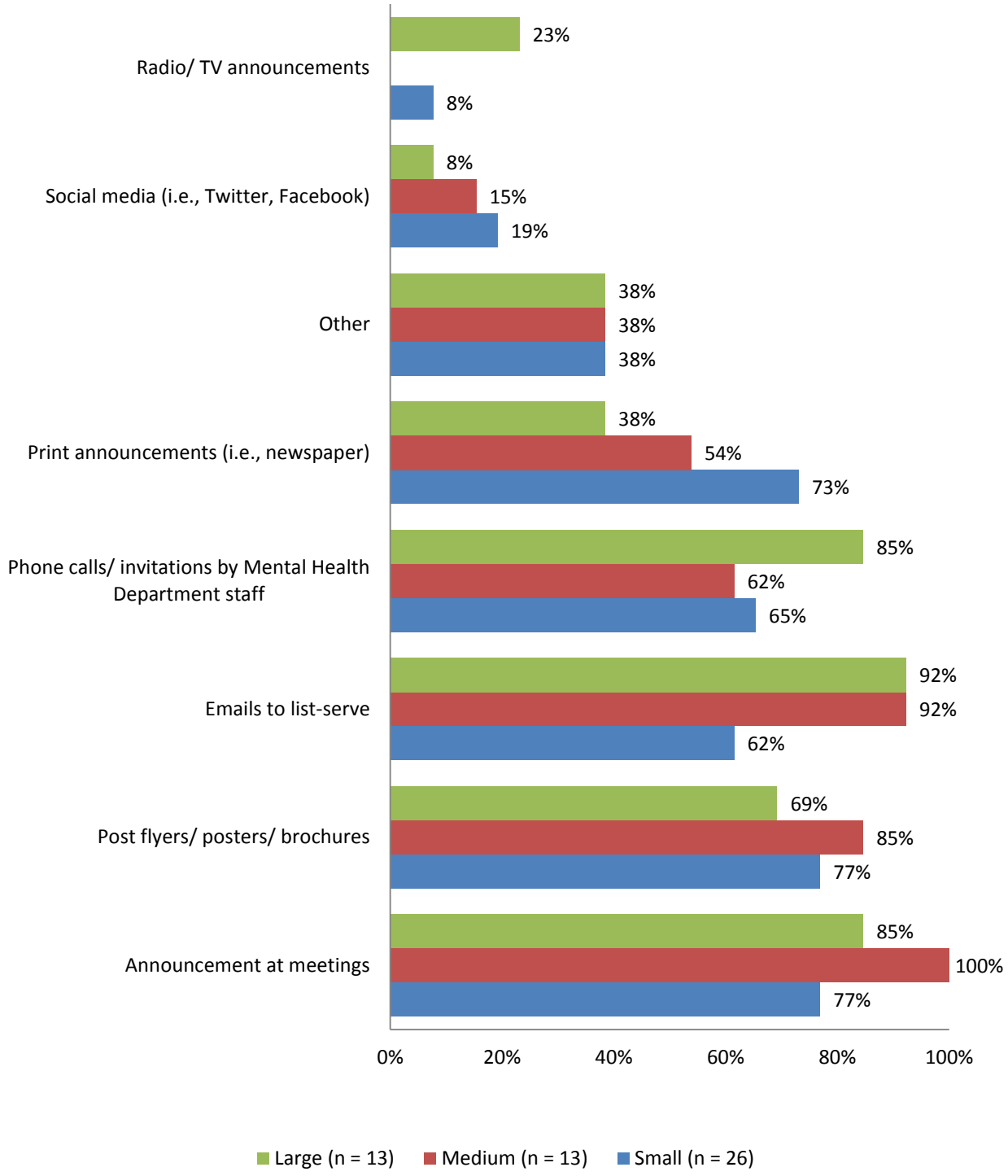
[δ] *SOURCE:* Stakeholder Survey

County Size

Rationale: Counties used the following outreach activities to inform stakeholders of CPP activities: 1) announcements at meetings, 2) flyers/posters/brochures, 3) emails to listservs, and 4) phone calls/invitations by the Mental Health Department staff. Additionally, small counties used print media (73%, *n* = 26) significantly more than medium (54%, *n* = 13) and large counties (38%, *n* = 13), respectively, while simultaneously rely less on email to listservs (62%, *n* = 26) in comparison to medium and large counties (92%, *n* = 13 for both). Social media and radio/TV announcements were least used across the

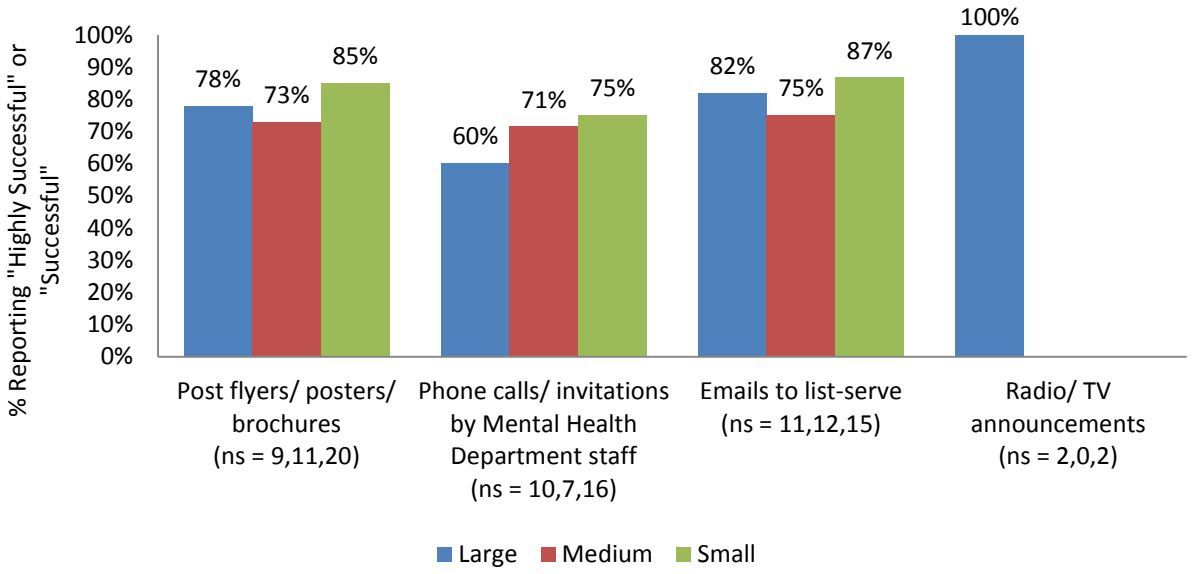
county size categories. Overall, counties perceived all of the outreach activities to be highly successful with the exception of print announcements (e.g., newspaper ads) (see Figure 14 and Figure 15).

Figure 13: Percent of County Informants who Indicated the Types of Outreach Activities Used to Engage Stakeholder Participation, by CMHDA Region ϕ



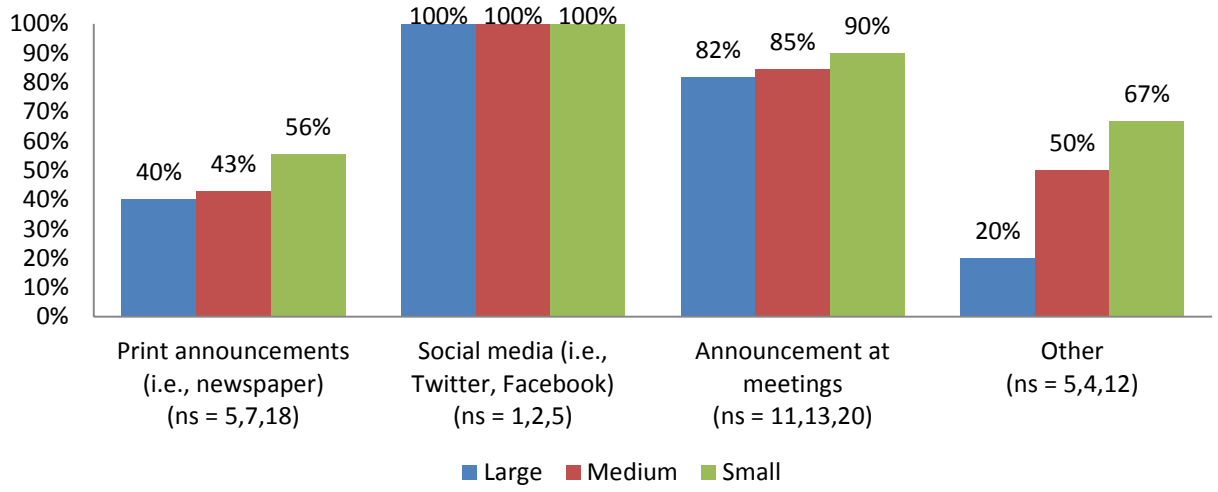
ϕ *SOURCE*: County Web-Based Data Request

Figure 14: Percent of County Informants Indicating Outreach Activity was Successful, by County Size ϕ



ϕ *SOURCE*: County Web-Based Data Request

Figure 15: Percent of County Informants Indicating Outreach Activity was Successful, by County Size ϕ

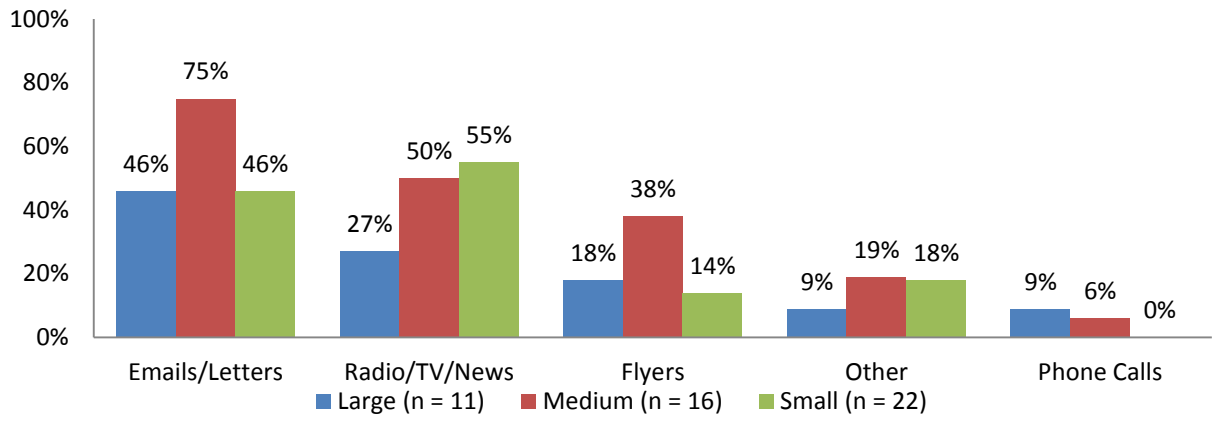


ϕ *SOURCE:* County Web-Based Data Request

According to the Annual Update Document Review, counties' primary CPP outreach activities for FY 2012-2013 were: 1) email/letter invites, 2) radio/TV/news announcements, and 3) flyers (see Figure 16). Across county size categories, county informants cited email/letter invites as the primary CPP outreach activity. Relative to large and small counties, email/letter invites and flyers were particularly popular outreach activities in medium counties. These findings are not consistent with County Web-Based Data, which illustrates county informants were least likely to use radio/TV announcements (see

Figure 13).

Figure 16: Outreach Activities County Informants Conducted in FY 2012-2013, by County Size [μ]



[μ] *SOURCE:* Annual Update Document Review

There were no significant differences across county size categories regarding the methods by which stakeholders received information about MHSA CPP activities (see

Table 7). The most common outreach activities were: 1) emails, 2) flyers, and 3) referrals from Mental Health Department staff. However, data indicates that stakeholders in medium (2%, *n* = 153) and small counties (*n* = 181) were least likely to find out about CPP activities through radio/TV, while stakeholders in large counties reported they were least likely to find out about CPP activities through newspapers and social media (4%, *n* = 256).

Table 7: Methods by which Stakeholders Received Information about MHSA CPP, by County Size δ

	Most Common	2nd	3rd	4th	5th	Least Common
Statewide (n=590)	Email 78%	Flyers 49%	Referral from Mental Health Dept. 38%	Phone 17%	Referral from Friend/Family 13%	Radio/TV 3%
Small Counties (n=181)	Email 67%	Flyers 50%	Referral from Mental Health Dept. 43%	Phone 22%	Newspaper 17%	Radio/TV 2%
Medium Counties (n=153)	Email 84%	Flyers 42%	Referral from Mental Health Dept. 35%	Phone 14%	Referral from Friend/Family 12%	Radio/TV 2%

Large Counties (n=256)	Emails 81%	Flyers 51%	Referral from Mental Health Dept. 37%	Phone 14%	Referral from Other Service 13%	Newspaper & Social Media 4%

[δ] *SOURCE:* Stakeholder Survey

Across county size categories, counties were most likely to provide meals at meetings to encourage stakeholder participation in the CPP process. Childcare was the least common activity in large (4%, *n* = 252) and small counties (4%, *n* = 181), while medium counties were least likely to offer continuing education credits to engage stakeholders in their CPP activities (6%, *n* = 152) (see

Table 8).

Table 8: Types of Activities Counties Used to Engage Stakeholder Participation in Meetings [δ]

	Most Common	2nd	3rd	4th	5th	Least Common
Statewide (n=585)	Meals at meetings 39%	Don't know 23%	Multiple meeting times 23%	Translation/ Interpretation 22%	Transportation to meetings 21%	Childcare 4%
Small Counties (n=181)	Meals at meetings 46%	Transportation to meetings 27%	Stipend/ Financial 20%	Multiple meeting times 20%	Don't know 18%	Childcare 5%
Medium Counties (n=152)	Meals at meetings 34%	Multiple meeting times 31%	Don't know 24%	Transportation to meetings 21%	Stipend/ Financial 14%	Continuing Education Credits 6%
Large Counties (n=252)	Meals at meetings 36%	Translation/ Interpretation 27%	Don't know 25%	Stipend/ Financial 24%	Don't know 19%	Childcare 3%

[δ] *SOURCE:* Stakeholder Surveys

AC-01B: What activities are used by the county to outreach to and engage stakeholders? (Activities to reduce the barriers to attendance by participants)

Results

Statewide: Counties reported the most popular activity used by counties to engage stakeholders in CPP activities was the provision of meals at meetings (69%); stakeholders supported this finding. Counties also used translation services, transportation to meetings, and multiple meetings at different times and locations as key activities to encourage stakeholder participation. Childcare (6%) and continuing education credits (2%) were the least common activities.

CMHDA Region: Across CMHDA Regions, providing meals at meetings was the primary incentive that counties offered to encourage stakeholder participation. Translation service was another key incentive, particularly for the Los Angeles and Southern regions. Central region counties identified holding multiple meetings at different times and locations as a common incentive. Central and Superior regions offered transportation services as a key incentive.

County Size: From the county perspective, the common activities that counties offered to encourage stakeholder participation differed across county size categories. For large counties, providing translation services and meetings in languages other than English were key incentives to engaging stakeholders. Medium counties reported providing meals and translation services at meetings to be popular activities. In addition to offering meals at meetings, small counties cited transportation to meetings as a key incentive. Stakeholder responses differed slightly across size categories by citing meal at meetings as the most frequently cited incentive instead. Similar to county informant data, stakeholders identified translation services as a key incentive in large counties (27%), while stakeholders in medium counties identified holding multiple meeting times as a key incentive (31%), and transportation to meetings was important to stakeholders in small counties (27%).

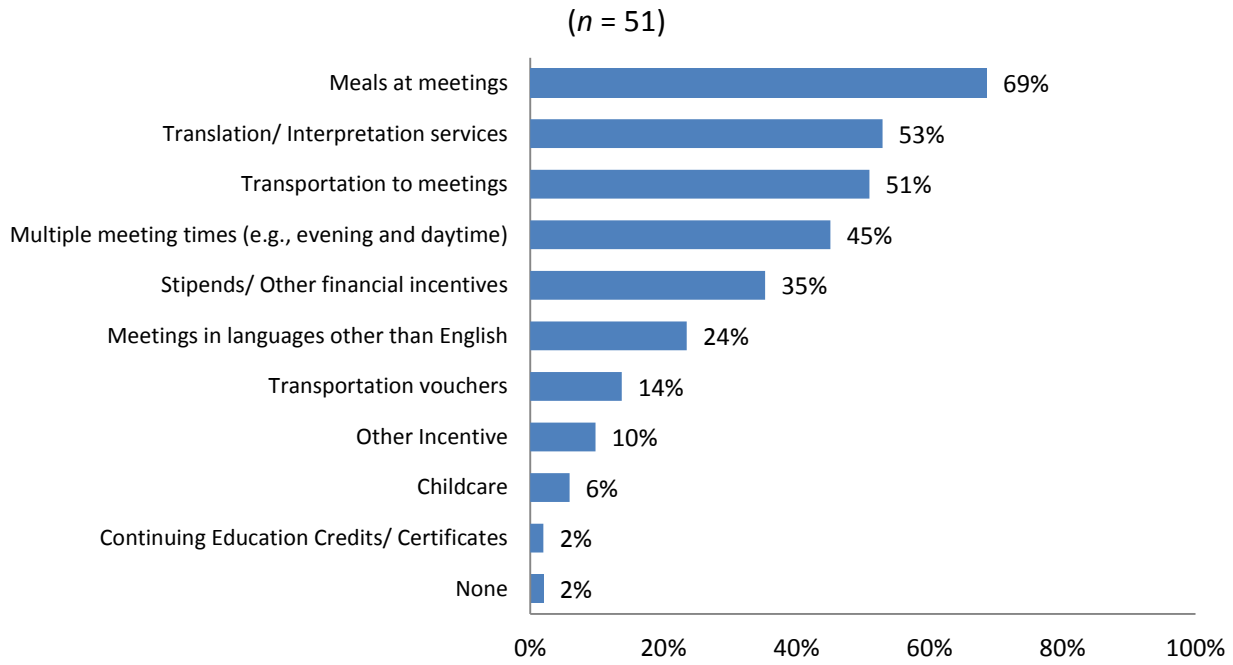
Statewide

Rationale: In order to understand what counties do to collect input from participants, the evaluation team analyzed statewide data from County Web-Based Data Requests, Annual Update Document Review, Stakeholder Focus Groups, and Stakeholder Surveys.

The majority of counties offer the following incentives to encourage stakeholders to participate in CPP activities (listed in order of decreasing popularity): 1) meals at meetings (69%), 2) translation/interpretation services (53%), 3) transportation to meetings (51%), and 4) multiple meeting times (45%). Childcare (6%) and continuing education credits (2%) were least likely to be offered to stakeholders (see Figure 17,

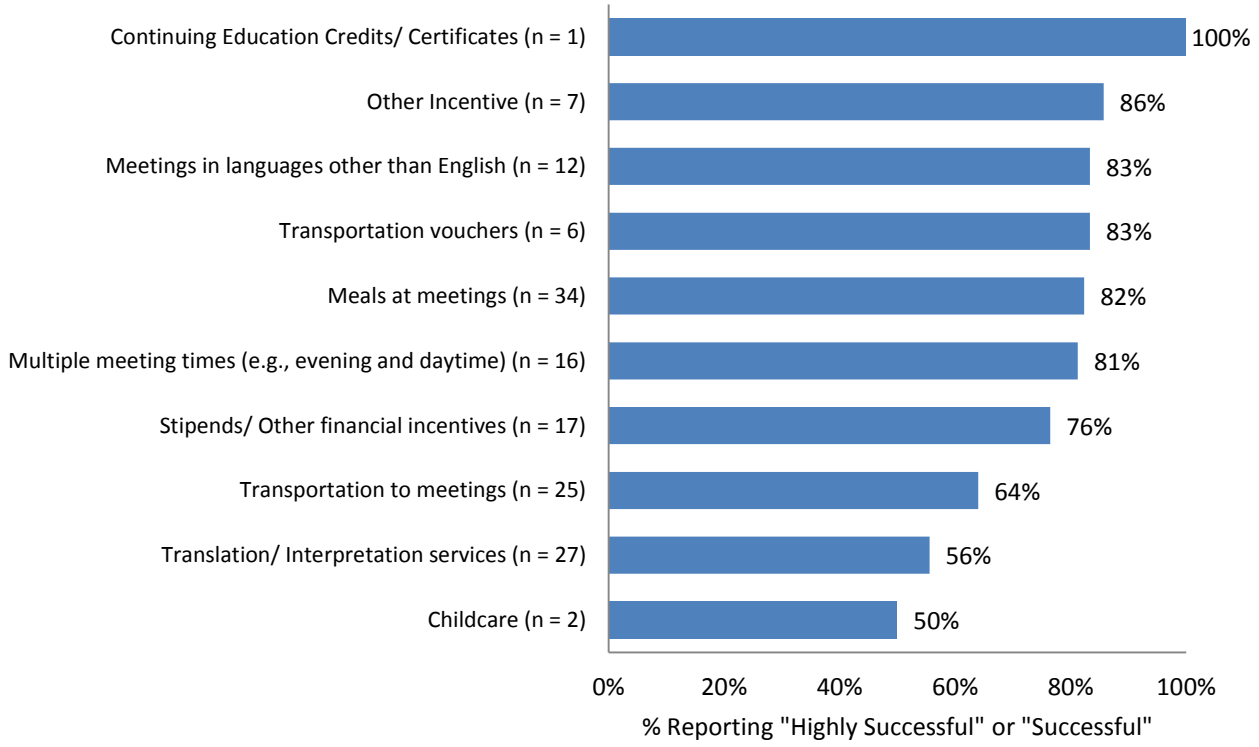
Figure 18).

Figure 17: Percentage of County Informants Indicating which Incentives were Offered to CPP Participants, Statewide [Φ]



ϕ *SOURCE:* County Web-Based Data Request

Figure 18: Perceived Success of Incentive in Encouraging Stakeholder Participation, Statewide ϕ



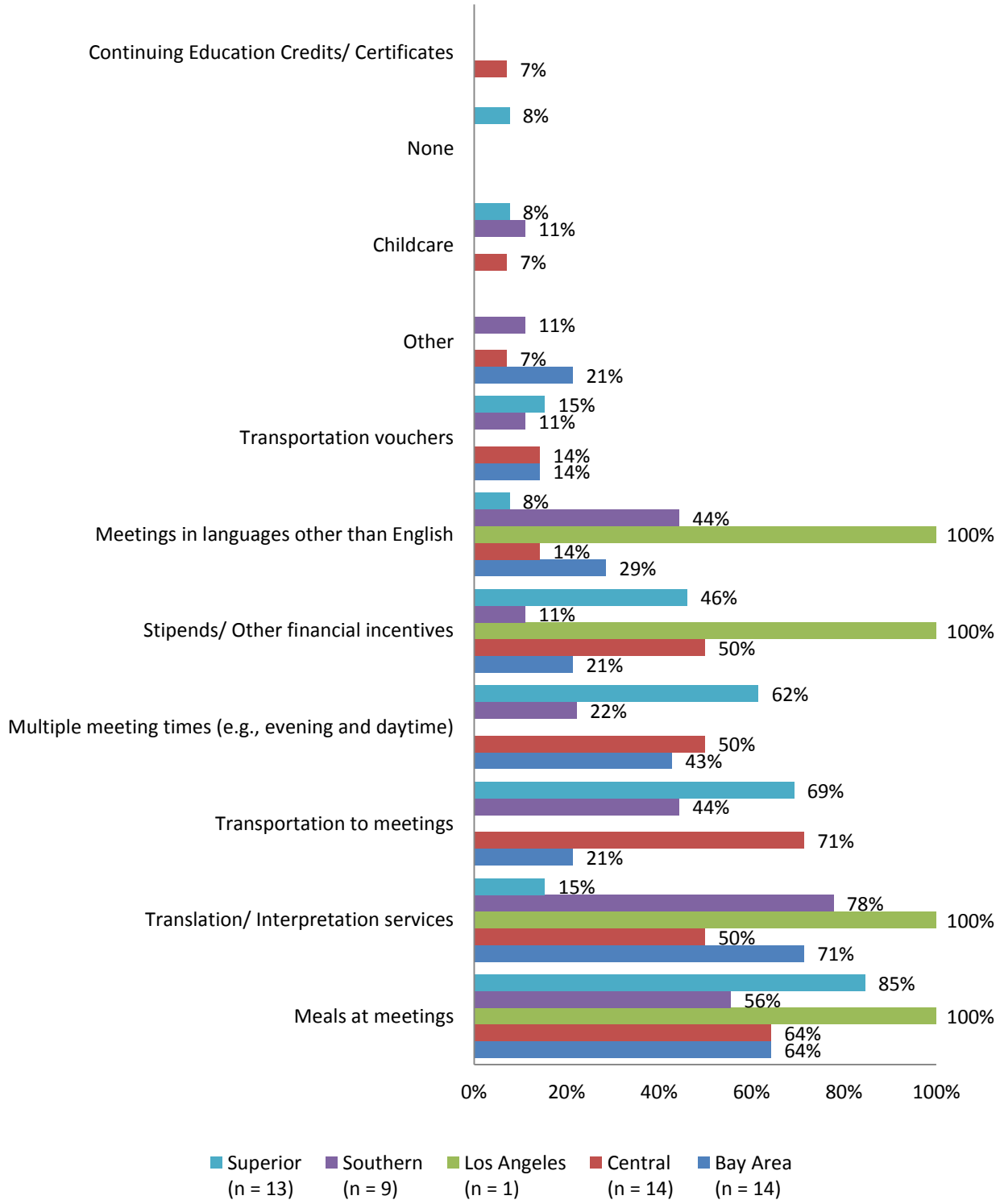
ϕ *SOURCE:* County Web-Based Data Request

CMHDA Region

Rationale: Across all CMHDA Regions, the provision of meals at meetings was one of the top incentives that counties offered to encourage stakeholder participation in CPP activities. Translation/interpretation service was the second most common incentive, with the exception of Superior region (15%). For the Central and Superior regions, transportation to meetings was a key incentive counties offered (Central =71%, Superior = 69%). Childcare services and continuing education credits were the least likely CPP incentives to be offered (see

Figure 19).

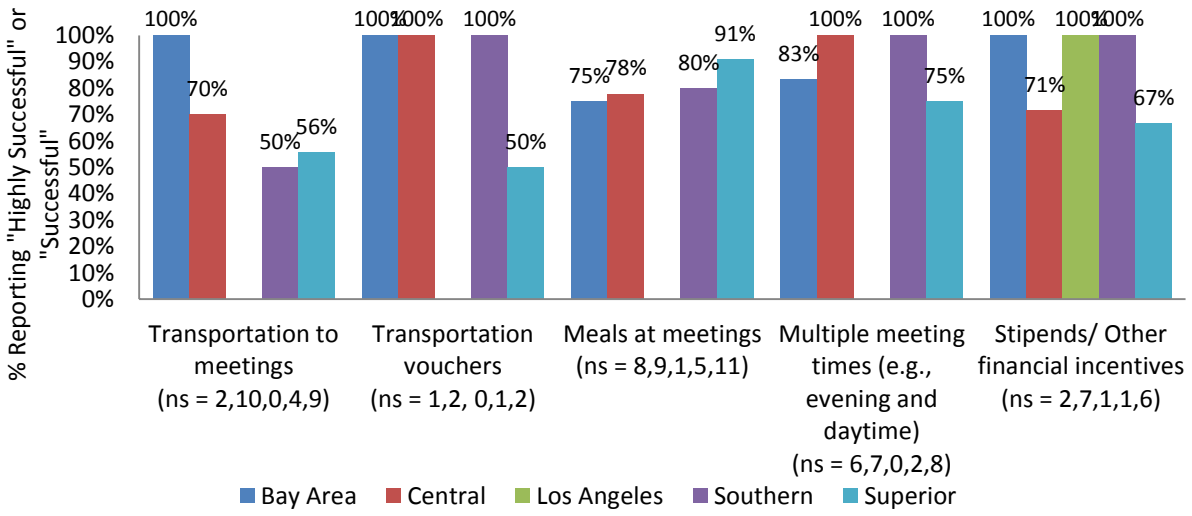
Figure 19: Percentage of County Informants Indicating which Incentives were Offered to CPP Participants, by CMHDA Region ϕ



ϕ *SOURCE:* County Web-Based Data Request

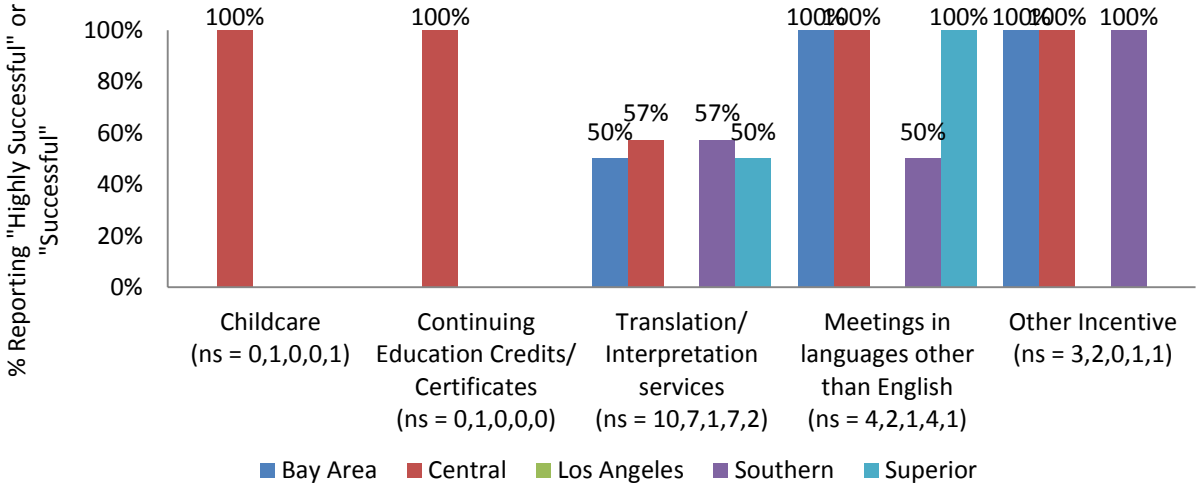
MHSA/CPP Coordinators were also asked to rate how successful they feel each of the incentives to be in encouraging stakeholders to participate in the CPP process. MHSA/CPP Coordinators reported less success with translation services relative to the other incentives offered to stakeholders (see Figure 21). Providing transportation to meetings was viewed as most successful in the Bay Area region (100%), while the Central, Southern, and Superior regions reported considerably less success (70%, 50%, 56%, respectively). The Los Angeles region found financial incentives to be a highly successful method for engaging stakeholder participation. Finally, the Central Region appeared to be the only region that found offering childcare and continuing education credits as a highly successful incentive.

Figure 20: Perceived Success of Incentive in Encouraging Stakeholder Participation, by CMHDA Region (1 of 2) ϕ



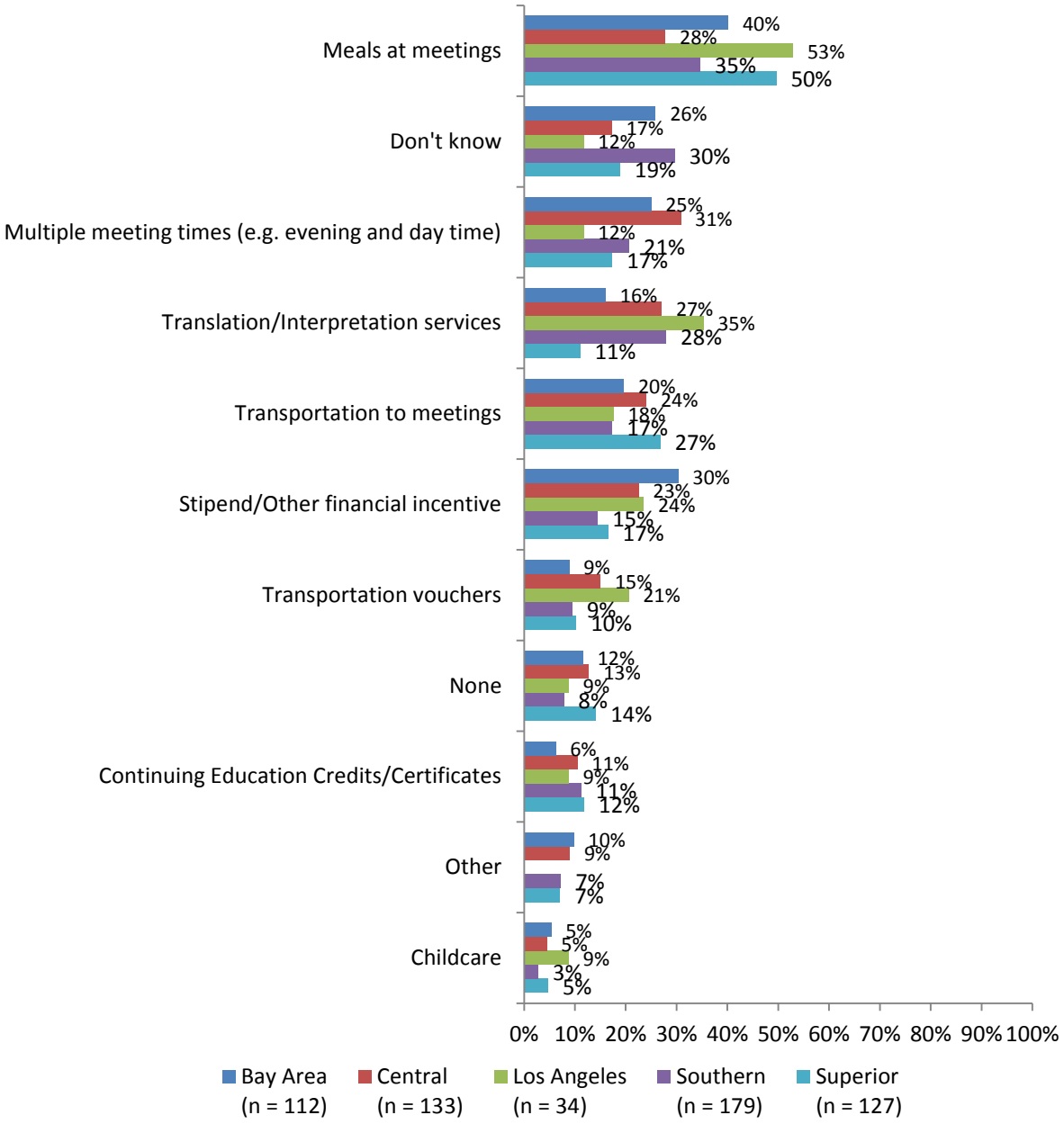
ϕ *SOURCE:* County Web-Based Data Request

Figure 21: Perceived Success of Incentive in Encouraging Stakeholder Participation, by CMHDA Region (2 of 2) ϕ



ϕ *SOURCE:* County Web-Based Data Request

Figure 22: Percent of Stakeholders Indicating which Incentives their County Offers to Encourage CPP Participation [δ 1]



[δ] *SOURCE*: Stakeholder Survey, respondents who reported participating in FY 2012-13 CPP processes

Stakeholders were also asked to identify the activities that their counties offered to encourage CPP participation. In general, stakeholders' responses corresponded with county informants' responses. Stakeholders in the Bay Area, Los Angeles, Southern, and Superior regions identified meals at meetings as the primary incentive offered by counties to encourage participation in CPP activities (40%, 53%, 35%, and 49.6%, respectively). Central region stakeholders reported multiple meeting times as the most common

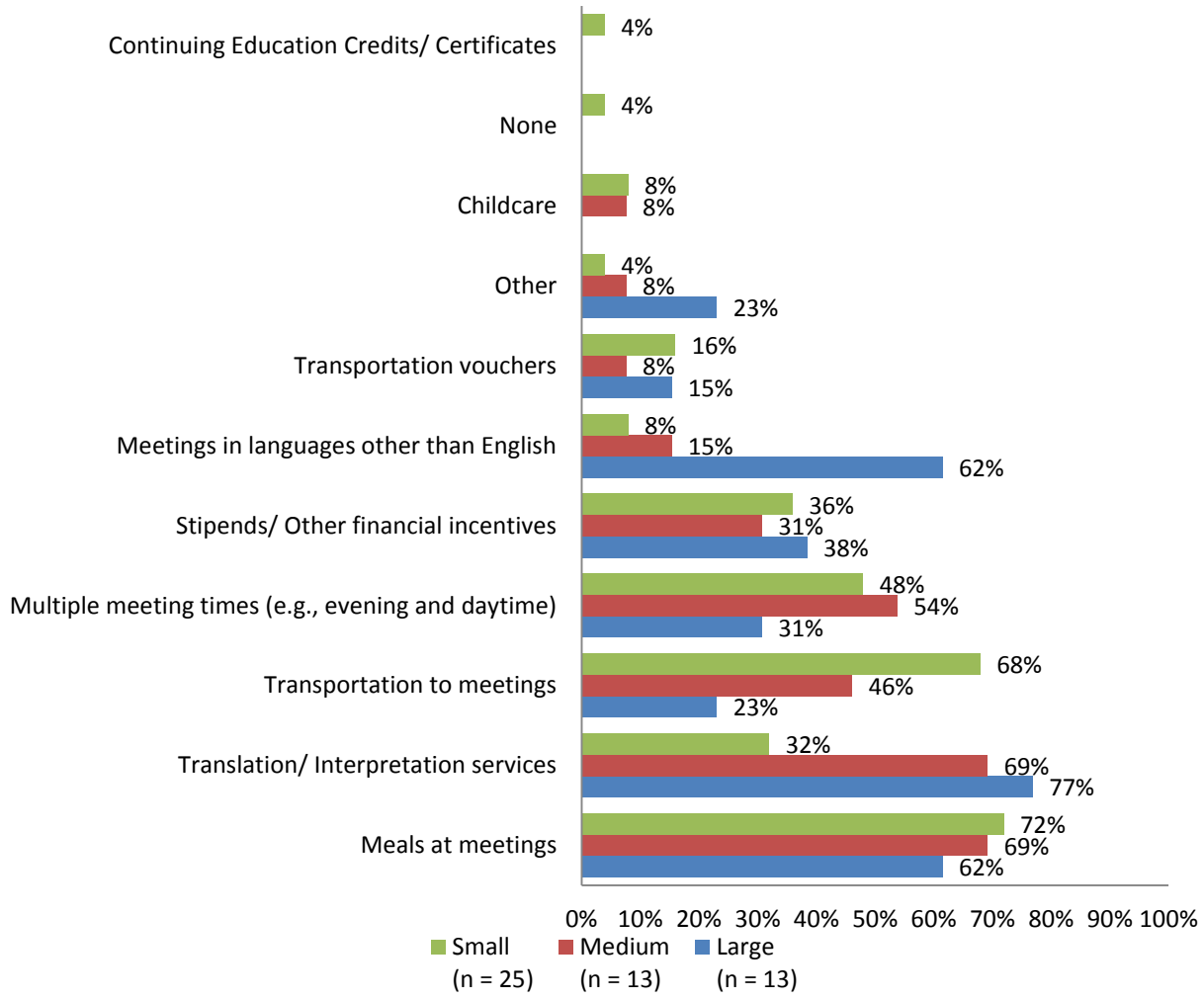
[1] Survey respondents were asked to check all that apply.

incentive (31%). Central, Los Angeles, and Southern region identified translation services as another common incentive (27%, 35%, and 28%, respectively), while transportation to meetings was a popular incentive in the Central and Superior regions (24% and 26.8%, respectively) (see Figure 22).

County Size

Rationale: Figure 23 presents data on the popularity of various incentives to encourage stakeholders to participate in Annual Update CPP activities during FY 2012-2013. For large counties, the most popular activities were translation services (77%) and holding meetings in languages other than English (62%). Popular incentives in medium counties also included translation services (69%) as well as providing meals at meetings (69%). Small counties most commonly used meals at meetings (72%) and transportation to meetings (68%) to encourage stakeholder participation.

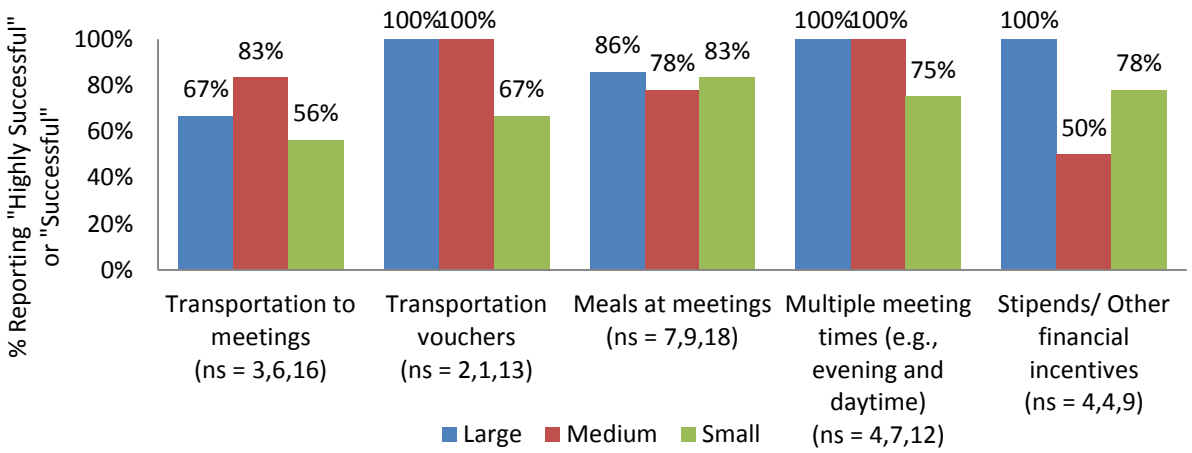
Figure 23: Percentage of County Informants Indicating Incentives Offered to CPP Participants During Planning for the FY 12/13 Annual Update, by County Size [ϕ]



[ϕ] *SOURCE*: County Web-Based Data Request

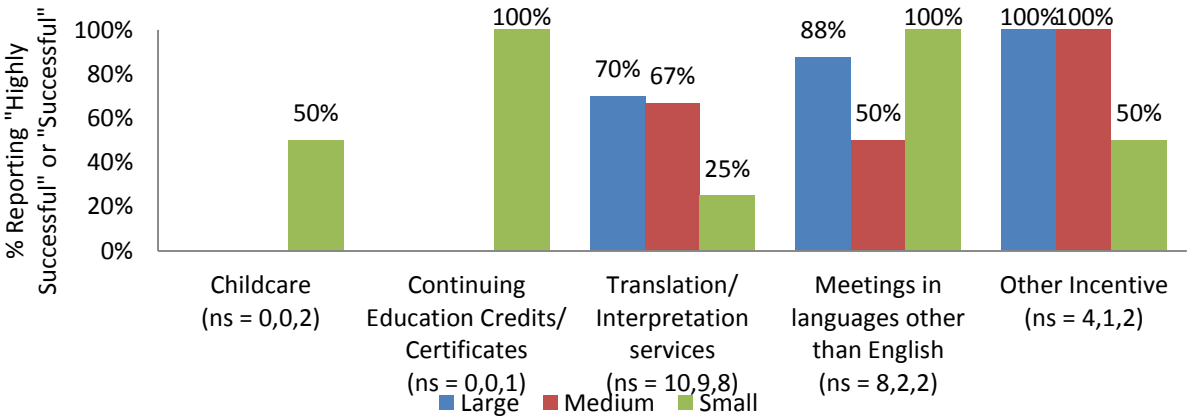
Figure 24 illustrates county informants' perceived success rate of each incentive. Large and medium counties perceived providing transportation vouchers and organizing multiple meeting times as a means for encouraging stakeholder participation as most successful(both 100%), though small counties indicated less success with that incentive (67% and 75%, respectively). At the same time, small counties found it highly successful to hold meetings in languages other than English (100%), while medium counties reported less success with this same activity (50%). Small counties also offered additional incentives such as childcare and continuing education credits. County informants reported the latter to be highly successful (100%), while childcare services was less successful (50%) (see Figure 25).

Figure 24: Percentage of County Informants Indicating Incentive was Successful in Encouraging Stakeholder Participation, by County Size (1 of 2) ϕ



ϕ *SOURCE*: County Web-Based Data Request

Figure 25: Percentage of County Informants Indicating Incentive was Successful in Encouraging Stakeholder Participation, by County Size (2 of 2) ϕ

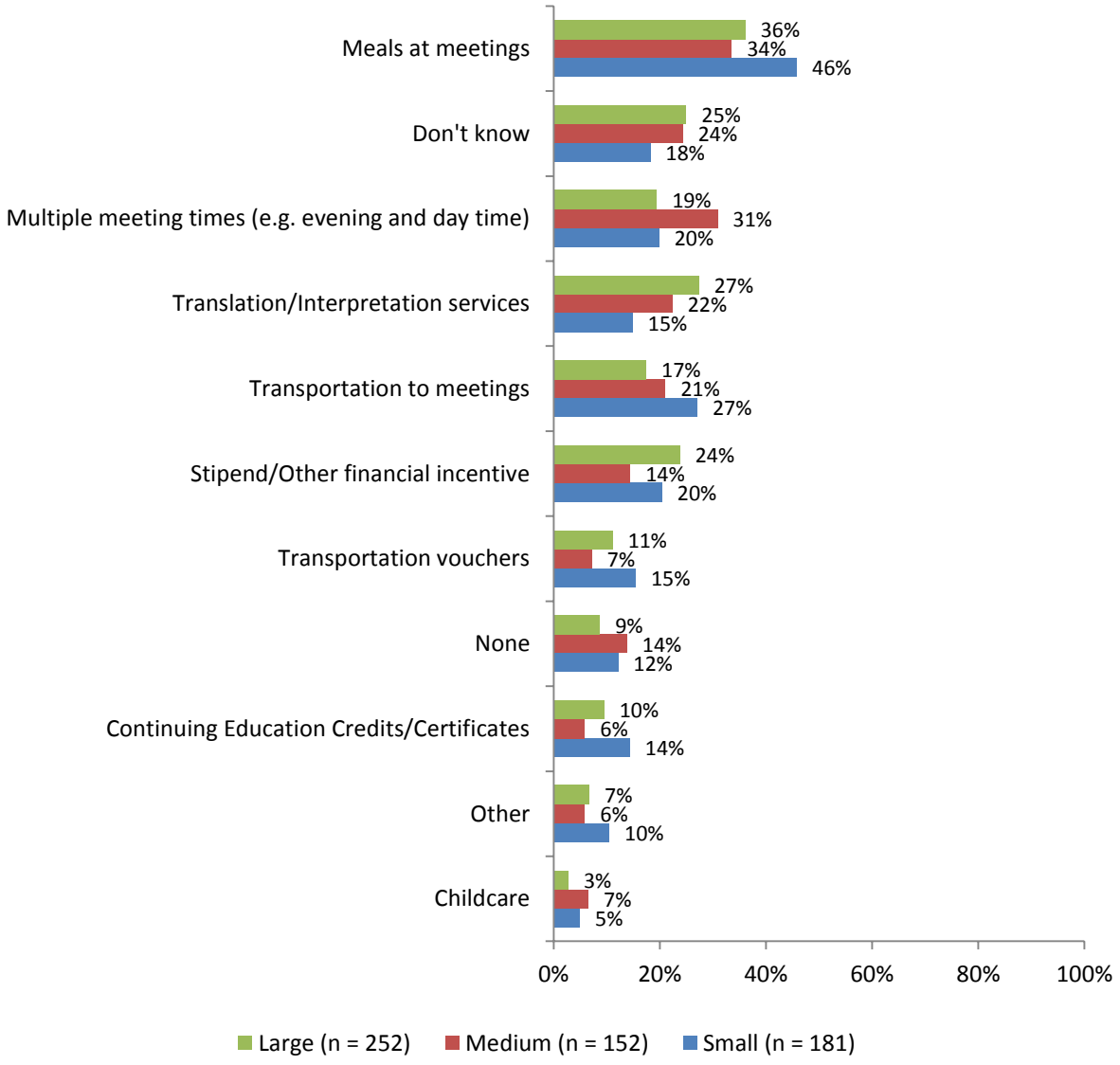


ϕ *SOURCE*: County Web-Based Data Request

Figure 26 illustrates those activities offered by counties to encourage stakeholder participation from the stakeholder's perspective. Across county size categories, the most popular activity identified by

stakeholders was the provision of meals at meetings. In particular, almost half of stakeholders in small counties reported meals at meetings as a top incentive. Offering translation services at CPP activities was a key incentive in large counties (27%), while holding multiple meeting times was a key incentive identified by medium counties (31%) and transportation to meetings was important to stakeholders in small counties (27%). Across county size categories, a smaller percentage of stakeholders identified continuing education credits and childcare as incentives offered by counties (see Figure 26).

Figure 26: Percentage of Stakeholders Indicating which Activities Counties Offered to Encourage Stakeholder Participation in CPP Activities, by County Size [δ]



[δ] *SOURCE*: Stakeholder Survey; Respondents who reported participating in FY 2012-13 CPP processes.

AC-02: Are clients with serious mental illness (SMI) and serious emotional disturbance (SED) and their family members targeted for outreach and given the opportunity to participate? If so, how?

Results

At least 87% of all counties statewide reported that the outreach methods the county engaged in were intended to target SMI/SED populations. All counties (100%) indicated using the following outreach methods to target SMI/SED populations: 1) social Media; 2) print announcements; 3) radio/TV announcements; and 4) post flyers/posters/brochures.

Overall, the Bay Area, Los Angeles, and Southern regions all (100%) reported that the CPP outreach methods each county engaged in were utilized to target SMI/SED populations. Comparatively, both the Central and Superior regions reported that some of the outreach methods they engaged in did not target SMI/SED populations.

The most common outreach methods, across CMHDA Regions, targeted to SMI/SED populations include: 1) post flyers/posters/brochures; 2) print announcements; and 3) social media.

Larger counties reported that all outreach methods (100%) were targeted towards SMI/SED populations, whereas both medium and small counties indicated that some outreach methods were not specifically targeted towards SMI/SED populations.

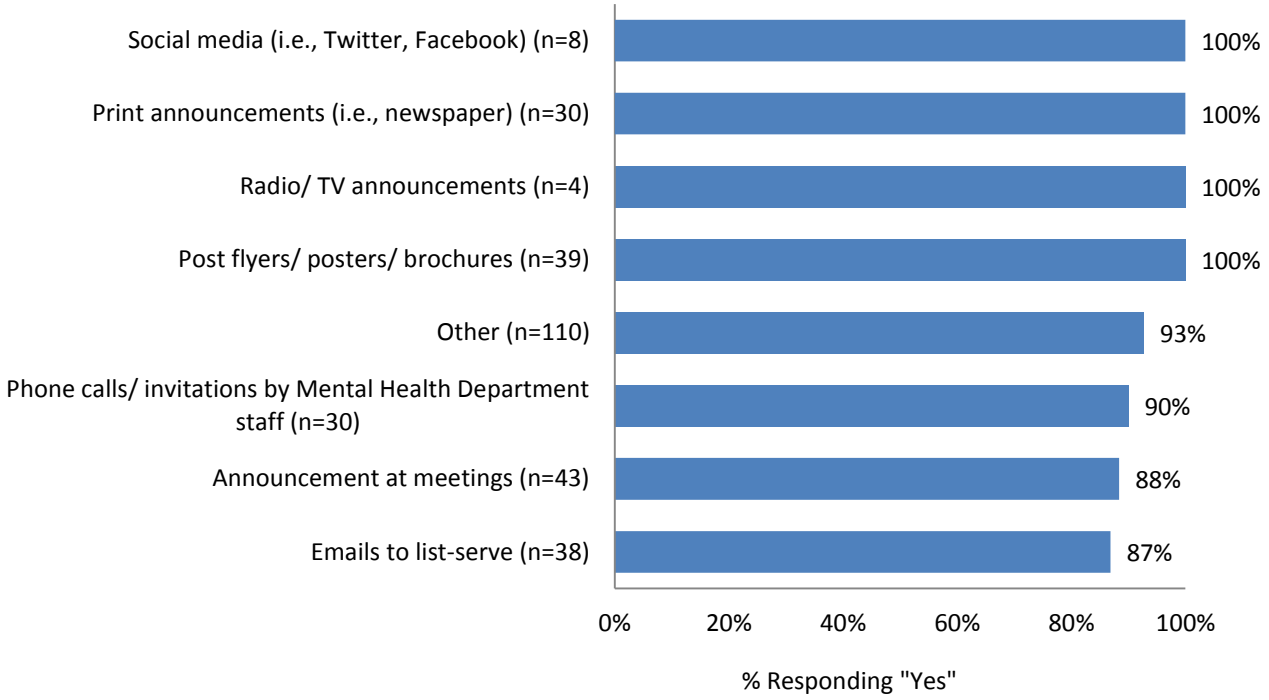
Statewide

Rationale: Each county's MHSA/CPP Coordinator reported whether the outreach methods the county engaged in was used to outreach to clients with SMI, SED, or family members of SMI/SED populations, as shown in

Figure 27.

Generally speaking, the vast majority of the CPP outreach methods that counties engaged in were used to outreach to SMI/SED populations, specifically through social media (100%), print announcements (100%), radio/TV announcements (100%), and posting flyers/posters/brochures (100%). Additionally, while phone calls/invitations by Mental Health Department staff (90%), announcements at meetings (88%), and emails to listservs (87%) were the bottom three CPP outreach methods targeted to SMI/SED populations, the figures still indicate that a vast majority of the outreach methods were intended to target SMI/SED populations.

Figure 27: Percentage of Respondents Indicating Outreach Method Targeted SMI/SED Populations, Statewide ϕ



ϕ *SOURCE*: County Web-Based Data Request

CMHDA Region

Rationale: Each county's MHSA/CPP Coordinator reported whether the CPP outreach methods the county engaged in were used to outreach to clients with SMI, SED, or family members of SMI/SED populations. This information is shown in Table 9 by CMHDA Region.

Generally speaking, the Bay Area, Los Angeles, and Southern regions all (100%) reported that the CPP outreach methods each county engaged in were utilized to target SMI/SED populations. Comparatively, both the Central and Superior regions reported that some of the CPP outreach methods that they engaged in did not target SMI/SED populations. Specifically, in the Superior region, emails to listservs (60%) and announcements at meetings (58%) were among the CPP outreach methods that did not consistently target SMI/SED populations.

Table 9: Percentage of Respondents Indicating Outreach Method Targeted SMI/SED Populations, by CMHDA Region ϕ

Was this method used to outreach to clients with SMI, SED, or family members of SMI/SED populations? [1]	Bay Area	Central	Los Angeles	Southern	Superior
Post flyers/ posters/ brochures (*ns* = 9,12,1,6,11)	100 %	100 %	100 %	100 %	100 %
Phone calls/ invitations by Mental Health Department staff (*ns* = 6,8,1,4,11)	100 %	88%	100 %	100 %	82%
Emails to listserv (*ns* = 8,10,1,8,10)	100 %	90%	100 %	100 %	60%
Radio/ TV announcements (*ns* = 0,3,0,1,0)	N/A	100 %	N/A	100 %	N/A
Print announcements (i.e., newspaper) (*ns* = 6,8,0,5,10)	100 %	100 %	N/A	100 %	100 %
Social media (i.e., Twitter, Facebook) (*ns* = 2,1,0,1,3)	100 %	100 %	N/A	100 %	100 %
Announcement at meetings (*ns* = 10,11,1,9,12)	100 %	100 %	100 %	100 %	58%
Other (*ns* = 22,30,2,19,34)	100 %	93%	100 %	100 %	82%

[1] Percentage represents only those counties that indicated utilizing the listed outreach method.
ϕ *SOURCE*: County Web-Based Data Request

County Size

Rationale: Each county's MHSA/CPP Coordinator reported whether the outreach methods the county engaged in were used to outreach to clients with SMI, SED, or family members of SMI/SED populations. This information is shown in

Table 10 by county size categories.

Generally speaking, large counties reported that all CPP outreach methods (100%) were targeted to SMI/SED populations. Comparatively, both medium and small counties indicated that some CPP outreach methods were not specifically targeted to SMI/SED populations. For example, while 100% of large counties indicated that announcements at meetings were targeted to SMI/SED populations, 93% of medium counties and 79% of small counties reported that this particular CPP outreach method targeted SMI/SED populations in their counties.

Table 10: Percentage of Respondents Indicating Outreach Method Targeted SMI/SED Populations by County Size [ϕ]

Was this method used to outreach to clients with SMI, SED, or family members of SMI/SED populations? [1]	Large	Medium	Small
Post flyers/ posters/ brochures (*ns* = 8,12,19)	100%	100%	100%
Phone calls/ invitations by Mental Health Department staff (*ns* = 7,8,15)	100%	88%	87%
Emails to listserv (*ns* = 10,13,15)	100%	100%	67%
Radio/ TV announcements (*ns* = 2,0,2)	100%	N/A	100%
Print announcements (i.e., newspaper) (*ns* = 4,8,18)	100%	100%	100%
Social media (i.e., Twitter, Facebook) (*ns* = 1,2,5)	100%	100%	100%
Announcement at meetings (*ns* = 10,14,19)	100%	93%	79%
Other (*ns* = 24,31,55)	100%	97%	87%

[1] Percentage represents only those counties that indicated utilizing the listed outreach method.

[ϕ] *SOURCE*: County Web-Based Data Request

AC-03: In what ways do counties outreach to unserved and/or underserved populations and family members of unserved/underserved populations?

Results

Across the state, the majority of counties' outreach activities was intended for un/underserved populations. Counties primarily relied on social media, print announcements, and radio/TV announcements.

The Southern and Los Angeles regions reported that 100% of their CPP outreach activities engaged un/underserved populations, while some of Central, Bay Area, and Superior regions targeted un/underserved populations. Stakeholders reported transportation, accessibility, and stigma as key barriers that prevented un/underserved populations from participating in CPP activities. Accessibility pertains to inconvenient meeting times and locations as well as general perceptions of unwelcoming and unsafe atmospheres for open participation. Stigma was particularly prominent in Central and Superior regions.

Large counties, more often than medium and small counties, focused 100% of their outreach activities on un/underserved populations. Stakeholders' identification of barriers to un/underserved populations' participation in CPP activities varied across county size categories. Geography prevented un/underserved populations from participating in large counties, as did communication and trust in medium counties, and community stigma in small counties.

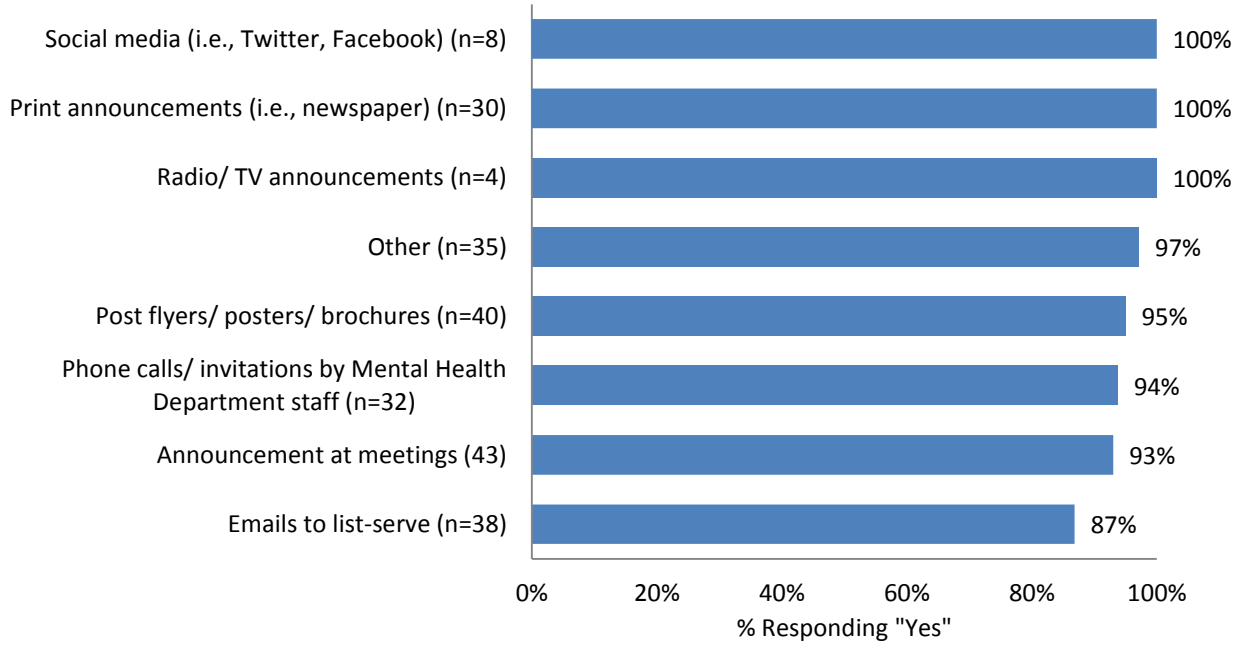
Statewide

Rationale: In order to understand what counties do to collect input from participants, the evaluation team analyzed statewide data from County Web-based Data Requests and Stakeholder Focus Groups.

At least 87% of all counties statewide reported that the outreach methods the county engaged in were intended to target un/underserved populations. The most common outreach methods used to target

un/underserved populations were: 1) Social Media; 2) Print Announcements; 3) Radio/TV Announcements (see Figure 28).

Figure 28: Percentage of Respondents Indicating Outreach Method Targeted Un/Underserved Populations, Statewide ϕ



ϕ *SOURCE*: County Web-Based Data Request

CMHDA Region

Rationale: Each county's MHSA/CPP Coordinator reported whether the CPP outreach methods the county engaged in were used to outreach to un/underserved populations. This information is shown in

Table 11.

Generally speaking, the Southern and Los Angeles regions all (100%) reported that the CPP outreach methods each county engaged in were utilized to target un/underserved populations. Comparatively, the Bay Area, Central region, and Superior regions reported that some of the CPP outreach methods those counties engaged in did not target un/underserved populations. Specifically, in the Superior region, emails to listservs (60%) and announcements at meetings (75%) were among the CPP outreach methods that did not consistently target un/underserved populations.

The most common outreach methods used across CMHDA Region targeted to un/underserved populations include: 1) social media; 2) print announcements; and 3) radio/TV announcements.

Table 11: Percentage of Respondents Indicating Outreach Method Targeted Un/Underserved Populations by CMHDA Region ϕ

Was this method used to outreach to un/underserved populations and family members of un/underserved populations?[1]	Bay Area	Central	Los Angeles	Southern	Superior
Post flyers/ posters/ brochures (*ns* = 9,13,1,6,11)	100 %	92%	100 %	100 %	91%
Phone calls/ invitations by Mental Health Department staff (*ns* = 6,9,1,5,11)	100 %	89%	100 %	100 %	91%
Emails to listserv (*ns* = 8,11,1,8,10)	88%	100 %	100 %	100 %	60%
Radio/ TV announcements (*ns* = 0,3,0,1,0)	N/A	100 %	N/A	100 %	N/A
Print announcements (i.e., newspaper) (*ns* = 6,9,0,5,10)	100 %	100 %	N/A	100 %	100 %
Social media (i.e., Twitter, Facebook) (*ns* = 2,2,0,1,3)	100 %	100 %	N/A	100 %	100 %
Announcement at meetings (*ns* = 10,11,1,9,12)	100 %	100 %	100 %	100 %	75%
Other (*ns* = 5,16,2,4,3)	100 %	100 %	100 %	100 %	100 %

[1] Percentage represents only those counties that indicated utilizing the listed outreach method.
ϕ *SOURCE*: County Web-Based Data Request

Stakeholders were also asked to identify those barriers and/or challenges that restricted individuals from un/underserved populations from participating in their counties' CPP activities. Transportation, accessibility, and stigma emerged from stakeholder focus groups as key issues. For some regions, such as the Central, Southern, and Superior regions, transportation issues not only pertained to lack of public transit, but also county geography. In other words, because some counties are geographically spread out, more isolated communities in rural or desert areas had a difficult time getting to the meetings.

Regarding accessibility, stakeholders described inconvenient meeting times and locations (since activities often occur during the work hours), language issues (particularly for undocumented and mono-lingual Spanish speakers), as well as trust issues. Stakeholders reported that there seems to be a general perception that the meetings are unwelcoming and unsafe; this was particularly prominent in the Southern region. Finally, while all CMHDA Regions noted stigma as a barrier to participation from un/underserved populations, this appeared to be a key barrier in the Superior and Central regions.

County Size

Result: Larger counties reported that all CPP outreach methods (100%) were targeted to un/underserved populations, whereas both medium and small counties indicated that some CPP outreach methods were not specifically targeted to un/underserved populations.

Rationale: Each county's MHSA/CPP Coordinator reported whether the CPP outreach methods the county engaged in were used to outreach to un/underserved populations. This information is shown in Table 12.

Generally speaking, large counties reported that all CPP outreach methods (100%) were targeted to un/underserved populations. Comparatively, both medium and small counties indicated that some outreach methods were not specifically targeted to un/underserved populations. For example, while 100% of large counties indicated that emails to listservs were targeted to un/underserved populations, 92% of medium counties and 73% of small counties reported that the CPP outreach method targeted un/underserved populations.

Table 12: Percentage of Respondents Indicating Outreach Method Targeted Un/Underserved Populations by County Size [ϕ]

Was this method used to outreach to un/underserved populations and family members of un/underserved populations?[1]	Large	Medium	Small
Post flyers/ posters/ brochures (*ns* = 8,12,20)	100%	100%	90%
Phone calls/ invitations by Mental Health Department staff (*ns* = 9,8,15)	100%	100%	87%
Emails to listservs (*ns* = 10,13,15)	100%	92%	73%
Radio/ TV announcements (*ns* = 2,0,2)	100%	N/A	100%
Print announcements (i.e., newspaper) (*ns* = 4,8,18)	100%	100%	100%
Social media (i.e., Twitter, Facebook) (*ns* = 1,2,5)	100%	100%	100%
Announcement at meetings (*ns* = 10,14,19)	100%	100%	84%
Other (*ns* = 9,3,18)	100%	100%	94%

[1] Percentage represents only those counties that indicated utilizing the listed outreach method.

[ϕ] *SOURCE*: County Web-Based Data Request

Stakeholders were also asked to identify barriers that prevented un/underserved populations from participating in CPP activities. Geography (particularly among rural and desert communities) and language/cultural barriers emerged as key issues for large counties. In medium counties, issues arose regarding communication and trust between the county mental health department and various populations, which resulted in a lack of knowledge/understanding of CPP. Finally, small counties raised the issue of stigma as a primary barrier to participation for un/underserved populations. Stakeholders specifically discussed the issue in terms of community stigma. In other words, the lack of anonymity and resultant fear of stigmatization characterized by residing in small towns prevented people from participating in CPP activities. This fear compounded for members of ethnic and un/underserved communities.

Activities – Participant Input

This section provides results from research questions in regards to the ways that counties ensure accessibility to their CPP activities, how they ensure that their CPP activities adhere to MHSA standards, and strategies they use to provide a safe and stigma-free environment for stakeholders. This section illustrates how counties collect and document stakeholder input, as well as how they use stakeholder input in current and future CPP planning.

AC-04: What do counties do to ensure accessibility to CPP activities?

Results

Statewide: Among all counties, the most frequently reported method used to ensure accessibility to CPP meetings was to hold CPP meetings at multiple times (33%); however, stakeholders reported this method far less frequently (13%). Conversely, stakeholders most frequently reported providing meals at meetings to ensure accessibility to CPP meetings (38%); however, counties reported this method far less frequently (19%). In terms of ensuring transportation accessibility to CPP meetings, among counties, the most frequently reported method was to hold CPP meetings at various locations (33%); however, stakeholders reported this method less frequently (21%). Conversely, stakeholders most frequently reported providing transportation to increase accessibility to CPP meetings; however, counties reported this method less frequently (25%).

CMHDA Region: When divided across CMHDA Regions, the results for this research question produced low respondent counts for each method, thus significantly skewing the data. As a result, it is not presented here.

County Size: Stakeholders and key informants from large and small counties reported engaging in a variety of methods to ensure accessibility to CPP stakeholders. Medium counties did not report any methods for ensuring accessibility. For transportation accessibility, 56% of stakeholders in small counties and 40% of stakeholders in medium counties reported providing transportation to meetings; however, no medium counties reported providing transportation and small counties reported this less frequently (36%). Conversely, large (25%), medium (67%), and small (33%) counties reported holding meetings at various locations; while only a third of stakeholders from small counties (33%) mention holding meetings in multiple locations.

Statewide

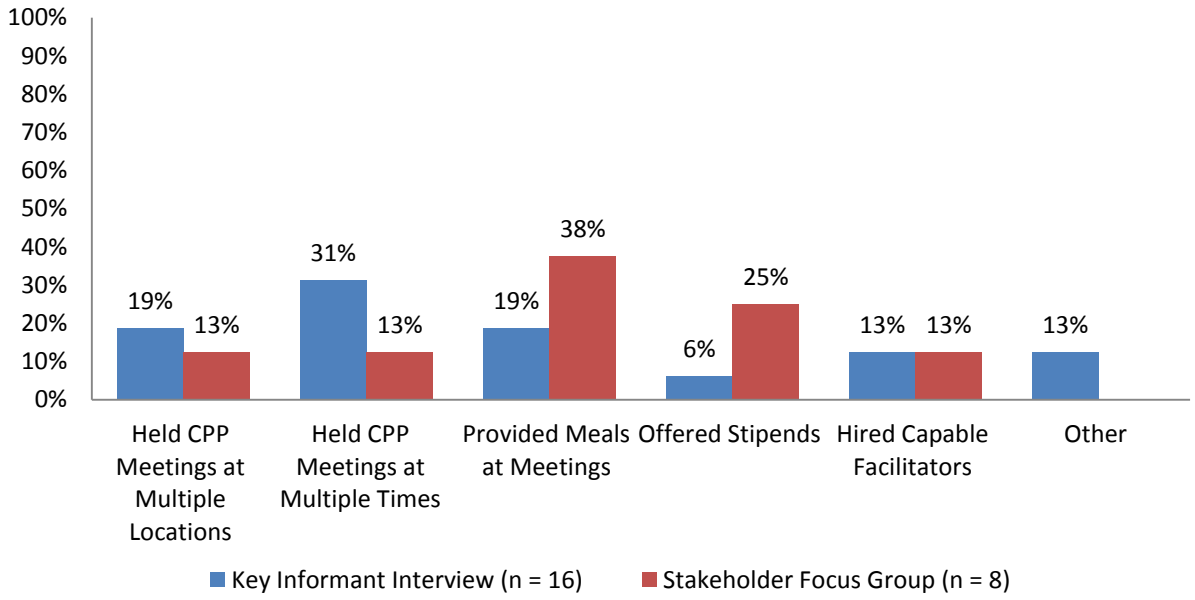
Rationale: Both counties[2] and stakeholders[3] were asked to identify barriers to participating in the CPP process, however only counties were asked to describe how these barriers were addressed. In some

[2] Key Informant Interview Question: "What barriers to participation do you think that stakeholders in your county face? How do you address these barriers? Are there any barriers you feel you are unable to address?"
[3] Stakeholder Focus Group Question: "Are there any barriers/challenges that prevent or restrict people from participating in CPP processes?"

instances, stakeholders did identify potential solutions to the barriers discussed, however, those responses were limited.

Figure 29 shows the methods that counties used to ensure accessibility to CPP meetings. The most frequently reported method used to ensure accessibility to CPP meetings was to hold CPP meetings at multiple times (33%); however, stakeholders reported this method far less frequently (13%). Conversely, among stakeholders, the most frequently reported method used to ensure accessibility to CPP meetings was to provide meals at meetings (38%); however, counties reported this method far less frequently (19%).

Figure 29: Methods Used by Counties to Ensure Accessibility to CPP Meetings, Statewide [β Δ]

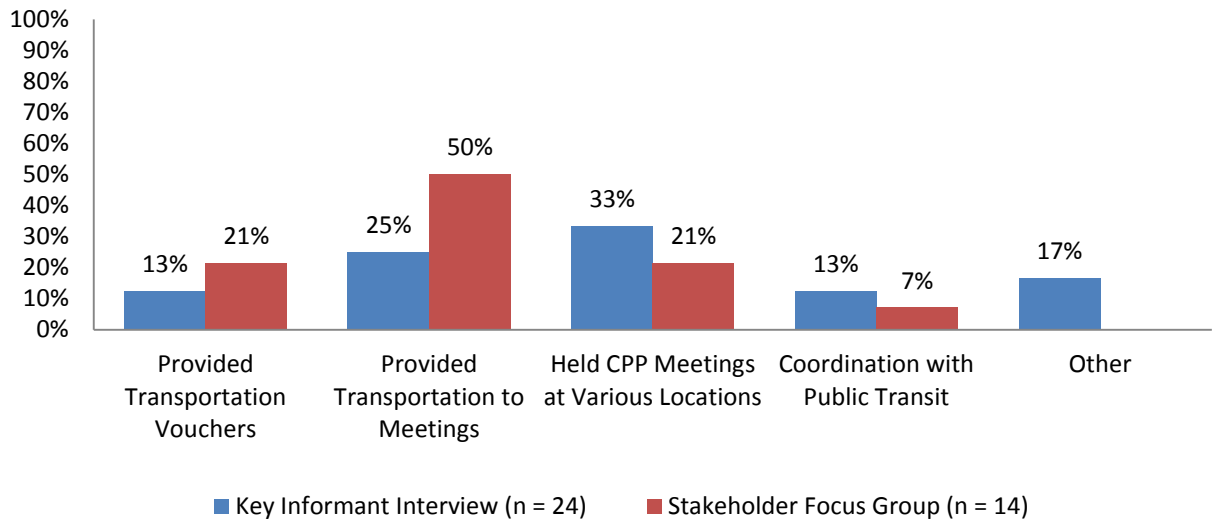


[β]*SOURCE:* Key Informant Interview
[Δ]*SOURCE:* Stakeholder Focus Group

The methods used to ensure transportation accessibility to CPP meetings is shown in

Figure 30. Counties most frequently reported holding CPP meetings at various locations (33%); however, stakeholders reported this method less frequently (21%). Conversely, among stakeholders the most frequently reported method for increasing transportation accessibility to CPP meetings was to provide transportation to meetings; however, counties reported this method less frequently (25%).

Figure 30: Methods Counties Use to Ensure Transportation Accessibility to CPP Meetings, Statewide [β Δ]



[β]*SOURCE:* Key Informant Interview
[Δ]*SOURCE:* Stakeholder Focus Group

CMHDA Region

Rationale: The methods reported by stakeholders that counties used to ensure accessibility to CPP meetings by CMHDA Region is provided in Table 13. Eight stakeholder focus groups provided information on methods used by counties to ensure accessibility. Only stakeholders from the Bay Area (*n* = 3), Central (*n* = 3), and Superior (*n* = 2) regions provided data on methods. For this data set, the n-values are too low to make any concrete conclusions about stakeholder perceptions of methods used to ensure accessibility; however, offering stipends was not mentioned by any county, which suggests the method was not used to ensure accessibility.

Table 13: Stakeholder Perceptions of Methods Used by Counties to Ensure Accessibility to CPP Meetings, by CMHDA Region [Δ]

CMHDA Region	Held CPP Meetings at Multiple Locations	Held CPP Meetings at Multiple Times	Provided Meals at Meetings	Offered Stipends	Hired Capable Facilitators	Other
Bay Area (*n* = 3)	0%	33%	33%	0%	0%	33%
Central (*n* = 3)	0%	0%	33%	0%	67%	0%
Los Angeles (*n* = 0)	0%	0%	0%	0%	0%	0%
Southern (*n* = 0)	0%	0%	0%	0%	0%	0%
Superior (*n* = 2)	50%	0%	50%	0%	0%	0%

[Δ]*SOURCE:* Stakeholder Focus Group

Table 14 illustrates the distribution of methods reported by key informants that counties used to ensure accessibility to CPP meetings by CMHDA Region. A total of 14 key informants provided data on the

methods that counties used. Similar to stakeholders in Table 13, methods were reported only from MHSA/CPP Coordinators in the Bay Area (*n* = 4), Central (*n* = 7), and Superior (*n* = 3) regions. All three regions reported holding meetings at different locations(50%, 29%, 33%; respectively). Low n-values for each method skewed the data, impeding concrete analysis and results.

Table 14: County Perceptions of Methods Used by Counties to Ensure Accessibility to CPP Meetings, by CMHDA Region [β]

CMHDA Region	Held CPP Meetings at Multiple Locations	Held CPP Meetings at Multiple Times	Provided Meals at Meetings	Offered Stipends	Hired Capable Facilitators	Other
Bay Area (*n* = 4)	0%	50%	50%	0%	0%	0%
Central (*n* = 7)	29%	29%	14%	0%	14%	14%
Los Angeles (*n* = 0)	0%	0%	0%	0%	0%	0%
Southern (*n* = 0)	0%	0%	0%	0%	0%	0%
Superior (*n* = 3)	33%	33%	0%	0%	0%	33%

[β]*SOURCE:* Key Informant Interview

Stakeholder perceptions of the methods used to ensure transportation accessibility to CPP meetings is depicted in Table 15 by CMHDA Region. Stakeholders from 15 counties reported the methods that they used. A majority of stakeholders from the Bay Area (75%) and Southern (100%) regions reported counties providing transportation vouchers; however, it is important to note the low n-value for the Southern region (*n* = 1). Having transportation to meetings provided by the counties was mentioned by a majority of stakeholders from the Superior (67%) and Central (50%) regions, as well as a quarter of the stakeholders from the Bay Area region (25%). Holding CPP meetings at various locations was identified by two counties from the Central region (50%) and one county from the Superior region (17%).

Table 15: Stakeholder Perceptions of Methods Used by Counties to Ensure Transportation Accessibility to CPP Meetings, by CMHDA Region [Δ]

CMHDA Region	Provided Transportation Vouchers	Provided Transportation to Meetings	Held CPP Meetings at Various Locations	Coordination with Public Transit	Other
Bay Area (*n* = 4)	75%	25%	0%	0%	0%
Central (*n* = 4)	0%	50%	50%	0%	0%
Los Angeles (*n* = 0)	0%	0%	0%	0%	0%
Southern (*n* = 1)	100%	0%	0%	0%	0%
Superior (*n* = 6)	0%	67%	17%	17%	0%

[Δ]*SOURCE:* Stakeholder Focus Group

Table 16 depicts county perceptions of methods used by counties to ensure transportation accessibility by CMHDA Region. Counties from the Bay Area (50%) and Central (46%) regions most commonly reported holding CPP meetings at various locations while the Superior region (50%) reported providing

transportation to meetings. Overall, transportation vouchers, coordination with public transit, and other methods were less commonly reported.

Table 16: County Perceptions of Methods Used by Counties to Ensure Transportation Accessibility to CPP Meetings, by CMHDA Region [β]

CMHDA Region	Provided Transportation Vouchers	Provided Transportation to Meetings	Held CPP Meetings at Various Locations	Coordination with Public Transit	Other
Bay Area (*n* = 2)	0%	0%	50%	0%	50%
Central (*n* = 13)	15%	15%	46%	8%	15%
Los Angeles (*n* = 0)	0%	0%	0%	0%	0%
Southern (*n* = 1)	0%	0%	0%	0%	100%
Superior (*n* = 8)	13%	50%	13%	25%	0%

[β]*SOURCE:* Key Informant Interview

County Size

County and stakeholder perceptions of methods counties is utilized to ensure accessibility to their CPP activities varies among differently sized counties. As depicted in Table 17, Stakeholders from three large counties reported that counties provided meals at meetings (*n* = 1), hired capable facilitators (*n* = 1), and used other strategies (*n* = 1) as methods. Stakeholder in five small counties reported that counties held CPP meetings at multiple locations (*n* = 1), held CPP at multiple times (*n* = 1), provided meals at meetings (*n* = 2), hired capable facilitators (*n* = 1), and used other methods (*n* = 1). Stakeholders from medium counties did not report such methods.

Table 17: Stakeholder Perceptions of Methods Used by Counties to Ensure Accessibility to CPP Meetings, by County Size [Δ]

County Size	Held CPP Meetings at Multiple Locations	Held CPP Meetings at Multiple Times	Provided Meals at Meetings	Offered Stipends	Hired Capable Facilitators	Other
Large (*n* = 3)	0%	0%	33%	0%	33%	33%
Medium (*n* = 0)	0%	0%	0%	0%	0%	0%
Small (*n* = 5)	20%	20%	40%	0%	20%	0%

[Δ]*SOURCE:* Stakeholder Focus Group

Table 18 provides the perceptions of counties as to the methods used to ensure accessibility of CPP activities. Overall, 13 counties reported methods, from both large (*n* = 4) and small (*n* = 9) counties. For small counties, holding CPP meetings at multiple times (*n* = 3) was reported most while large counties only mentioned this method once. Similar numbers of large (*n* = 2) and small (*n* = 2) counties identified providing meals at meetings. Small counties mentioned holding meeting at multiple locations (*n* = 2) and

other (*n* = 2), while large counties identified hiring capable facilitators one time. Medium counties did not mention any ways counties ensure accessibility.

Table 18: County Perceptions of Methods Used by Counties to Ensure Accessibility to CPP Meetings, by County Size [β]

County Size	Held CPP Meetings at Multiple Locations	Held CPP Meetings at Multiple Times	Provided Meals at Meetings	Offered Stipends	Hired Capable Facilitators	Other
Large (*n* = 4)	0%	25%	50%	0%	25%	0%
Medium (*n* = 0)	0%	0%	0%	0%	0%	0%
Small (*n* = 9)	22%	33%	22%	0%	0%	22%

[β]*SOURCE:* Key Informant Interview

Stakeholder perceptions of the methods used by counties to ensure transportation accessibility to CPP activities are presented in Table 19. Stakeholders from 14 counties provided information on how they perceived the counties have ensured transportation accessibility to CPP activities. Providing a transportation voucher (*n* = 3) was the most common method in medium counties. Providing transportation to meetings was most the most common method overall and the only to be reported by stakeholders in both medium (*n* = 2) and small (*n* = 5) counties. Also common among small counties was holding CPP meetings at various locations (*n* = 3); stakeholders from one small county mentioned coordination with public transit. Stakeholders from large counties did not identify any ways that their counties ensured transportation accessibility.

Table 19: Stakeholder Perceptions of Methods Used by Counties to Ensure Transportation Accessibility to CPP Meetings, by County Size [Δ]

County Size	Provided Transportation Vouchers	Provided Transportation to Meetings	Held CPP Meetings at Various Locations	Coordination with Public Transit	Other
Large (*n* = 0)	0%	0%	0%	0%	0%
Medium (*n* = 5)	60%	40%	0%	0%	0%
Small (*n* = 9)	0%	56%	33%	11%	0%

[Δ]*SOURCE:* Stakeholder Focus Group

Table 20 provides county perceptions of ways that counties ensure transportation accessibility to CPP meetings. Overall, the most common method reported by large (*n* = 1), medium (*n* = 4), and small (*n* = 3) counties was to hold meetings at multiple locations. Large counties reported giving out transportation vouchers (*n* = 1), providing transportation (*n* = 1), holding meeting at various locations (*n* = 1), and other (*n* = 1). Medium counties reported holding meetings at various location most often (*n* = 4) while transportation vouchers (*n* = 1) and other (*n* = 1) were mentioned once. Small counties had the most variation in methods reported. Providing transportation to meetings (*n* = 5) was most common followed by holding CPP meetings at various locations (*n* = 3), coordination with public transit (*n* = 3), and other methods (*n* = 2). For small counties, transportation vouchers (*n* = 1) were least common.

Table 20: County Perceptions of Methods Used by Counties to Ensure Transportation Accessibility to CPP Meetings, by County Size[β]

County Size	Provided Transportation Vouchers	Provided Transportation to Meetings	Held CPP Meetings at Various Locations	Coordination with Public Transit	Other
Large (*n* = 4)	25%	25%	25%	0%	25%
Medium (*n* = 6)	17%	0%	67%	0%	17%
Small (*n* = 14)	7%	36%	21%	21%	14%

[β]*SOURCE:* Key Informant Interview

AC-05: What do counties do to ensure that the CPP process adheres to the general standards of MHSA?

Results

Statewide: Across the state, 44% (*n* = 54) of counties reported that CPP processes are consistent with all five MHSA principles. Counties described a variety of practices they engaged in to ensure CPP processes are consistent with MHSA principles.

To ensure cultural competency in CPP processes, counties focused on the needs of racial and ethnic minority populations by focusing on conducting outreach to specific populations to participate, providing translation services for Spanish speakers, and building cultural competency among providers.

Counties ensured that CPP processes were consistent with the community collaboration principle by holding town hall meetings, collaborating with advocacy groups, and encouraging stakeholder participation in the planning process. Overall, counties reported progress in this area while at the same time noting that there was still room for improvement.

In order to ensure integrated services experience in CPP processes, counties reported focusing on collaboration across county departments, developing interagency connections, and holding CPP meetings at various county departmental sites.

Counties ensured that CPP processes were consistent with the family- and client-driven principle through concerted efforts to seek out and incorporate consumer input into the planning process. Counties reported having consumers speak at CPP meetings, setting goals for consumer participation, and creating more stakeholder-run groups. For the recovery-oriented principle, counties noted that recovery as a concept and value was something that was deeply ingrained in their work.

CMHDA Region: Results from counties by CMHDA Region were not unique from statewide findings.

County Size: Results from counties by population size were not unique from statewide findings.

Statewide

Rationale: MHSA/CPP Coordinators from counties across the state were asked, "What does the CPP staff or county do to ensure that the CPP process is consistent with the principles of the MHSA? Please give specific examples."

Across the state, 44% (*n* = 54) of counties and municipalities reported that CPP processes were consistent with all five MHSA principles. In order to comply with the MHSA cultural competency principle, counties focused on the needs of racial and ethnic minority populations by focusing on conducting outreach to specific populations to encourage their participation, providing translation services for Spanish speakers, and building cultural competency among providers. For the community collaboration principle, counties reported progress while also noting room for improvement. Counties reported encouraging community collaboration by holding town hall meetings, collaborating with advocacy groups, and encouraging stakeholder participation in the planning process. For the integrated services experience principle, Counties reported a focus on collaboration across county departments, developing interagency connections, and holding CPP meeting at various county departmental sites. For the family- and client-driven principle, counties reported concerted efforts to seek out and incorporate consumer input into planning processes. Counties reported having consumers speak at CPP meetings, setting goals for consumer participation, and creating more stakeholder run groups. For the recovery-oriented principle, counties noted that recovery as a concept and value was something that was deeply ingrained in their work.[β]

CMHDA Region

Rationale: Across the Bay Area region, 31% (*n* = 13) of counties noted that their CPP processes were consistent with all five MHSA principles. For the cultural competency principle, counties focused on the needs of particular racial/ethnic minority populations, making sure their providers were culturally competent, and providing translation services for Spanish speakers. For the community collaboration principle, one county identified it as an area for growth, while another county's CPP staff hosted a town hall for different services to announce what they provided/offered in the community. For the integrated services experience principle, four counties noted that it was an area for improvement. For the family- and client-driven principle, 62% (8 of 13) of counties made a concerted effort to seek and include consumer and family input. One county noted that it liked to have consumers speak at CPP meetings to share how MHSA services helped them. For the recovery-oriented principal, two counties noted that they were particularly sensitive to recovery principles in their work.[β]

Across the Central region, 47% (*n* = 17) of counties noted that their CPP processes were consistent with all five MHSA principles. For the cultural competency principle, counties focused on the needs of particular racial/ethnic minority populations (particularly Native American communities), providing translation services for Spanish speakers, and building in contracts with organizations representing particular minority groups to solicit feedback for the county's CPP process. For the community collaboration principle, collaboration with NAMI was cited often, and having consumers' voices included in the CPP process was important. For the integrated services experience principle, stakeholder input meetings were held by a variety of mental health departments. For the family- and client-driven principle, consumer input was continuously sought for and valued; one county noted that it sought 50% representation from

consumers in its MHSA work. For the recovery-oriented principal, counties strove for recovery as a concept, but many also noted that there was a lot of work left to do still.[β]

In Los Angeles County, all of the MHSA principles in its CPP processes were described in the county's planning materials.[β]

Across the Southern region, 78% (*n* = 9) of counties noted that their CPP processes were consistent with all five MHSA principles. For the cultural competency principle, counties had outreached to a variety of minority populations to participate in their CPP processes, used multilingual materials, and offered translation at meetings. For the community collaboration principle, counties believed that there was community collaboration throughout their CPP processes, but that it still needs improvement. For the integrated services experience principle, counties understood the importance of having collaboration across mental health departments. For the family- and client-driven principle, counties continuously sought for and valued consumer input; one county reported that most of its CPP meetings were run by stakeholders. For the recovery-oriented principal, counties generally believed that recovery was a concept that they all strove for and that their work was deeply rooted in.[β]

Across the Superior region, 29% (*n* = 14) of counties noted that their CPP processes were consistent with all five MHSA principles. For the cultural competency principle, counties had outreached to a variety of minority populations to participate in their CPP processes, but some counties also noted that they needed to hire multilingual staff in the future to get more people involved in the stakeholder process. For the community collaboration principle, counties noted that they were open to CPP participation from all stakeholders. For the integrated services experience principle, counties commented that they were in the process of creating inter-agency connections, which will presumably help their CPP processes. For the family- and client-driven principle, counties noted that a lot of their CPP activities were consumer-driven, and some counties noted that NAMI had helped to organize a lot of events for them. For the recovery-oriented principal, counties generally believed that recovery was possible and that the concept of recovery was ingrained in their work.[β]

County Size

Rationale: Among large counties, 61% (*n* = 13) of counties noted that their CPP processes were consistent with all five of the MHSA principles. Large counties kept CPP processes consistent with the cultural competency principle by providing outreach to different ethnic and cultural groups, utilizing cultural brokers, and establishing cultural competency committees in CPP processes. For the community collaboration principle, counties emphasized working with diverse stakeholder groups through stakeholder steering committees. For the integrated services experience principle, counties mentioned collaborating with primary care providers and developing effective avenues for referral. For the family- and client-driven principle, counties mentioned creating family and consumer advisory committees within their stakeholder steering committees. Counties also noted that a lot of their CPP activities were already consumer-driven. For the recovery-oriented principal, counties reported building MHSA values into planning and using recovery language and values during CPP activities.[β]

Among medium counties, 50% (*n* = 14) of counties reported that their CPP processes were consistent with all five of the MHSA principles. For the cultural competency principle, medium counties kept CPP processes consistent by providing translation services at all CPP meetings and hiring bi- or multi-cultural staff. For the Community Collaboration principle, medium counties mentioned using collaborative practices when meeting and collaborating with outside agencies, and developing stronger partnerships with outside departments. For the integrated services experience principle, medium counties mentioned integrating with outside departments, especially behavioral health and probation. For the family- and client-driven principle, medium counties noted a lot of their CPP activities involve consumers in the CPP process by creating advisory committees, and actively seeking input from consumers and families. For the recovery-oriented principal, medium counties reported keeping CPP activities consistent by promoting the idea of recovery through wellness centers and anti-stigma campaigns.[β]

Among small counties, 42% (*n* = 26) of counties reported that their CPP processes are consistent with all five of the MHSA principles. For the cultural competency principle, small counties kept CPP processes consistent by providing translation services for CPP activities, using cultural brokers, and outreaching to underserved communities. For the community collaboration principle, small counties described fostering collaborative relationships with providers, promoting meetings at other community forums, and keeping meetings open. For the integrated services experience principle, small counties described integrated partnerships with other departments and organizations; small counties also acknowledged this was an area for improvement. For the family- and client-driven principle, small counties felt that overall they could improve in this area; however, some counties described high levels of family and consumer participation and attendance at CPP activities. For the recovery-oriented principal, small counties felt that they were moving in that direction but there was room for improvement. Some counties mentioned using recovery language, providing trainings on the recovery model, and hiring peer providers in order to make CPP consistent.[β]

AC-06: What do counties do to ensure that the process is safe, free from stigma, discrimination and retaliation?

Results

Statewide: Across the state, counties felt that they took a lot of steps to create safe environments for their CPP processes (average of 4.8; 1 to 5 scale). While there was variation as to the method used to create a safe and stigma free CPP process, some common themes included: breakout groups were utilized to solicit more open stakeholder feedback, and meeting ground rules were laid-out at the beginning of CPP meetings. Counties also noted that providing food made stakeholders feel safer to be open with their responses.

CMHDA Region: Counties in each CMHDA Region reported that they took a lot of steps to create safe environments for their CPP process. Among counties in each CMHDA Regions, there were variations as to the methods through which counties built open and transparent dialogue in meetings and built greater trust among stakeholders. Compared to other CMHDA Regions, more counties in the Central region made

efforts to conduct their CPP activities in inclusive, neutral, and safe environments, as well as provided alternate forms of communication for stakeholders to provide feedback.

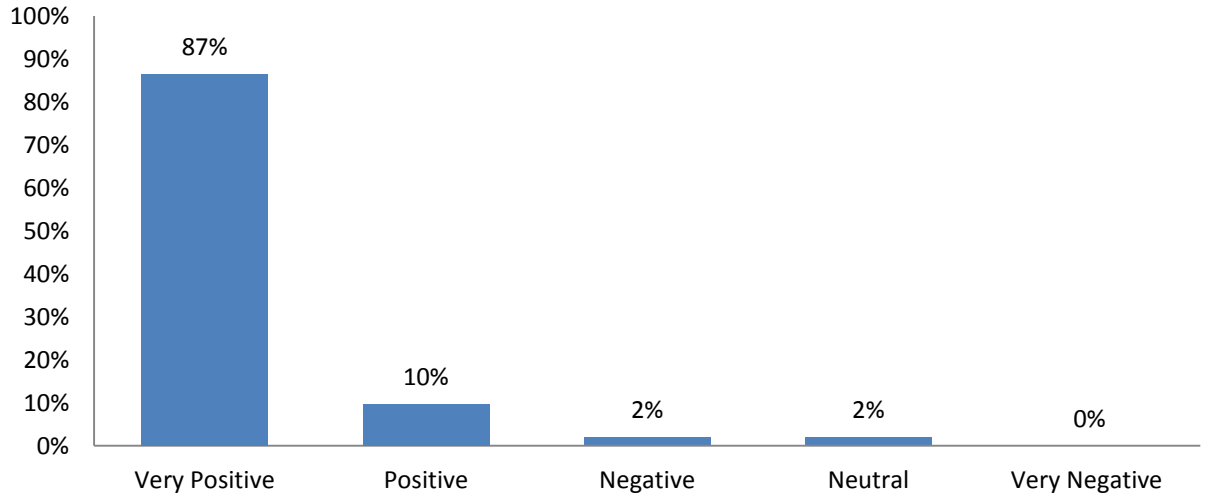
County Size: Regardless of county size, counties felt they had taken a lot of steps to create safe environments for their CPP processes. Similar to statewide results, there were variations in the practices used by counties to create safe environments. Medium counties noted using smaller breakout groups and alternate methods of communication to encourage more stakeholder participation (both of these methods were not noted with multiple frequencies in the small and large counties).

Statewide

Rationale: Across the state, key informants were asked, "What does the CPP staff or county do to create safe environments for the CPP process activities and meetings? (i.e., free from stigma, discrimination, and retaliation)." While counties were asked to describe the ways in which counties created safe environments for the CPP process, the vast majority of responses were perceptions of how safe the environment felt for stakeholders. As a result, the key informant responses were scored on scale of 1 to 5 (1 = very negative, 2 = negative, 3 = neutral, 4 = positive, 5 = very positive). As depicted in Figure 31, 87% of counties who responded felt very positively that CPP meetings were safe environments.

Figure 31: County Perceptions of Whether CPP processes are Safe Environments and Free of Stigma, Discrimination and Retaliation, Statewide [β]

(*n* = 52)



[β]*SOURCE:* Key Informant Interview

CMHDA Region

Rationale: As shown in Table 21, counties in all five CMHDA Regions felt they had taken steps to create safe environments for their CPP activities.

Table 21: Average County Perceptions of Whether CPP Processes Are Safe Environments and Free of Stigma, Discrimination and Retaliation, by CMHDA Region [β]

CMHDA Region	Average Score of County Response (1 to 5 Scale)
Bay Area (*n* = 12)	4.8
Central (*n* = 16)	4.8
Los Angeles (*n* = 1)	5.0
Southern (*n* = 9)	5.0
Superior (*n* = 14)	4.7

[β]*SOURCE:* Key Informant Interview

Across the Bay Area region, counties reported taking steps to create safe environments for their CPP processes (average of 4.8). Thirty-one percent (*n* = 13) of counties set-up agreements/rules at the beginning of their CPP meetings and described the importance of CPP to stakeholders. Fifteen percent (*n* = 13) of counties believed their CPP staff were well-trained and friendly. One county noted that its CPP meetings were incorporated into standing MHSA meetings to allow for more open dialogue about CPP. Fifteen percent (*n* = 13) of counties split-up larger groups into smaller groups in an effort to encourage more candid responses from stakeholders. Fifteen percent (*n* = 13) of counties provided food at meetings as a way to make meetings more informal and have stakeholders provide more open feedback.

Counties from the Central region took steps to create safe environments for their CPP processes (average of 4.8). Twenty four percent (*n* = 17) of counties set-up agreements/rules at the beginning of CPP meetings and described the importance of CPP to stakeholders. Thirty-five percent (*n* = 17) of counties noted that they had their CPP activities at locations that were inclusive and neutral for its stakeholders; whereas 29% (*n* = 17) of counties made sure to have their CPP activities in safe locations. Two counties noted that they had smaller breakout groups during their CPP meetings to encourage more stakeholder participation. Two counties used alternate ways for stakeholders to provide feedback, such as written surveys.

The Los Angeles region reported having a very safe environment at its CPP meetings (average of 5.0). In Los Angeles, facilitators were used to leading CPP meetings. The MHSA/CPP Coordinator noted how their CPP activities created a transparent and trusting environment. In the Los Angeles region, the county also reported high levels of trust and safety already present at stakeholder meetings prior to the MHSA.

All counties from the Southern region also reported taking steps to create safe environments for their CPP processes (average of 5.0). Twenty-two percent (*n* = 9) of counties used alternate forms of communication to get stakeholder feedback. Thirty-three percent (*n* = 9) counties noted CPP staff are well-trained and friendly; one county noted that CPP staff had been through training to reduce stigma. One county noted that its leadership was comprised of members with lived experiences, and that they spoke-up during introductions to highlight that people with lived experiences were in levels of leadership.

Across the Superior region, counties reported taking steps to create safe environments for their CPP processes (average of 4.7). Forty-three percent (*n* = 14) of counties used alternate forms of communication to solicit open feedback from stakeholders. Forty-three percent (*n* = 14) of counties held

CPP meetings at locations that were inclusive, neutral, and/or safe for stakeholders. One county organized social activities, such as BBQs, to create informal environments for its CPP process and encourage open stakeholder participation. One county noted that while all of its CPP activities were open to all stakeholders, all of its CPP activities were held at the mental health department; this coincided with the county noting that it did not get a lot of stakeholder participation at its CPP activities.

County Size

Rationale: As shown in Table 22, large, medium, and small counties felt that they had done a lot to create safe environments for their CPP processes.

Table 22: County Perceptions of Whether CPP Processes Are Safe Environments and Free of Stigma, Discrimination And Retaliation, by CMHDA Region. [β]

County Size	Average Score of County Response (1 to 5 Scale)
Large (*n* = 13)	4.9
Medium (*n* = 15)	4.7
Small (*n* = 24)	4.8

[β] *SOURCE:* Key Informant Interview

Across large counties, counties reported taking steps to create safe environments for their CPP processes (average of 4.9). Fifteen percent (*n* = 13) of counties conducted their CPP activities at inclusive, neutral, and safe locations. One county provided alternate methods of communication for stakeholders to be able to provide feedback. Fifteen percent (*n* = 13) of counties laid-out ground rules for participation at the beginning of their CPP meetings. One county noted that it had smaller break-out groups at CPP meetings to encourage more open participation from stakeholders. One county noted that it was important to have peers involved at all levels in order to promote trust and more open communication within the community.

Across medium counties, counties took steps to create safe environments for their CPP processes (average of 4.7). Thirty-three percent (*n* = 15) of counties conducted their CPP activities at inclusive, neutral, and safe locations. Twenty percent (*n* = 15) of counties provided alternate methods of communication for stakeholders to be able to provide feedback. Twenty percent (*n* = 15) of counties laid-out ground rules for participation at the beginning of their CPP meetings. One county noted that it had smaller break-out groups at CPP meetings to encourage more open participation from stakeholders.

Small counties reported taking steps to create safe environments for their CPP processes (average of 4.8). Forty-six percent (*n* = 26) of counties conducted their CPP activities at inclusive/neutral/safe locations. Twenty-three percent (*n* = 26) of counties provided alternate methods of communication for stakeholders to be able to provide feedback. Twelve percent (*n* = 26) of counties laid-out ground rules for participation at the beginning of their CPP meetings. One county held social activities, such as BBQs, to encourage informal communication and participation in its CPP process.

AC-07: What do counties do to retain participation?

While counties were not specifically asked to identify strategies for retaining participation, they were asked to identify incentives that were offered to CPP participants in an effort to reduce some of the barriers to attendance (see AC-01B starting on Page 35). These incentives included:

- Transportation to meetings
- Transportation vouchers
- Meals at meetings
- Multiple meeting times
- Stipends/ Other financial incentives
- Childcare
- Continuing education credits/ certificates
- Translation/ interpretation services
- Meetings in languages other than English
- Other incentives

Similarly, both counties and stakeholders were asked to identify methods used to ensure accessibility to CPP meetings (see AC-04 starting on Page 51). These methods included:

- Holding CPP meetings at multiple locations
- Holding CPP meetings at multiple times
- Providing meals at meetings
- Offering stipends
- Hiring capable facilitators
- Providing transportation vouchers
- Providing transportation to meetings
- Coordinating with public transit
- Other methods

Although this data did not directly answer the research question above, understanding which incentives were most commonly used and their perceived effectiveness, and the methods employed by counties to ensure accessibility to CPP meetings, may shed light onto the strategies that counties used to retain participation throughout the CPP process.

AC-08: What do counties do to collect input from participants?

Results

Statewide: Across the state, counties gathered input from CPP participants through a variety of methods. In their MHSA Annual Update plans, 64% of counties (*n* = 49) ranked town hall meetings as the most common activity through which counties collect input from participants. Counties also reported using focus groups (27%), surveys (22%), and key informant interviews (14%). Interestingly, data from the MHSA Annual Update plans showed that 59% of counties (*n* = 51) reported using surveys and questionnaires and 47% reported using focus groups to collect participant input.

Although stakeholders were not asked directly what activities counties used to collect stakeholder input, 66% of stakeholders (*n* = 590) reported participating in an MHSA Planning Committee. Similar percentages of stakeholders (60%) reported participating in an MHSA town hall or community meeting and questionnaire (54%), and participating in an MHSA focus group (43%) to that of counties. A lower percent of stakeholders reported participation in public hearings (44%) than counties did. In discussions, 62% of stakeholders across the state described participating in stakeholder steering committee meetings, but only 15% reported participation town hall or community meetings. Stakeholders also mentioned participating in mental health advisory boards (40%) and informal MHSA-related activities (28%) with some regularity. A lower percent of stakeholders (15%) described participating in town hall and community meetings than statewide data from counties reports.

CMHDA Region: Counties in all five CMHDA Regions reported using public hearings, town hall/community meetings, and other activities as methods for collecting stakeholder input. Public hearings were reported most often among all five CMHDA Regions. Town hall and community meetings also made up a portion of input collection activities reported in the Central (74%), Bay Area (69%), and Los Angeles (100%) regions. Eighty percent of counties in the Central region and 67% of counties in the Southern region reported conducting surveys and questionnaires while smaller percentages reported using surveys in the Bay Area (38%), Los Angeles (0%), and Superior (50%) regions. Focus groups were reported by 53% of counties in the Central region while a slightly less percentage of counties reported focus groups in the Bay Area (46%), Southern (44%), and Superior (43%) regions. Other activities were reported by nearly a third of counties in the Bay Area (31%) and Southern (33%) regions, while lower percentages of counties reported focus groups in the Central (13%) and Superior (14%) regions. Slightly more than 20% of counties in the Central (20%), Southern (22%), and Superior (21%) regions reported using key informant interviews, while only 8% of Bay Area region counties reported using that activity. Suggestions boxes were only used in the Central (20%) and Superior (29%) regions.

Results from stakeholders who were surveyed from each of the CMHDA Regions varied slightly from statewide data. The Southern region stood-out from statewide data; 74% of its stakeholders participated in MHSA Planning Committees, compared to 66% statewide. Similarly, larger percentages of Central region stakeholders (65%) participated in MHSA Planning Committees compared to 54% statewide. Stakeholders and counties agreed on the type of activities they participated in. The only major difference

was the percentage of stakeholders who reported participating in public hearings; this was lower than county results in all CMHDA Regions by at least 20%.

In discussions, stakeholders most frequently mentioned participating in stakeholder steering committees, mental health advisory boards, and informal MHSA-related activities. A large percentage of stakeholders frequently mentioned steering committees as an activity they participated in in the Bay Area (55%), Central (69%), Southern (67%), and Southern (62%) regions. A majority of stakeholders also mentioned they participated in mental health board meetings frequently in the Los Angeles (100%), Southern (89%), and Superior (54%) regions. A portion of stakeholders in the Central (23%) region mentioned participating in a mental health advisory board. Informal MHSA-related activities were mentioned frequently by stakeholders from counties in the Superior (54%) and Central (38%) regions. Stakeholders from the Bay Area (18%), Central (15%), Southern (11%), and Superior (15%) regions mentioned participating in town hall and community meetings less frequently than was reported by counties in each of those regions.

County Size: Among counties of similar sizes, there was little variation in terms of how differently-sized counties collect stakeholder input. Regardless of size, counties reported public hearings and town hall and community meetings as the most frequently reported type of activity conducted by counties to collect stakeholder input. Use of public hearings as way to collect stakeholder input varied across counties of different sizes. Public hearings were reported the most among large counties (92%) and small counties reported the public hearings the least (77%). The percent of counties that reported other activities varied among medium (43%), large (33%), and small (23%) counties. Similarly, the number of counties that reported using key informant interviews also varied; small counties reported it most frequently (19%), followed by large counties (17%), while medium counties reported using this approach 7% of the time.

Overall, participation among stakeholders from counties of different sizes aligned with the percentages of counties that reported input collection activities. Stakeholders reported participating in MHSA program planning committees and town hall meetings most often. Small counties stood out when the number of counties that reported using surveys and questionnaires exceeded (55%) the number of small counties reporting attending a town hall or community meeting.

In discussions, participation in steering committees was more frequently mentioned by stakeholders in medium counties (85%) compared to large (54%) and small (52%) counties. Among large counties, 54% reported participating in mental health advisory boards, while 38% of small counties and 31% of medium counties reported participating in this CPP activity. Interestingly, informal MHSA-related activities were reported by 48% of stakeholder groups from small counties, which is second only to the percent of small county stakeholders that participated in steering committees (52%) in terms of stakeholder participation among small counties.

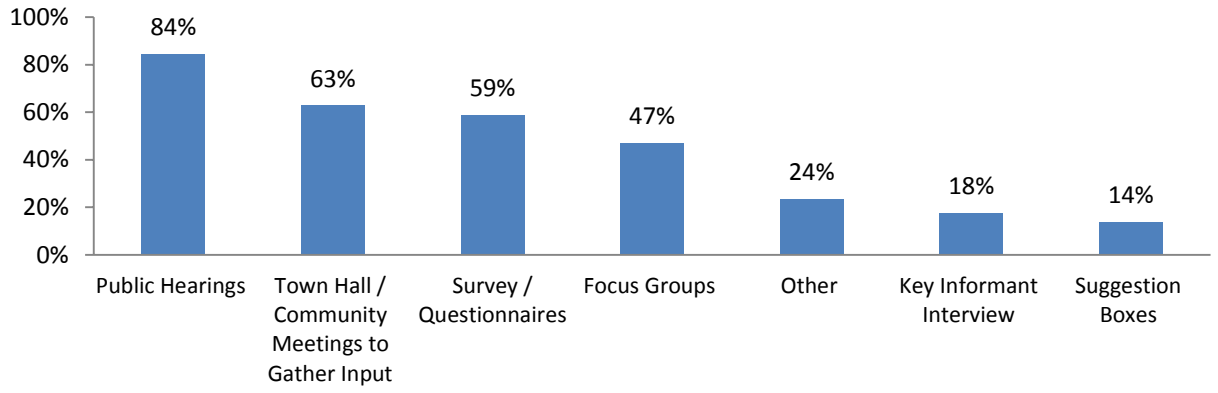
Statewide

Rationale: In order to understand what counties do to collect input from participants, the evaluation team analyzed statewide data from County Web-based Data Requests, Annual Update Document Review, Stakeholder Focus Groups, and Stakeholder Surveys. Figure 32 depicts the input collection activities that counties reported conducting during planning for 2012/2013 annual update. Public hearings (84%, *n* = 51)

were reported by the greatest number of counties, and suggestion boxes (14%) were reported by the least number of counties. Town hall and community meetings (63%) and surveys (59%) were reported by a majority of the counties that answered, while focus groups (47%), other (24%), and key informant interviews (18%) were reported by fewer numbers of counties.

Figure 32: Activities Conducted by Counties to Collect Stakeholder Input for CPP Processes, Statewide[ϕ]

(*n* = 51)

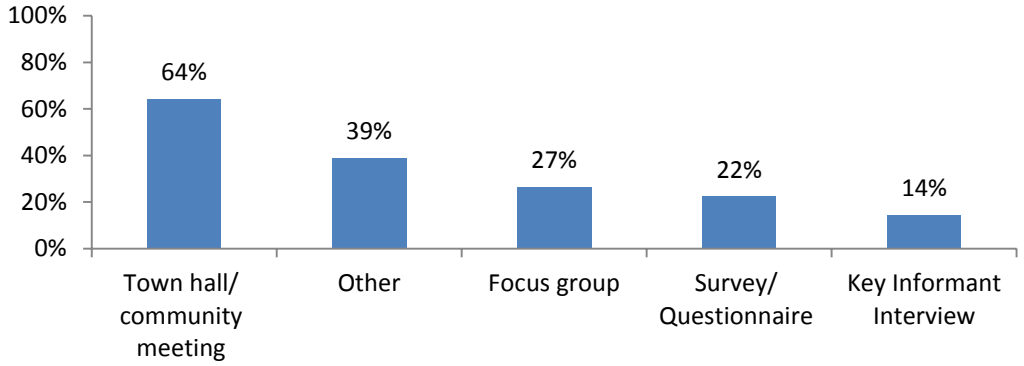


[ϕ] *SOURCE*: County Web-Based Data Requestrted by a portion of counties.

Figure 33 provides data from MHSA Annual Update plans regarding the types of activities used by counties to collect stakeholder input. Town hall and community meetings (64%, *n* = 49) were reported the most while MHSA/CPP Coordinators reported among the lowest number of counties (14%). Other activities (39%), focus groups (27%), and surveys and questionnaires (22%) were also reported by a portion of counties.

Figure 33: Activities to Collect Stakeholder Input Reported by Counties in the MHSA Annual Update Report, FY 2012-2013, Statewide [μ]

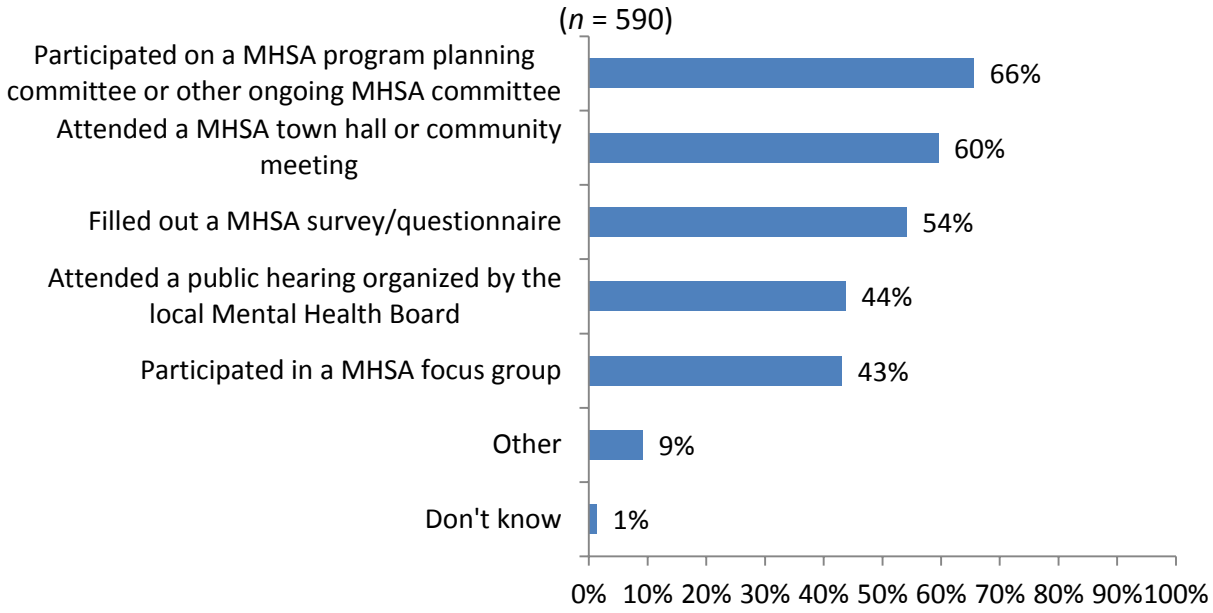
(n = 49)



[μ]*SOURCE:* Annual Update Document Review

Figure 34 illustrates the types of activities that stakeholders reported participating in. The largest number of stakeholders (66%, *n* = 590) reported participating in MHSA program planning committees and the least number of participants reported other activities (9%) or didn't know (1%). More than a majority of responding stakeholders reported attending town hall or community meetings (60%) and filling-out a MHSA survey or questionnaire (54%). Large portions of stakeholders also reported attending public hearings (44%) and participating in MHSA focus groups (43%).

Figure 34: CPP Activities Stakeholder Participated in FY 12/13, Statewide [δ]



[δ]*SOURCE:* Stakeholder Survey

Stakeholders who participated in stakeholder focus groups were asked "what types of community program planning activities do you participate in and how often?" A total of 46 counties provided stakeholder responses for this question. Stakeholders frequently mentioned participating in stakeholder steering committees in 63% (*n* = 46) of focus groups. Stakeholders mentioned participating in mental health advisory boards in 41% (*n* = 46) of focus groups. Twenty-eight percent (*n* = 46) of focus groups mentioned participating in informal MHSA related activities. MHSA-related activities referred to informal activities such as BBQs, social gathering, and community based activities that were related to CPP processes. Fewer counts of stakeholder focus groups reported participation in community town hall and community meetings (15%), advocacy groups (15%), and public campaigns (6%).[Δ]

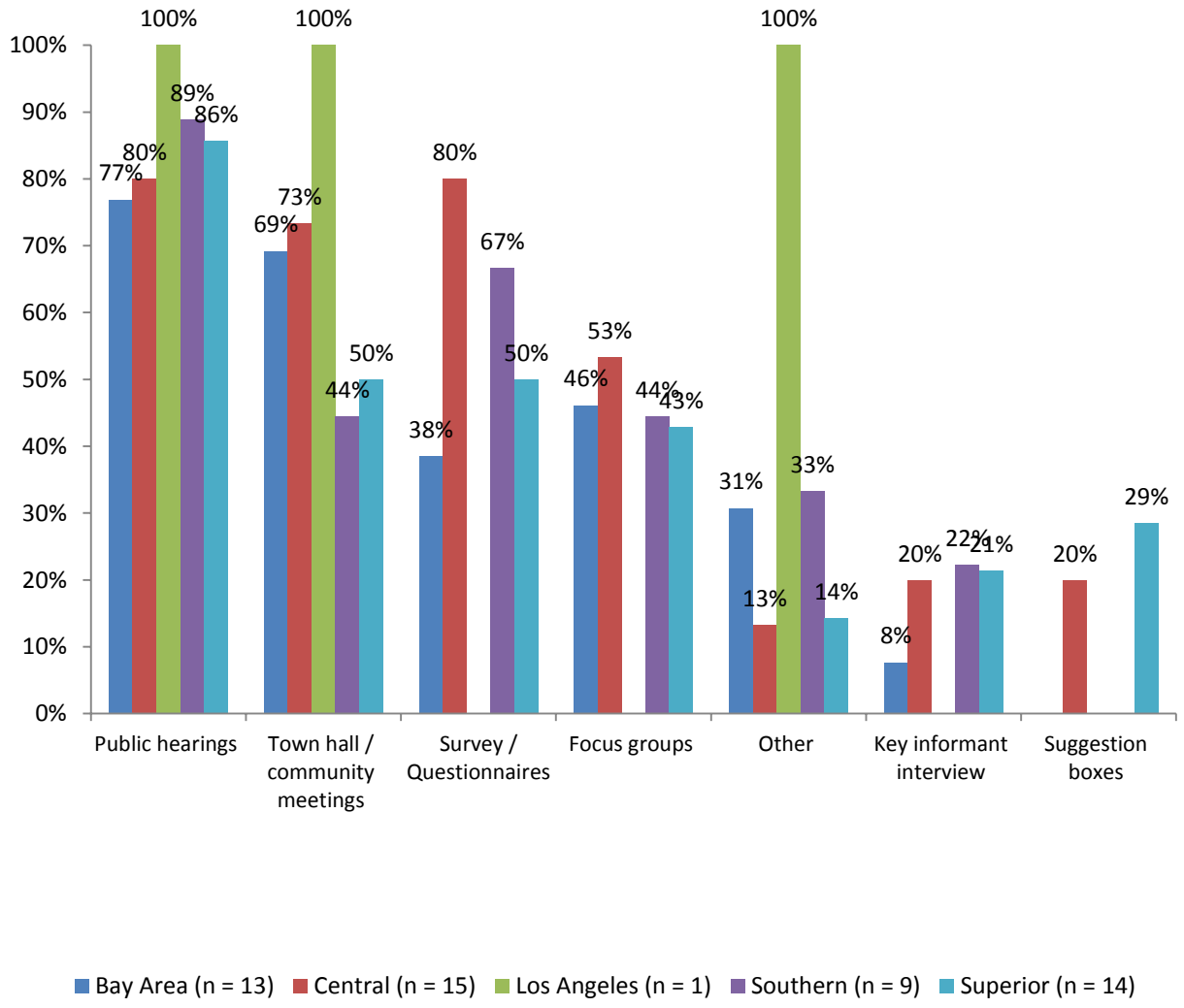
CMHDA Region

Rationale: Across CMHDA Regions, counties reported a variety of activities used to collect stakeholder input for CPP planning. .

Figure 35 depicts the percentage of activities that counties in each CMHDA Region reported. Overall, CMHDA Region data varied slightly from statewide data. The n-values for each region represented the

number of counties that responded to this question. A large percentage of counties in the Central (80%) and Southern (67%) regions reported using surveys and questionnaires compared to the Bay Area (38%), Los Angeles (0%), and Superior (50%) regions. Lower percentages of counties in the Southern (44%) and Superior (50%) regions reported using town hall and community meetings. Suggestion boxes were only used in the Central (20%) and Superior (29%) regions among a small portion of counties. With an n-value of 1, any activity reported by the Los Angeles region represented the sole county reporting there.

Figure 35: Activities Conducted by Counties to Collect Stakeholder Input for CPP processes, by CMHDA Region [ϕ]

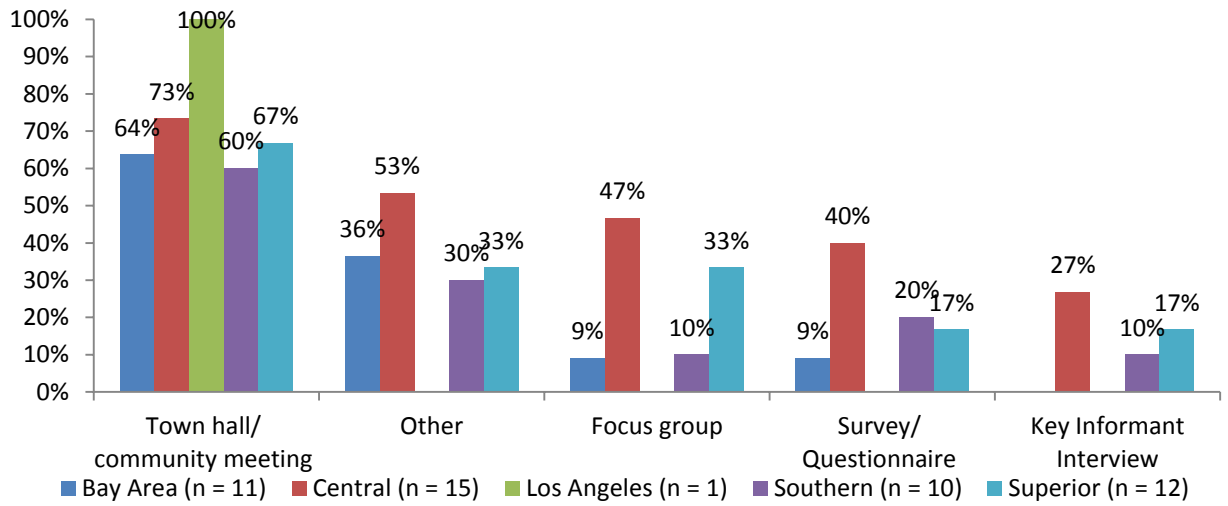


[ϕ]*SOURCE:* County Web-Based Data Request

Data collected from counties' 2012-2013 MHSA Annual Update plans showed more variation between each of the five CMHDA Regions. The Central region had consistently high percentages of counties that reported each activity whereas the Bay Area and Southern regions tended to report lower percentages of counties for each activity. Los Angeles only reported using town hall and community meetings. The Bay

Area region reported the least variation in input collection activities (with the Los Angeles region being an exception) only reported using town hall and community meetings (64%), other activities (36%), focus groups (9%), and surveys (9%).

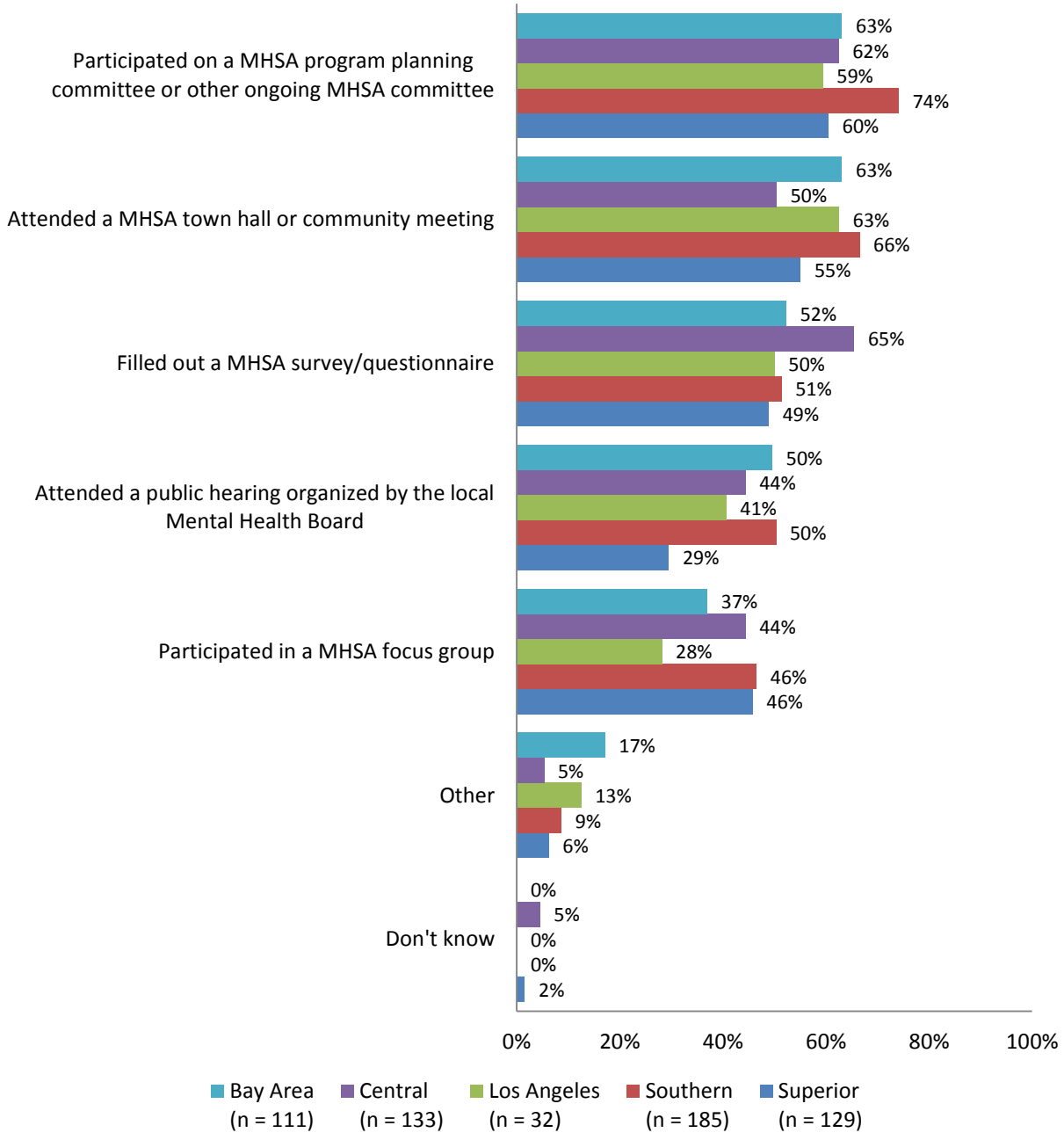
Figure 36: Activities Conducted to Gather Stakeholder Input in FY 2012-2013, by CMHDA Region [µ]



[µ]*SOURCE:* Annual Update Document Review

Figure 37 shows types of activities that the surveyed stakeholders reported participating in. The n-values for each of the CMHDA Regions represented the number of stakeholders from counties in each of the regions of that answered this question. Similar to statewide findings, a majority of the stakeholders in each of the CMHDA Regions reported participating in MHSA program planning committees, town hall and community meetings, and filling out questionnaires. The stakeholders from the Southern region that reported participating in an MHSA program planning committee (74%) stood out as having the highest percentage of stakeholders in any activity. A much greater percentage (65%) of stakeholders in the Central region reported filling out a questionnaire. A much smaller percentage (29%) of stakeholders in the Superior region reported attending a mental health board public hearing compared stakeholders from the other four CMHDA Regions. Similarly, a smaller percentage (28%) of stakeholders from the Los Angeles region reported participation in a focus group compare to the other four CMHDA Regions.

Figure 37: Participation in CPP Activities Reported by Stakeholders, by CMHDA Region [δ]



[δ]*SOURCE:* Stakeholder Survey

Stakeholders focus groups from the Bay Area (*n* = 11), Central (*n* = 13), Los Angeles (*n* = 1), Southern (*n* = 9), and Superior (*n* = 13) regions described a variety of activities that allowed them to participate in CPP processes. Large percentages of stakeholders frequently mentioned steering committees as an activity they participate in the Bay Area (55%), Central (69%), Southern (67%), and Superior (62%) regions. A majority of Stakeholders in the Los Angeles (100%), Southern (89%), and Superior (54%) regions also mentioned that they participated in mental health board meetings frequently. A portion of stakeholders

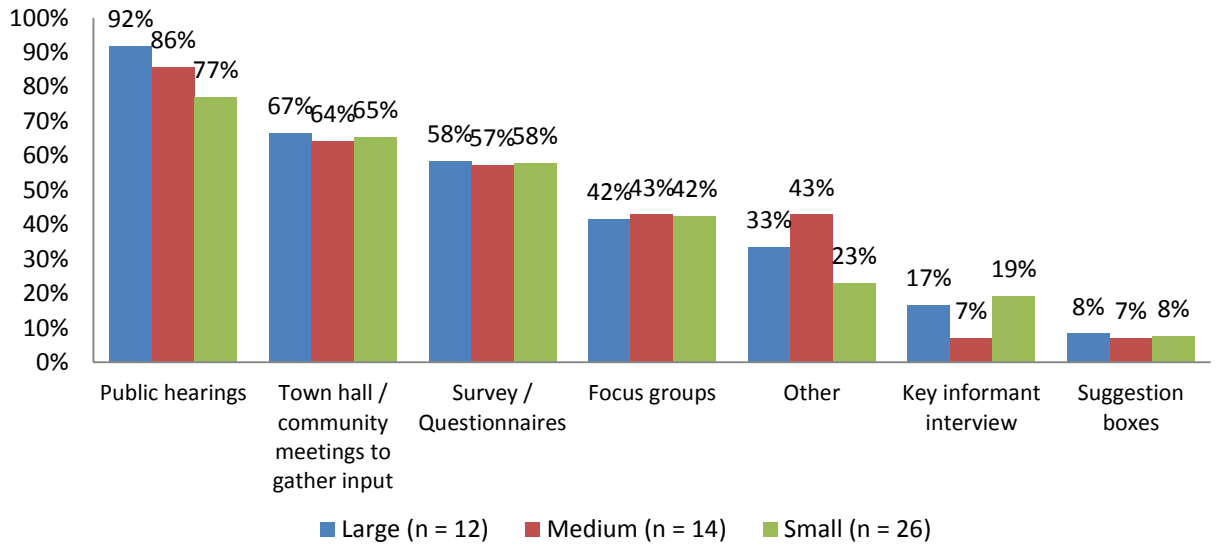
in the Central (23%) region mentioned participating in mental health advisory boards. Informal MHSA-related activities were mentioned by frequently by stakeholders from counties in the Superior (54%) and Central (38%) regions. In discussions, stakeholders from the Bay Area (18%), Central (15%), Southern (11%), and Superior (15%) regions mentioned participating in town hall and community meetings less frequently than reported statewide. Stakeholders also described participating in advocacy groups among counties in the Bay Area (36%), Central (15%), and Superior (8%) regions. Stakeholders from two counties in the Bay Area region and one county in the Superior region mentioned public campaigns.[Δ]

County Size

Rationale: What counties do to collect input from stakeholders varied by county size. Figure 38 illustrates the types of input collection activities reported by counties of similar sizes. The n-values for each county size represented the number counties of that size that provided any data on input collection activities. Among counties of similar sizes, there was little variation in terms of how differently sized counties collect stakeholder input. Regardless of size, the majority of counties reported using public hearings and town hall and community meetings as an activity to collect stakeholder input. Among large counties, 92% reported using public hearing, followed by medium counties (86%). Small counties had the lowest percentage of counties (77%) that reported using public hearings. The percent of small counties that used public hearings was also lower than the statewide percentage (84%). The percent of counties that reported other activities varied among medium (43%), large (33%), and small (23%) counties. Similarly, counties that reported using key informant interviews also varied; the highest percent was among small counties (19%), followed by large (17%) and medium (7%) counties.

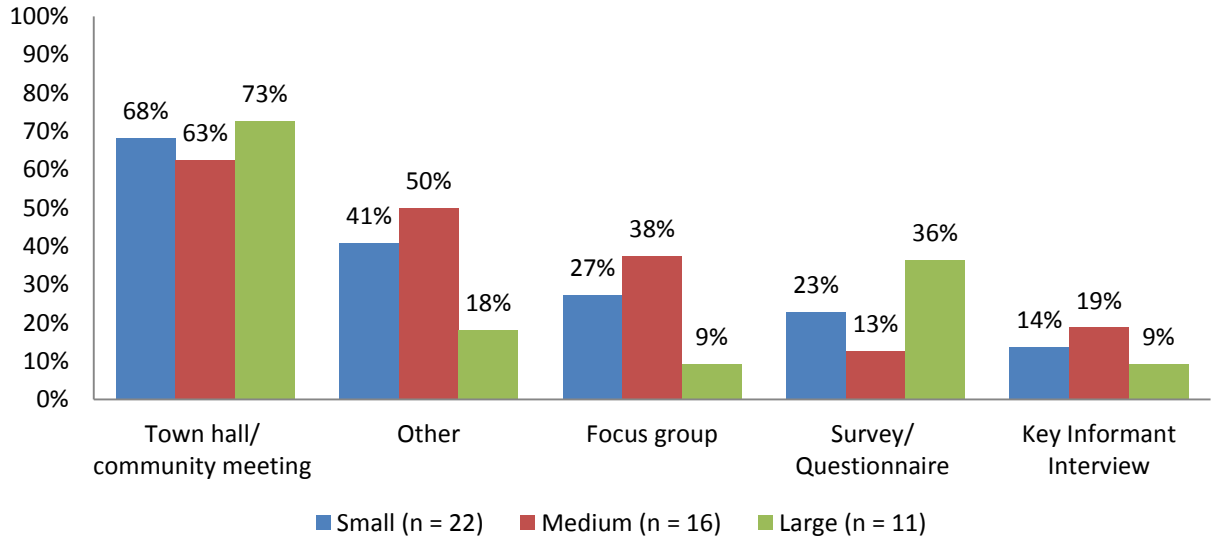
Figure 39 illustrates the input collection activities counties recorded in their 2012-2013 MHSA Annual Update. The n-values for large, medium, and small counties represented the number of counties of that size that provided data on input collection activities recorded in their MHSA Annual Update plan. The use of certain activities varied based on the size of the county. The majority of large (68%), medium (62%), and small (73%) counties reported using town hall meetings. Using key informant interviews was reported by the lowest percentage of counties in among large (14%), medium (19%), and small (9%) counties. Small counties reported using surveys and questionnaires (36%) more than focus groups (9%) and other activities (18%). Conversely, higher percentages of large and medium counties reported using other activities (41% and 50%, respectively) than focus groups (27% and 38%, respectively) and surveys and questionnaires (23% and 13%, respectively).

Figure 38: Input Activities Reported by Counties in the 2012/13 Annual Update, by County Size [ϕ]



[ϕ]*SOURCE:* County Web-Based Data Request

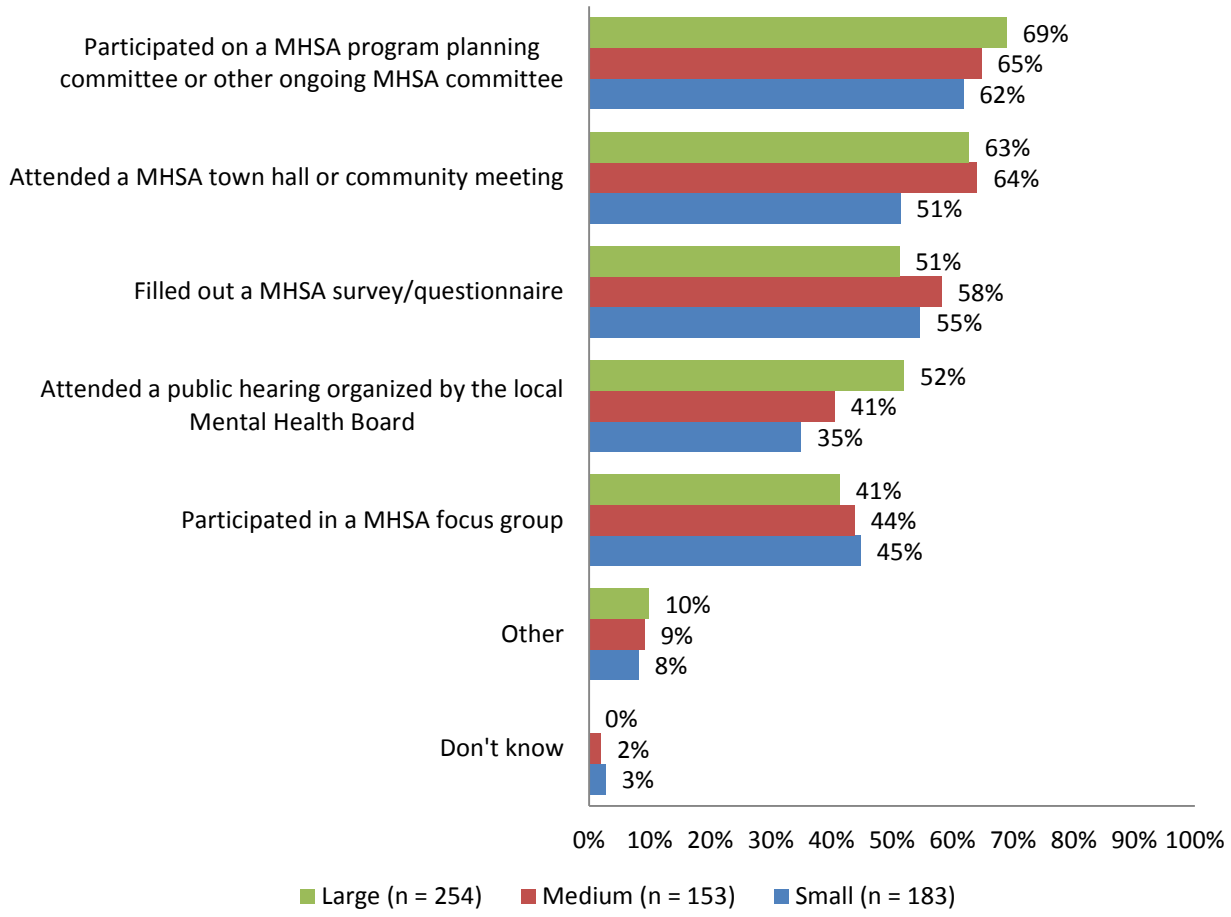
Figure 39: Activities Conducted to Gather Stakeholder Input in FY 2012-2013, by County Size [μ]



[μ]*SOURCE:* Annual Update Document Review

Figure 40 depicts the types of activities that stakeholders reported participating in. Overall, participation among stakeholders from counties of different sizes aligned with the percentages of counties that reported input collection activities. Stakeholders reported participating in MHSA program planning committees and town hall meetings most often. The smallest percentages of stakeholders selected other activities among small, medium and large counties. The percentage of stakeholders that attended a public hearing varied the most between large (52%), medium (41%), and small (35%) counties.

Figure 40: Participation in Various CPP Activities, by County Size [δ]



[δ]*SOURCE:* Stakeholder Survey

Stakeholders from large (*n* = 13), medium (*n* = 13), and small (*n* = 21) counties described a variety of CPP activities that they participated in. Stakeholder steering committees were most common in medium counties (85%) compared to a large (54%) and small (52%) counties. Among large counties, 54% reported participating in mental health advisory boards, while 38% of small counties and 31% of medium counties reported participating in mental health advisory boards. Informal MHSA-related activities were common among small (48%) and medium counties (23%). Participation in advocacy groups was also mentioned by a smaller portion of stakeholders in large (23%), medium (15%), and small (10%) counties. Town hall meetings were only mentioned by stakeholders in a small number of medium (8%) and small (29%) counties. Participation in public campaigns were mentioned by stakeholders in one county among each of the county size categories.[Δ]

AC-09: Do counties post draft annual updates and 3-Year Program and expenditure plans for 30-day public comment period, and does the Local Mental Health Board conduct a public hearing? Does the annual update include a summary and analysis of substantive recommendations and a description of methods used to circulate the plan?

Results

Statewide: Nearly all counties reported providing a 30-day posting of their Annual Update plans (96%) and holding a public hearing to review the plans (92%). Counties most commonly distributed their plans and solicited public comments by posting them on their website (93%) in addition to a variety of other methods, such as posting hard copies in county offices and clinics (44%), emailing stakeholders (42%), posting to local libraries (31%), and making announcements through news outlets (31%). About half (53%) of counties incorporated public comments into the final draft of their Annual Update plans, while a quarter (27%) of counties reported that they did not receive substantive comments to incorporate.

CMHDA Region: All the counties in the Central, Los Angeles, and Superior regions reported providing a 30-day posting of their Annual Update plans while 90% of counties in the Bay Area and Southern regions reported doing so. The majority of counties in these regions also held public hearings to review their plans. The Bay Area region was the only region in which one or more counties (9%) did not hold such a public hearing. The majority of counties reported posting their Annual Update plans and soliciting public comments through their websites, including all Bay Area and Los Angeles counties. There was some variation among the CMHDA Regions in the types of distribution methods and the usage frequency of each method. Aside from the Los Angeles region, which reported incorporating public comments into its Annual Update plan's final draft, about half of the counties in the other four CMHDA Regions reported incorporating feedback into the final drafts of their plans.

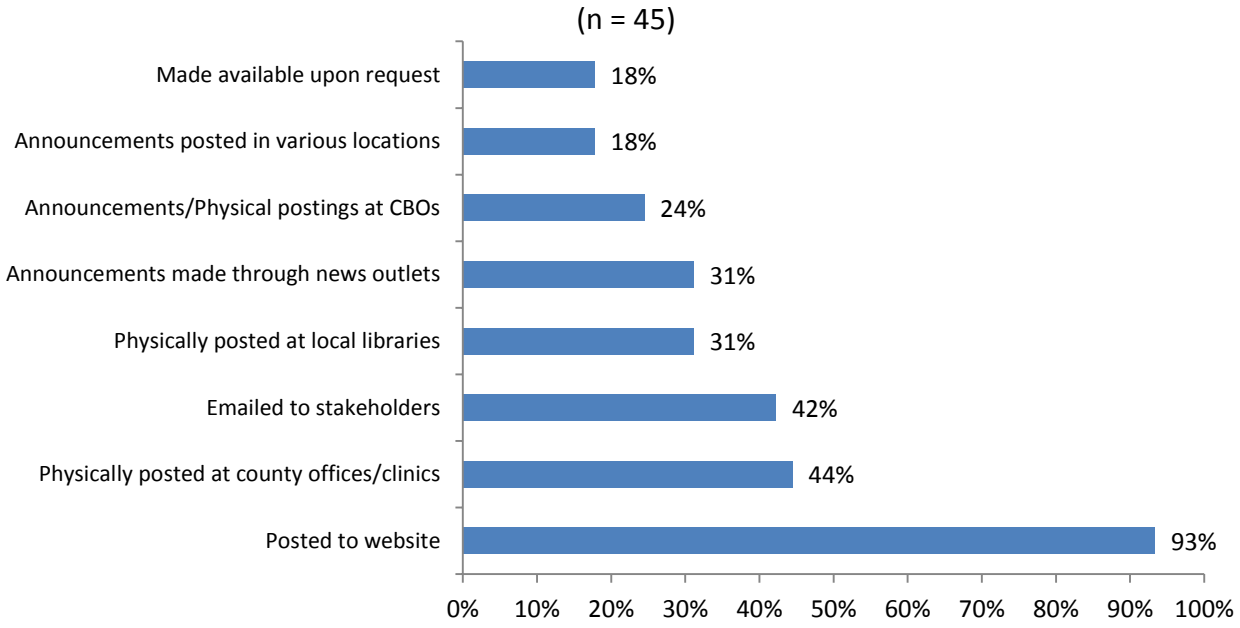
County Size: All small counties (*n* = 22) reported providing a 30-day posting and holding a public hearing to review their Annual Update plans. Further, small counties typically used more distribution methods at greater frequencies to disseminate their plans and solicit feedback than counties of other sizes. Additionally, a greater proportion of small counties (55%) reported incorporating public comments into their final plans than counties of other sizes. An area of noticeable difference between medium and large counties was in the various methods of plan distribution used and the frequency of usage. Medium counties (*n* = 16) typically relied on posting the plans to their websites (100%) and emailing stakeholders (71%), whereas large counties (*n* = 9) relied on positing to their websites (78%) and using other methods much less frequently (33% or fewer). There were minimal other differences between medium and large counties in these areas of Annual Update plan posting, reviewing, and revising.

Statewide

Rationale: In the Annual Update Document Review, the evaluation team discovered that about 96% of the 49 counties with a FY 2012-13 Annual Update Plan explicitly reported providing a 30-day posting and commenting period. It was unknown if the remaining 4% of counties provided a 30-day posting or not. Counties that did provide a 30-day posting typically sent the plan to the local mental health board and nearly all counties (93%) posted their Annual Update plans to their websites. Beyond that, methods for

plan distribution and public comment solicitation varied (see Figure 41). Additionally, 92% of counties reported holding a public hearing to review their Annual Update plans, 2% did not hold a public hearing, and the remaining 6% did not indicate if they held a public hearing.

Figure 41: Annual Update Distribution Methods in FY 2012-2013, Statewide [μ]



[μ] *SOURCE*: Annual Update Document Review

CMHDA Region

Rationale: All counties with a FY 2012-13 Annual Update plan explicitly reported providing a 30-day posting, with the exception of 9% of those in the Bay Area region and 10% of those in the Southern region for whom it was unknown in the Annual Update Document Review if the counties provided a 30-day posting or not (see

Table 23).

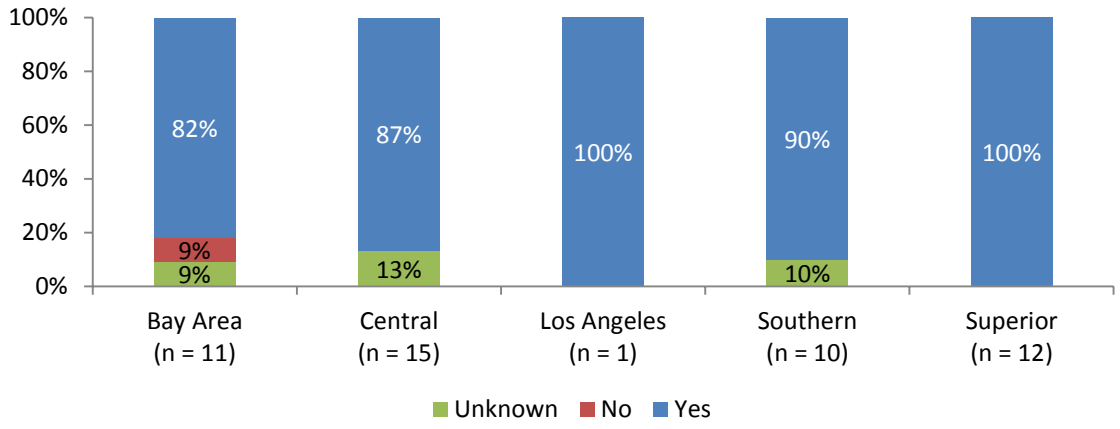
Table 23: Execution of a 30-day posting of the Annual Update, by CMHDA Region [µ]

	Yes	No	Unknown
Bay Area (*n* = 11)	91%	0%	9%
	"The draft plan was distributed to the Local Mental Health Board, contractors, and to stakeholders. It was also posted on our Internet site, and made available in hard copy to anyone who requested it. We placed ads in our local newspapers to inform the community at large of its availability."		
Central (*n* = 15)	100%	0%	0%
	"A copy was posted on the county website. Hard copies of the plan were available at all County public libraries, 3 mental health offices, the County Administration Building, and County Social Services."		
Los Angeles (*n* = 1)	100%	0%	0%
	"Posted on the LA County Department of Mental Health website."		
Southern (*n* = 10)	90%	0%	10%
	"A public notice was posted in the [local newspaper] and sent to other local media. The draft Annual Update was also posted on the County Mental Health Services website and distributed by email to over 500 stakeholders. In addition, copies were made available at each Mental Health Services clinic and all County libraries."		
Superior (*n* = 12)	100%	0%	0%
	"Posted on the County website, distributed to all active stakeholders via email, and made available in hard copy at department clinics, the peer support center, and the tribal wellness center by mail or by request."		

[µ] SOURCE: Annual Update Document Review

As depicted in Figure 42, nearly all counties across all CMHDA Regions reported hosting a public hearing to review their Annual Update. According to the Annual Update Document Review, about 9% of the counties in the Bay Area region (*n* = 11) explicitly stated that they did not hold a public hearing while it was unclear if another 9% held a public hearing or not. It was also unclear if 13% of the counties in the Central region (*n* = 15) and 10% of the counties in the Southern region (*n* = 10) held a public hearing.

Figure 42: Execution of public hearing of the Annual Update, by CMHDA Region [μ]

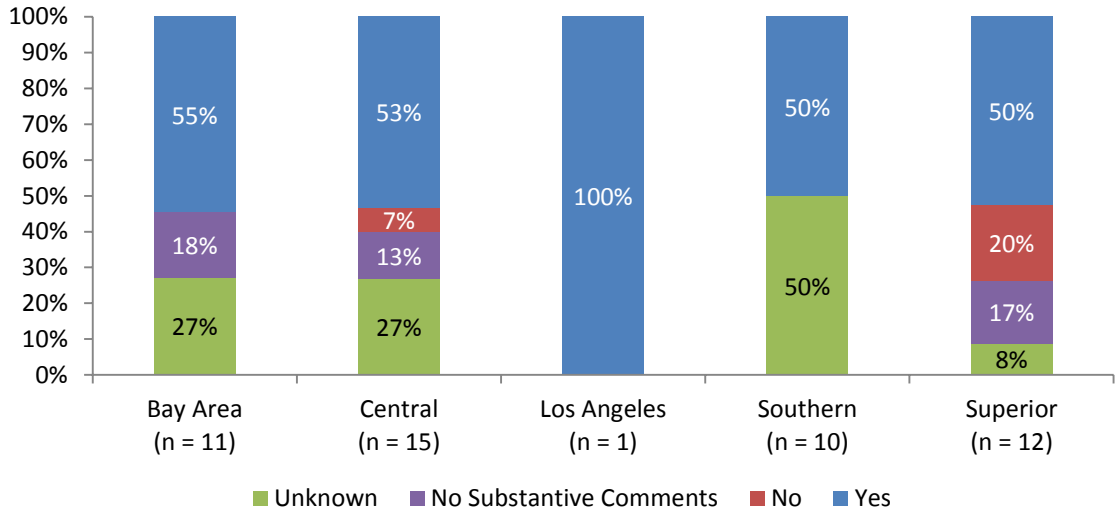


[μ] *SOURCE*: Annual Update Document Review

Once public comments were gathered following the 30-day posting and public hearing, the Los Angeles region (*n* = 1) reported incorporating public feedback and comments in the final draft of its Annual Update plan; about half the counties in the remaining four regions also reported doing this (see

Figure 43). In the Southern region (*n* = 15), while 50% of the counties reported incorporating public feedback and comments, it was unclear if the remaining 50% did this or not. The Central (*n* = 15) and Superior (*n* = 12) regions were the only regions with counties that did not incorporate public feedback and comments in their final plans. Meanwhile, outside of the Los Angeles region, the Bay Area region (*n* = 11) had the greatest proportion of counties reporting that they did incorporate public comments in their final plans (55%).

Figure 43: Public Hearing Incorporation into Final Draft of the Annual Update plan, by CMHDA Region [μ]

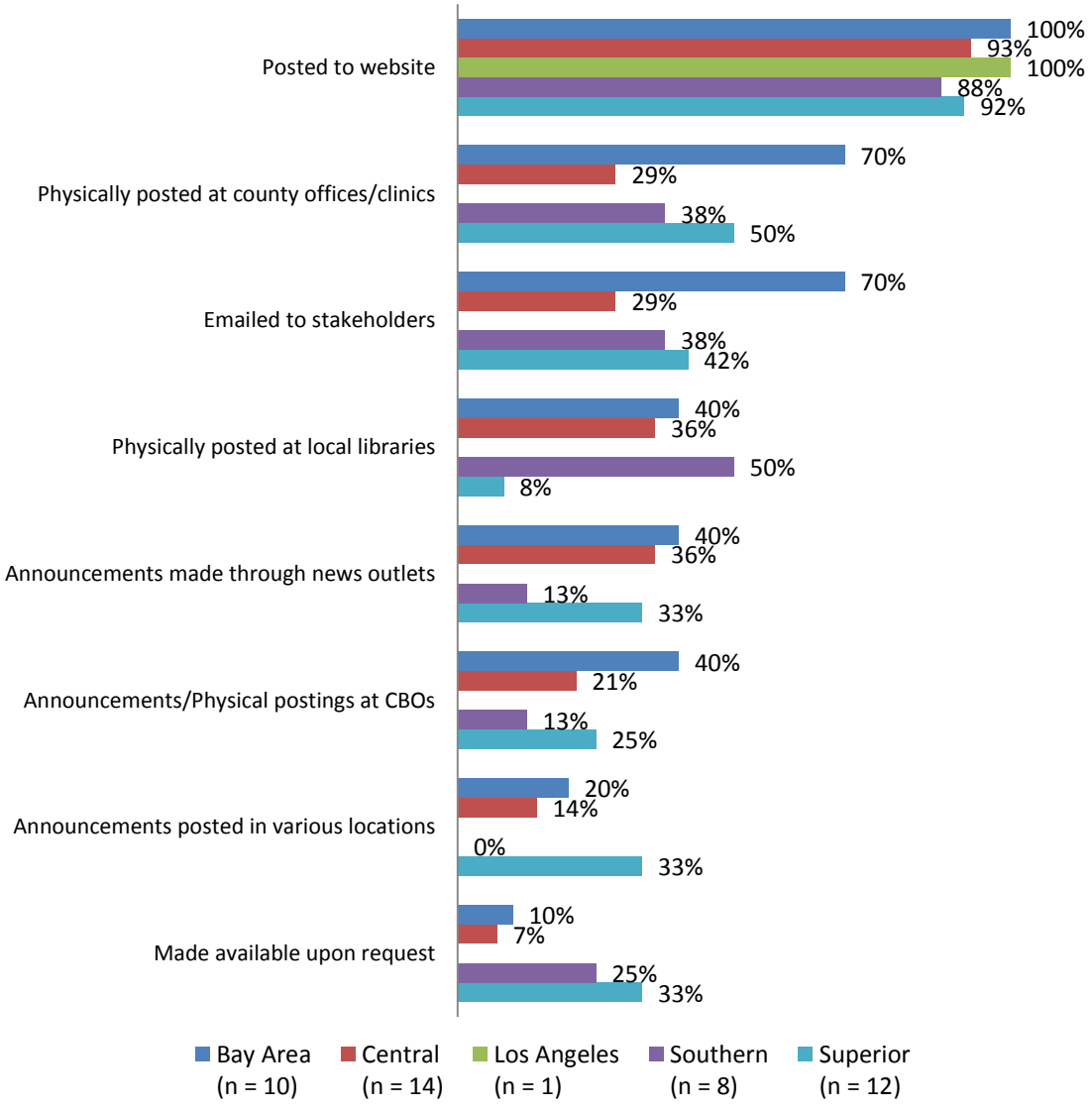


[µ] *SOURCE*: Annual Update Document Review

The Los Angeles region only reported using their website to distribute its plan. Moreover, counties in the Bay Area region used fewer methods of distribution and solicitation, relying on their website (100%), emails to stakeholders (70%), and physical postings to county offices (70%), as shown in

Figure 44. Counties in the Superior region reported using multiple methods at consistently higher frequencies than counties in other CMHDA Regions (typically 33% and above). For example, counties in the Central region also used many methods, but at frequencies typically at 36% and below.

Figure 44: Annual Update Distribution Methods in FY 2012-2013, by CMHDA Region [µ]



[µ] *SOURCE*: Annual Update Document Review

County Size

Rationale: The Annual Update Document Review showed that all small counties (*n* = 22) explicitly reported a 30-day posting of their Annual Update plans (see Table 24). None of the counties explicitly reported not providing a 30-day posting; among medium (*n* = 16) and large (*n* = 11) counties, it was unclear if one or more counties provided a 30-day posting or not.

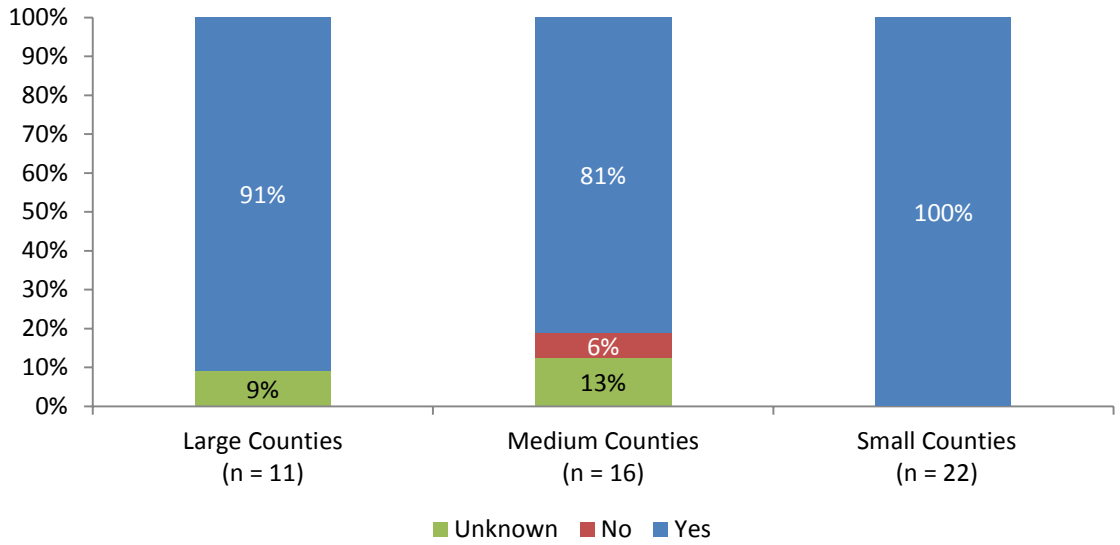
Table 24: Execution of a 30-day posting of the Annual Update, by County Size[µ]

	Yes	No	Unknown
Small (*n* = 22)	100%	0%	0%
	"The plan was posted on the county/agency website. Public Notice was in the local media announcing availability of the plan. Copies were also made available at the local library, County Behavioral Health and County Administrative Office."		
Medium (*n* = 16)	94%	0%	6%
	"An electronic copy was posted on the County's MHSA website, paper copies were sent to County Public Library resource desks, electronic notification was sent to BHRS service sites with a link to the report, public notice was posted in nine newspapers throughout the County, an announcement was posted on the BHRS Cultural Competency Newsletter and the NAMI Newsletter."		
Large (*n* = 11)	91%	0%	9%
	"The Draft Plan Update and Feedback Forms were available in English and Spanish and posted on the Department website, at county clinics, disseminated to all county libraries as well as distributed through the Mental Health Board and all MHSA Planning Committees."		

[µ] *SOURCE*: Annual Update Document Review

All small counties (*n* = 22) reported holding a public hearing to review their Annual Update plans, followed by 91% of large counties (*n* = 11); the remaining 9% of which did not state whether or not a public hearing was held (see Figure 45). Finally, 81% of medium counties (*n* = 16) stated that they held a public hearing, while 6% stated that they did not hold a public hearing, and the remaining 13% did not state such either.

Figure 45: Execution of a public hearing of the Annual Update, by County Size [μ]

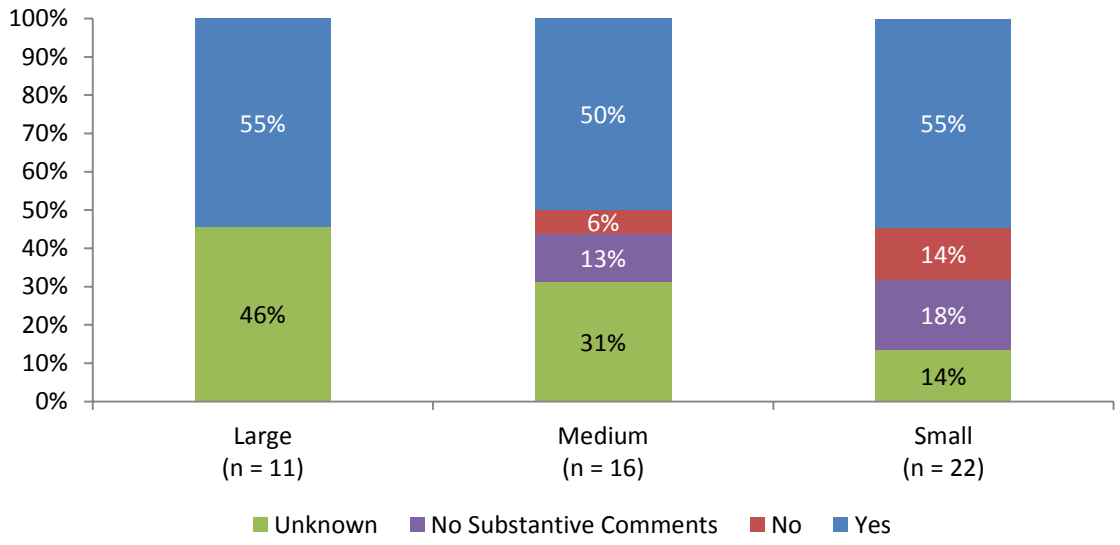


[μ] *SOURCE*: Annual Update Document Review

Once public feedback and comments were gathered from the 30-day posting and public hearing, 55% of small (*n* = 22) and large (*n* = 11) counties and 50% of medium counties (*n* = 16) reported incorporating the feedback and comments into the final draft of their Annual Update plans. However, among the remaining half of counties who did not explicitly incorporate public comments into their final plans, there were noticeable differences between counties of different sizes. Among the remaining 46% of large counties, it was unclear if public comments were incorporated into their final plans. Of the remaining half of medium counties, 6% stated that they did not incorporate public feedback into the final plan, 13% stated that the public comments were non-substantive, and it was unclear if 31% of the counties incorporated comments or not. Of the remaining 45% of small counties, 14% explicitly stated that public comments were not incorporated into final plans, 18% stated that comments were non-substantive, and it was unclear if 14% of the counties incorporated public comments or not.

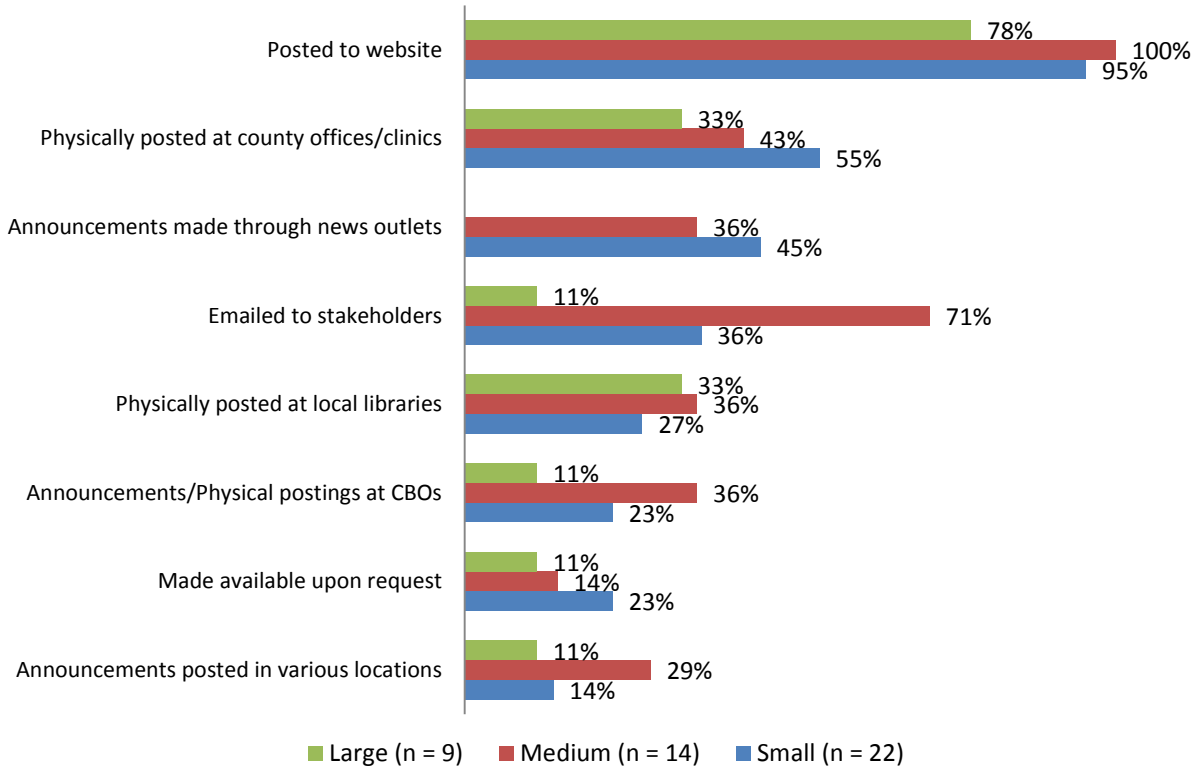
To distribute drafts of their Annual Update plans and solicit public feedback, most of the counties relied on posting the plans to their websites. However, there were many other methods used as well, and the frequency of using these other methods varied between counties of different sizes. Large counties (*n* = 9) relied on posting the plans to their websites (78%) and posting to public buildings as suggested by the MHSOAC (33%), but using other methods much less frequently (11% or less). Medium counties (*n* = 16) typically relied on posting the plans to their websites (100%) and emailing stakeholders (71%), typically using other methods at even rates (about 36% frequency). Small counties also relied on positing the plans to their websites (95%), but engaged in many other distribution methods at varying frequencies.

Figure 46: Incorporation of Public Hearing Feedback into Final Draft of the Annual Update plan, by County Size [µ]



[µ] *SOURCE*: Annual Update Document Review

Figure 47: Annual Update Distribution Methods in FY 2012-2013, by County Size [µ]



[µ] *SOURCE*: Annual Update Document Review

AC-10: How is participation and input documented by the county?

Note: These results focus on stakeholder input that was provided during counties' public commenting periods once the Annual Update plans had been drafted, not during counties' CPP processes.

Results

Statewide: Counties documented CPP participation and input by recording and publishing input, comments, and responses in their Annual Update plans.

CMHDA Region: There were slight differences in how counties from different CMHDA Regions documented, responded to, and incorporated stakeholder input into their Annual Update plans.

County Size: None of the small counties received substantive comments; therefore, none adjusted their plans based on public feedback. Medium counties reported receiving comments for substantive changes to program information and updated their plans accordingly, but no substantive program changes resulted from public comment. Large counties reported noting, responding to, and recording comments in their Annual Update plans.

Statewide

Rationale: The County MHSA/CPP Coordinators noted that stakeholders' participation and input during CPP processes were documented by recording and publishing input, comments, and responses in counties' Annual Update plans. According to the Annual Update Document Review, only five counties reported the number of participants that they had in attendance at public hearings of their Annual Update plans. The total number of participants at public hearings at these counties ranged from nine to "over 60" stakeholders. Further, only 15 counties reported having received public comments, ranging from one to 87 comments per county. Fewer than five counties explicitly stated that concerns were individually addressed and/or were slated for inclusion in the next Annual Update plan. Based on the comments received, counties reported that they either made no changes or that changes made were not substantive and included adjustments such as corrected program information.

CMHDA Region

Rationale: While counties reported hosting public hearings and documenting stakeholder input, there were differences in how this was done from one CMHDA Region to the next, suggesting that there was no uniform method. Based on the Annual Update Document Review, counties in the Central and Los Angeles regions were less specific about how comments were addressed, simply stating that the comments were "noted." Counties from the Bay Area, Southern, and Superior regions reported addressing comments in some way, but did not provide further clarifications.

Table 25 details the average number of public hearing participants and average number of public comments received per reporting region, as well as an example of how counties reported using stakeholder input.

Table 25: Public Hearing Participants and Comments, by CMHDA Region [µ]

	Average # Public Hearing Participants	Average # Comments Received
Bay Area (*n* = 11)	50 (*n* = 2)	7 (*n* = 3)
	"Comments received individual responses, ranging from 'MHSUS will analyze this more closely for upcoming MHSA planning processes' to 'MHSUS will include that in the next Annual Update.'" "Changes have been made to the report correcting information in the draft. These changes do not represent substantive changes in the content of the report nor services provided to the public."	
Central (*n* = 15)	11 (*n* = 2)	Not specified
	"Comments were noted for future planning."	
Los Angeles County (*n* = 1)	Not reported	Not reported
	"Comments were noted."	
Southern (*n* = 10)	Not reported	Large range: 1 – 87 (*n* = 4)
	"Comments were reviewed at the public hearing. Department staff reported which aspects of the stakeholder's concerns would be addressed."	
Superior (*n* = 12)	11 (*n* = 1)	5 (*n* = 4)
	"Based on comments, additional data and information was added to the document." "No comments called for substantial changes to the plan."	

[µ] *SOURCE*: Annual Update Document Review

County Size

Rationale: According to the Annual Update Document Review, based on the counties that reported receiving and addressing stakeholder input, there were slight differences in how this was done across counties of different sizes. None of the small counties received substantive comments; therefore, none adjusted their Annual Update plans based on public feedback. Medium counties reported receiving comments for substantive changes to program information and updated their plans accordingly; no substantive program changes resulted from public comment. Large counties did not report how many participants were in attendance at public hearings, nor did they report the numbers of comments receive; however, a few large counties reported documenting stakeholder feedback in the final draft of their Annual Update plans, editing language as appropriate without making substantive changes.

Table 26: Public Hearing Participants and Comments, by County Size [μ]

	Average # Public Hearing Participants	Average # Comments Received
Small (*n* = 22)	11 (*n* = 3)	4 (*n* = 6)
	"Comments were responded to individually, as needed."	
Medium (*n* = 16)	50 (*n* = 2)	34 (*n* = 4)
	"Comments were addressed individually and were included (with both question/comment and response) in the Annual Update."	
Large (*n* = 11)	Not reported	Not reported
	"All input, comments, and Board recommendations were documented and included in the Annual Update."	

[μ] *SOURCE*: Annual Update Document Review

AC-A: How was input used to inform the development of the 2012/2013 Annual Updates?

Results

Statewide: Stakeholders provided a myriad of feedback on program and expenditure planning, including recommendations for new or adjusted program services and suggestions for resource allocations. The 50 responding MHSA/CPP Coordinators most frequently (55%) reported incorporating the input into their Annual Update plans and least frequently (4%) reported using the input to inform resource allocations.

CMHDA Region: Each of the CMHDA Regions most frequently reported incorporating stakeholder input into their Annual Updates, with the Los Angeles region reporting only using this method to inform Annual Update plan development. Counties in the Central region (*n* = 15) reported using input to add or modify program services more frequently (33%) than counties in other regions. The Los Angeles and Southern regions reported using stakeholder input in the least variety of methods in developing their Annual Updates. Meanwhile, counties in the Superior region reported the lowest usage rates of stakeholder input to inform their Annual Update plans.

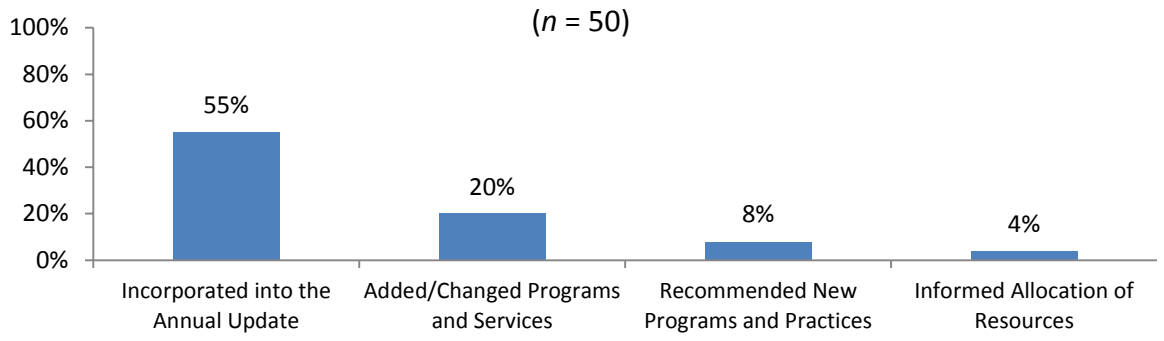
County Size: Large and medium counties were fairly comparable in their input usage rates across the different ways counties used stakeholder input to develop Annual Update plans. The exception was medium counties (*n* = 14), which more frequently reported using stakeholder input to add or modify their program services (30%); this was the greatest overall usage rate when compared to counties of other sizes. Small counties (*n* = 24) reported the lowest usage rates of stakeholder input with only 47% of counties incorporating input into their Annual Update plans and 11% adding or changing services based on stakeholder input.

Statewide

Rationale: Based on information in the County Web-Based Data Request, 20% of the 50 responding counties explained that the stakeholder comments that they received resulted in new or adjusted program services, while 8% of the counties said that comments were recommendations for new programs and practices and 4% of the counties said that the comments informed the allocation of resources. The

remaining 55% of counties reported that stakeholder comments were generally incorporated into their Annual Update plans.

Figure 48: How Input Was Used to Inform the Development of Annual Updates, Statewide ϕ

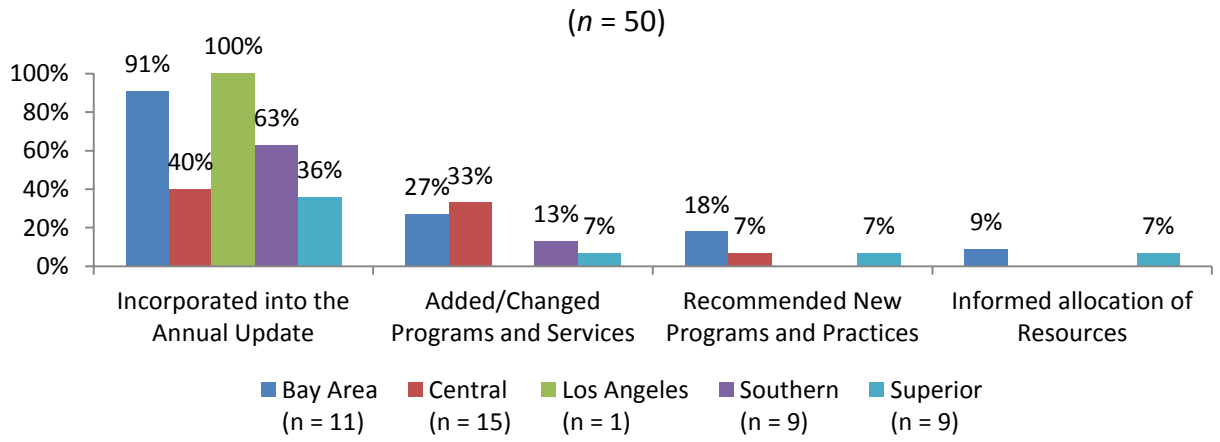


ϕ *SOURCE*: County Web-Based Data Request

CMHDA Region

Rationale: Further analysis of the data showed differences across CMHDA Regions in how counties used stakeholder input to inform the development of their Annual Update plans. For example, Los Angeles only reported incorporating stakeholder input into their Annual Update plan, but did not report using the input to inform its services, practices, or resource allocation. Nearly all counties (91%) in the Bay Area region (*n* = 11) reported incorporating stakeholder input into their Annual Update plans, and to a much smaller extent (less than 30%) these counties also reported using the input to inform their programming, practices, and resource allocation. Less than 10% of counties from the Bay Area and Superior regions reported using stakeholder input to inform their resource allocation while none of the remaining counties reported doing this at all.

Figure 49: How Input Was Used to Inform the Development of Annual Update, by CMHDA Region ϕ

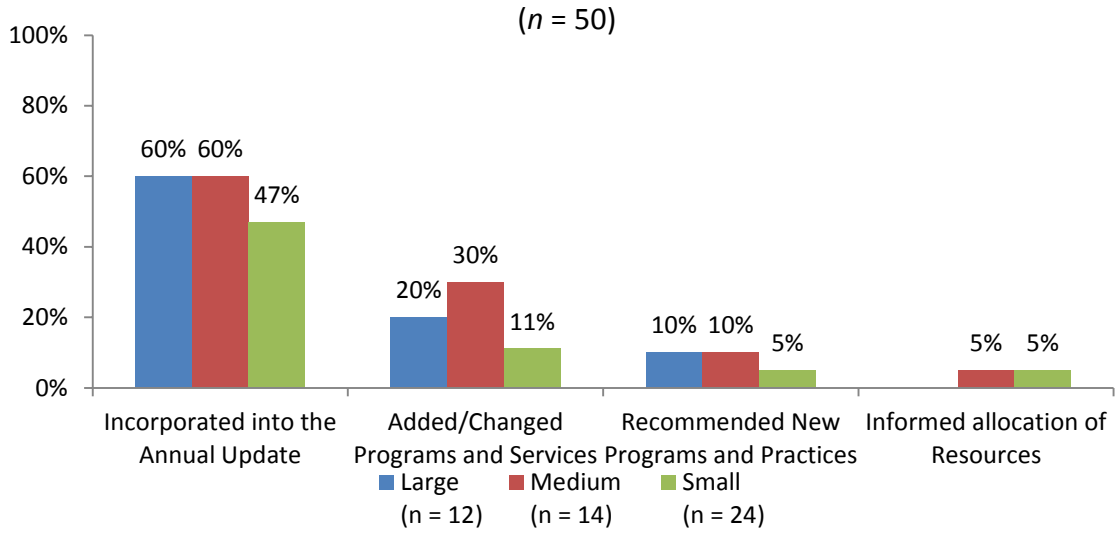


ϕ *SOURCE*: County Web-Based Data Request

County Size

Rationale: Medium counties (*n* = 14) reported the greatest rates of using stakeholder input to develop their Annual Update plan, most frequently incorporating input into their Annual Update plans (60%) and using the input to add or modify program services (30%). Small counties reported the lowest rates of using stakeholder input to develop their Annual Update plans, with less than half the counties reporting using any one form of usage.

Figure 50: How Input Was Used to Inform the Development of Annual Update, by County Size ϕ



ϕ *SOURCE*: County Web-Based Data Request

Activities – Training

This section will provide results from research questions relating to the ways and the extent to which counties provide stakeholders with training and education opportunities to better prepare them for CPP participation.

AC-11: In what ways and to what extent is training and education provided to participants of the CPP process by the county?

Results

Statewide: Overall, data from counties and stakeholders provided conflicting results on the ways and the extent that training and education was provided to participants of counties' CPP processes. A larger percentage of counties across the state reported providing training and education activities than were reported by stakeholders.

Of the counties throughout the state that reported providing training and education activities, a majority (57%) produced and distributed CPP educational materials. A large percentage of counties (46%) also reported conducting county-specific trainings on how to participate in the local stakeholder planning process. Smaller percentages of counties reported providing support for participants to attend training not sponsored by the county (18%) and other training and education activities (18%). One county (4%) offered participants CPP training in the form of professional development or continuing education credits.

Stakeholders mentioned very little training and education opportunities for participation in their counties' CPP processes. Only 25% of stakeholders felt the counties provided them with training or education to better prepare stakeholder to participate in the CPP process. According to stakeholders, having CPP training and education activities occur at standing MHSA-related meetings and activities was the most common training and educational activities that their counties provided. Stakeholder also mentioned that counties used flyers and newsletters to share information about their CPP processes. Conversely, 58% of stakeholders felt that there was not enough or no training or educational opportunities provided by counties to better prepare stakeholders for CPP participation.

CMHDA Region: The types of CPP-related educational and training opportunities counties reported varied across CMHDA Regions. The most common CPP-related education and training opportunity provided by counties was county specific trainings on how to participate in the local stakeholder process. All counties from the Superior region (100%) and a majority of Central (88%) and Southern (50%) region counties reported producing and distributing CPP educational materials. Los Angeles region only reported providing county-specific trainings on participation. A majority of Central (63%) and Superior (50%) region counties reported county specific trainings on participation, while only a third (33%) of Southern and Bay Area region counties reported this activity. Support for participating in training not sponsored by the county was reported by 50% of Superior region counties and 33% of Southern region counties as well as one county (11%) from the Bay Area region. The region with the largest percent of counties that reported other activities was the Bay Area region (33%), followed by small percentages of counties from the Central (13%) and Southern (17%) regions. Offering professional development or continuing education credits

only occurred in the Superior region where 25% of counties reported this activity. The Bay Area region stood out for having the lowest percentages of counties that reported producing and distributing CPP educational materials, county-specific trainings on participation, and support for participation in trainings not sponsored by the county.

In each of the CMHDA Regions, more stakeholders felt that there was not enough or no training or education opportunities provided by counties to better prepare stakeholders for CPP participation than those that felt their counties provided them with training or education to better prepare them to participate in CPP processes.

County Size: There was variation in the types of educational and training opportunities that were provided by counties based on county size categories. Producing and distributing CPP educational materials was the most common educational activity among small (89%) and large (60%) counties, and less common among medium counties (22%). Fifty percent of large counties, and most of medium counties (44%) and small counties (44%), reported having county-specific trainings on participation. Other activities were less common and were reported only in large (20%) and medium (33%) counties. Support for participants to attend trainings not sponsored by the county was also less common and reported by 22% of medium and small counties and by one (10%) large county. Offering professional development only occurred in one small county (11%).

Over three-fourths of stakeholders (77%) from large counties felt that there was not enough or no training or educational opportunities provided by counties to better prepare stakeholders for CPP participation, while only 15% felt that counties provided them with training or education to better prepare them for participation. Large county stakeholders that felt there was adequate training noted that CPP trainings/education were incorporated into standing MHSA meetings in the county.

A majority of stakeholders from medium counties (50%) felt that counties provided them with training or education to better prepare them for participation, while 30% felt there was not enough or no training. Stakeholders in five medium counties described receiving CPP information during current county-administered MHSA meetings and activities. Stakeholders from two medium counties described outside agencies, such as NAMI, providing trainings to its stakeholders about the CPP process.

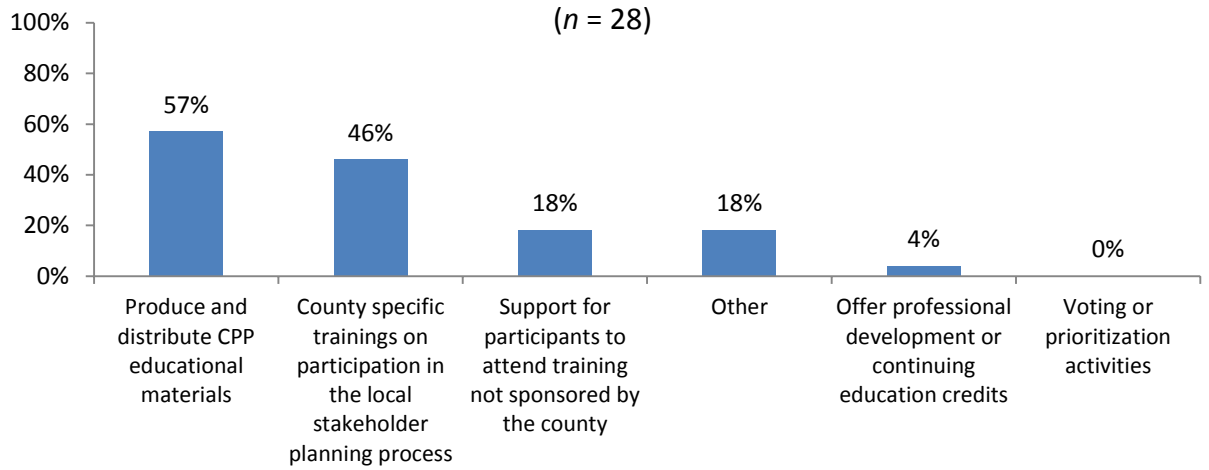
A majority of stakeholders (59%) in small counties felt that there was not enough or no training provided by counties to better prepare stakeholders for CPP participation. Only 18% of stakeholders from small counties felt there was enough training provided by counties on CPP participation. Although large percentages of stakeholders felt that training was not adequate or non-existent, small county stakeholders did describe some training and education effort provided by their counties. Stakeholders from seven counties noted that their counties provided CPP information in conjunction with standing MHSA-related meetings. Additionally, stakeholders from six small counties mentioned that that their counties provided CPP process information in a flyer or newsletter format.

Statewide

Rationale: In order to understand the methods and the extent of training and education provided to participants of the CPP processes, the evaluation team analyzed statewide data from the County Web-Based Data Request and Stakeholder Focus Groups. The data describing training and educational activities provided by counties and stakeholders produced conflicting results. Overall, higher percentages of counties reported training and educational activities than did stakeholders.

Counties reported providing several types of training and educational activities. Figure 51 depicts the training and education activities that counties reported providing for their CPP participants. As depicted, producing and distributing CPP education materials (57%) and county-specific trainings on participation in the local stakeholder planning process (46%) were more common while support for participants to attend non-county trainings (18%) and other activities (18%) were less common. Only one county (4%) reported offering professional development or continuing education credits.

Figure 51: Training and Education Activities Provided for CPP Participants, Statewide [Φ]



[Φ]*SOURCE*: County Web-Based Data Request

Statewide, stakeholders described very few training and educational activities for how to participate in the CPP processes offered by their counties. Among stakeholders from 40 counties that discussed CPP training and education activities, only stakeholders from 10 counties (25%) felt counties provided adequate training on CPP participation. Stakeholders from 23 counties (58%) felt there was no training or not enough training to better prepare stakeholders for CPP participation. Stakeholders from seven counties (17%) did not agree on whether their counties provided training and education to better prepare stakeholders for CPP participation.[Δ]

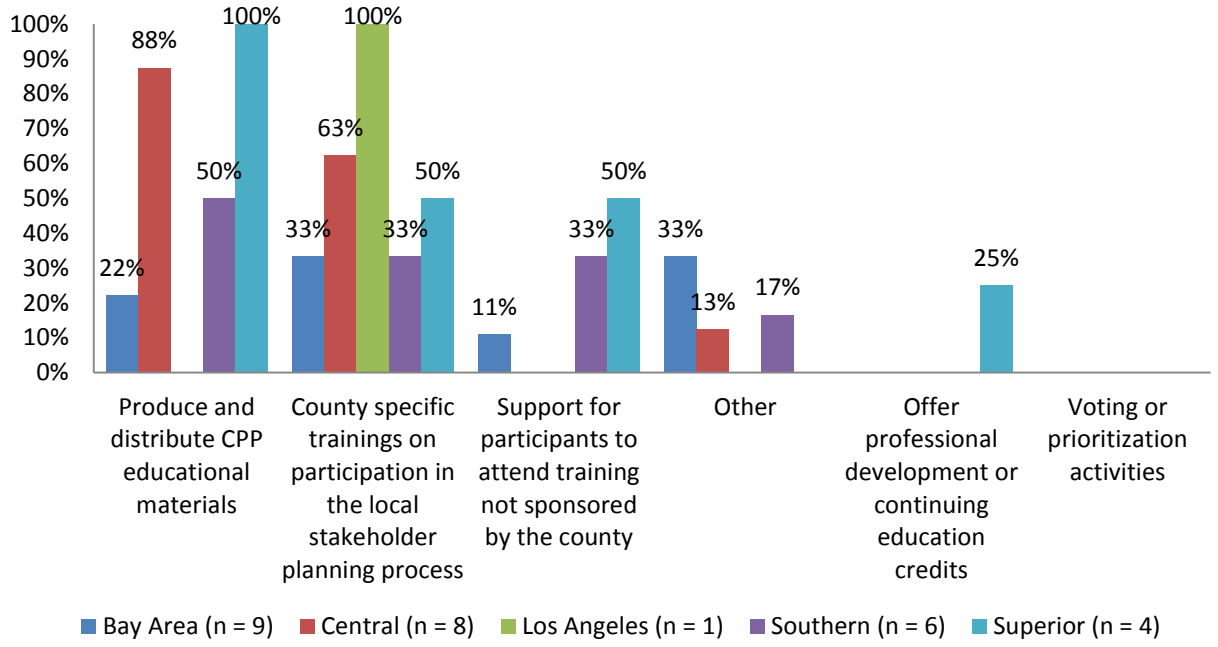
Stakeholders described a variety of ways that their counties provided training and education on CPP participation. Having CPP trainings/education occur with current, standing MHSA-related meetings/activities was a common theme. Some counties used flyers/newsletters that were handed out at MHSA-related meetings/activities to share information about their CPP processes. One county wanted descriptions of their CPP process at meetings to use less jargon and be more understandable to general

stakeholder populations. A few counties had outside agencies, such as NAMI, train its stakeholders about the CPP process. In one small county, transportation support was provided to stakeholders to participate in a CPP training gathering. Continuing education units (CEUs) were given out to CPP training participants in one county.[Δ]

CMHDA Region

Rationale: The types of CPP educational and training activities that counties reported offering to participants varied in each of the CMHDA Regions, as shown in **Error! Not a valid bookmark self-reference.**. The n-values for each of the CMHDA Regions represented the number of counties that provided data on CPP training and educational activities. It is important to note that the differences in n-values for each of the region may skew how the data is presented, especially for the Superior and Los Angeles regions which have lower n-values. As depicted below, there was variation in the types of education and training activities that counties offered CPP participants.

Figure 52: Training and Education Activities Provided for CPP Participants, by CMHDA Region[Φ]



[Φ]*SOURCE*: County Web-Based Data Request

Stakeholders from each of the CMHDA Regions reported very few CPP training and education activities provided by their counties. Stakeholders from six counties in the Bay Area region reported that very little trainings and education for participation in the CPP process were offered to stakeholders. Stakeholders from 67% (*n* = 6) of Bay Area counties felt that there were not enough or no trainings to better prepare stakeholders for CPP participation, while stakeholders from 33% (*n* = 6) of Bay Area counties felt there were training and educational activities to better prepare stakeholders. One county offered CPP trainings along with the focus groups that it conducted, but other opportunities for trainings were limited. Stakeholders from one county noted that their county needed to reach-out more to the community to let

them know about the CPP trainings that it had. Of the training and education strategies that were noted, one county provided CPP educational materials and another county provided county-specific training on how stakeholders could participate.[Δ]

Stakeholders from 12 counties in the Central region described little training and education activities for participation in their CPP processes were offered to stakeholders. Stakeholders from 42% (*n* = 12) of Central counties said that they received adequate training or education about their counties' CPP processes, while stakeholders from 42% *(*n = 12) of Central counties said they did not receive any such training. In two Central counties (17%, *n* = 12), stakeholders described receiving training, but that it was not from the county and not directly about CPP. One county offered CEU credits for participating in CPP trainings. Thirty-three percent (*n* = 12) of counties offered training about MHSA, of which the CPP process could be assumed to have been covered. One county noted that NAMI provided a lot of trainings for its stakeholders. Additionally, one county used newsletters as a method of training/education.[Δ]

In Los Angeles (*n* = 1), stakeholders said there were no formal trainings or orientations for stakeholders. Stakeholders described informal mechanisms of CPP training, such as presentations at Service Area Advisory Committee and System Leadership Committee meetings.[Δ]

Across the Southern region, stakeholders from nine counties described very few trainings and education activities for participation in the CPP processes that their counties offered. Stakeholders from only one county (11%, *n* = 9) said that the county provided CPP-related training and education while stakeholders from six Southern counties (67%, *n* = 9) described inadequate or no training and educational activities to better prepare stakeholders for participation in their counties' CPP processes. Stakeholders from two counties (22%, *n* = 9) could not agree on whether their counties provided training for participation in their counties' CPP processes. Thirty-three percent (*n* = 9) of stakeholders from Southern counties noted that there used to be a number of MHSA/CPP trainings, however these trainings did not occur anymore. Stakeholders from two Southern counties noted that outside agencies did CPP trainings in their counties. Stakeholders in 33% (*n* = 9) of Southern counties said that while there were no formal training/educational opportunities about the CPP processes in their counties, they did learn about the CPP processes informally through the various MHSA-related meetings that they attended in their counties. Stakeholders from one county noted that children and transition-aged youth (TAY) were frequently left-out of its county's CPP trainings.[Δ]

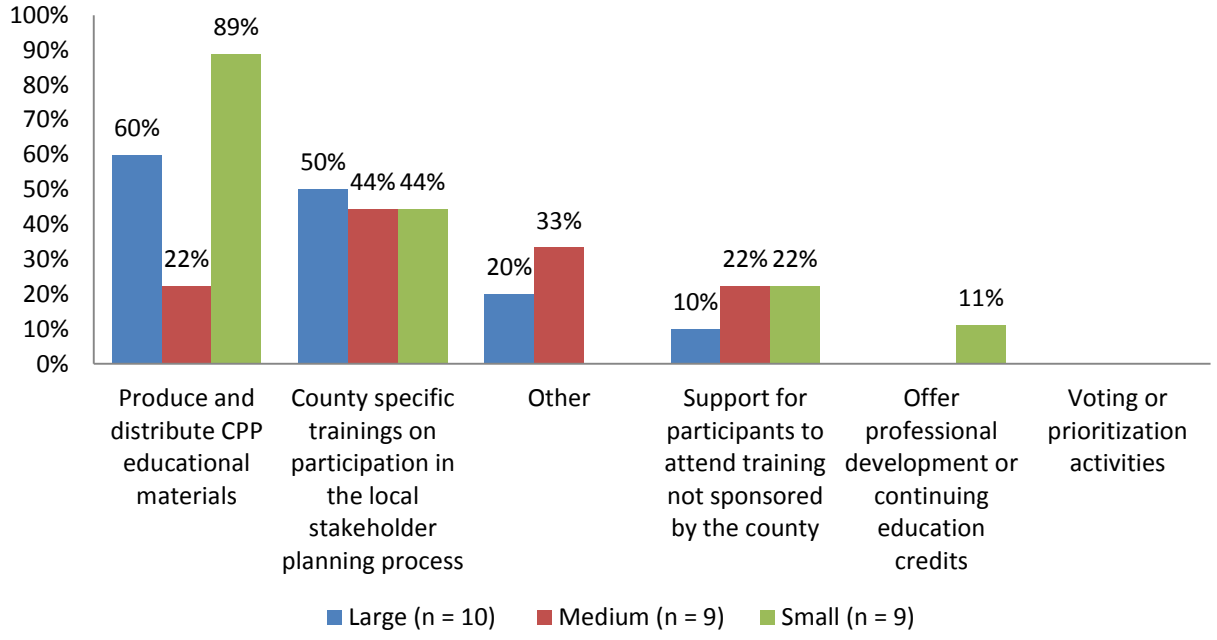
Across the Superior region, stakeholders from 12 counties noted very few trainings and educational opportunities for participation in the CPP process were offered to their stakeholders. Stakeholders in 17% of Superior counties (*n* = 12) described receiving training to better prepare them for participation in CPP processes, while stakeholders in 58% of Superior counties (*n* = 12) felt there were not enough or no training. Stakeholders in 25% (*n* = 12) of Superior counties could not agree on whether the county provided enough training and educational activities to better participate in their counties' CPP processes. Stakeholders from five Superior counties (42%, *n* = 12) noted that they wished that they had any or more CPP trainings. Stakeholders in 33% (*n* = 12) of Superior counties used some sort of flyer/notice that was handed-out at meetings to share information about their counties' CPP processes with stakeholders. Stakeholders in two counties noted that it had trainings for staff and providers, but not for stakeholders.

Stakeholders in one county mentioned that its CPP trainings needed to use less jargon so that people in the county could understand and participate. Stakeholders from one county suggested that CPP trainings happen during dates and times that people could attend and not have to worry about childcare.[Δ]

County Size

Rationale: There was variation in the types of education and training opportunities provided by counties based on county size, as shown in **Error! Not a valid bookmark self-reference.**. The n-values for each of the county sizes represented the counties of that size that reported CPP-related education and training activities. Percentages for each of the activities on the horizontal axis represent the number of counties out of n-value for each size that reported that activity. Producing and distributing CPP educational materials was the most common educational activity among small (89%, *n* = 9) and large (60%, *n* = 10) counties, and less common among medium counties (22%, *n* = 9). Fifty percent of large counties (*n* = 10), 44% of medium counties (*n* = 9), and 44% of small counties (*n* = 9) reported having county-specific trainings on how to better participate in their CPP processes. Other activities were less common and reported only in large (20%, *n* = 10) and medium (33%, *n* = 9) counties. Support for participants to attend trainings not sponsored by counties were also less common and reported by 22% of medium (*n* = 9) and small counties (*n* = 9), and by one large county (10%, *n* = 10). Only one small county offered professional development (11%, *n* = 9).

Figure 53: Training and Education Activities Provided for CPP Participants, by County Size [Φ]



[Φ]*SOURCE*: County Web-Based Data Request

Stakeholders in 13 large counties described having very few training and education activities to better prepare participants for their counties' CPP processes. Stakeholders in 15% (*n* = 13) of large counties felt that their counties provided trainings for CPP processes, while stakeholders in 77% (*n* = 13) of large

counties felt that there were not enough or no trainings. Stakeholders from one county described trainings in its county's past CPP processes, but noted that most training was conducted by NAMI. Stakeholders in 31% (*n* = 13) of large counties wished there were more opportunities to be trained or to learn about their counties' CPP process. Stakeholders in two counties noted that there used to be a lot of training around the CPP process, but that training has since ceased. Stakeholders in one county noted that its CPP process felt very exclusive and that there was no training given to stakeholders. Stakeholders in only two counties noted that CPP trainings/education were incorporated into standing MHSA meetings in the counties.[Δ]

Stakeholders in 10 medium counties described having some training and education activities for participation in their counties' CPP processes. Stakeholder in 50% (*n* = 10) of medium counties felt counties provided training and education activities to better prepare participants for their CPP processes, while 30% (*n* = 10) felt there were not enough or no training. Stakeholders in two counties felt that there were some trainings provided by their counties, but that they were not ongoing. Stakeholders in two counties said that outside agencies, such as NAMI, provided trainings to its stakeholders about their counties' CPP processes.[Δ]

Stakeholders in 17 small counties described very few trainings and education for participation in their counties' CPP processes. Stakeholders in 18% (*n* = 17) of small counties felt counties provide training and education on CPP participation, while stakeholders in 65% (*n* = 17) of small counties felt counties did not provide enough or no trainings. Stakeholders in 18% (*n* = 17) of small counties did not agree on whether their counties provided adequate training. In one county, stakeholders described transportation being offered to participants. Stakeholders in one county suggested that trainings needed to use less jargon and be conducted in a language that all stakeholders could understand. Stakeholders in 41% (*n* = 17) of small counties described CPP information being provided in conjunction with standing MHSA-related meetings. Stakeholders in 35% (n = 17) of small counties provided CPP process information in a flyer/newsletter format to participants. Stakeholders in 29% (*n* = 17) of counties requested that their counties have more CPP training and education.[Δ]

Activities – Evaluation

This section will provide results from a research question regarding methods used by counties evaluate their own CPP process and how results from evaluation activities were used to improve their own CPP processes.

AC-12: How do counties evaluate and attempt to improve their own CPP processes?

Results

Statewide: About 72% of responding counties (*n* = 50) reported conducting some sort of activity to evaluate their CPP processes. The most common evaluation activity reported was collecting participant data (47%), followed by participant satisfaction surveys (39%) and discussion and focus groups (39%). Most counties that conducted evaluation activities also reported using the results to inform and improve future their CPP processes.

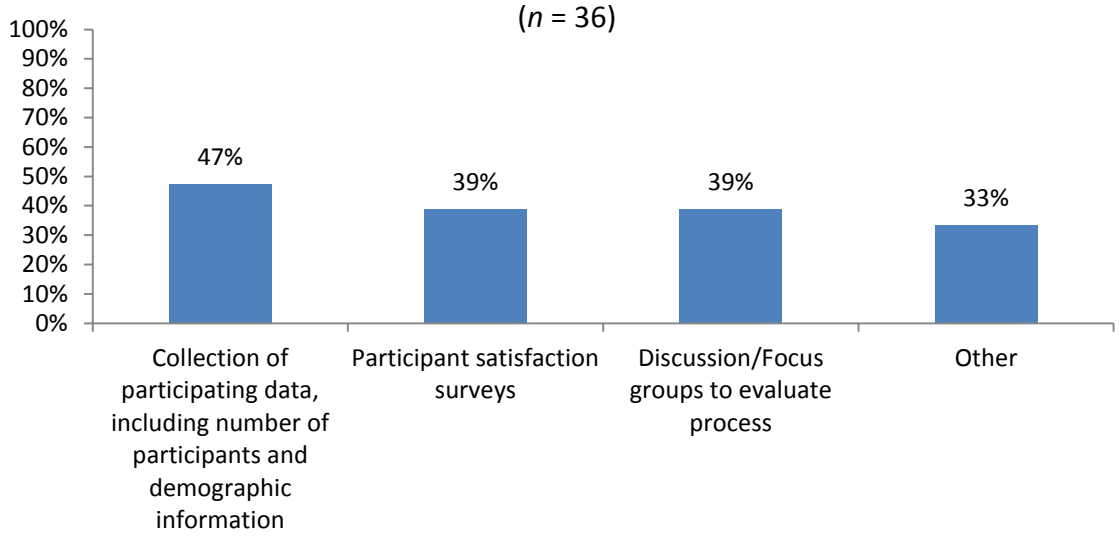
CMHDA Region: There were some differences between CMHDA Regions in the usage rates of each evaluation method. While the Southern and Superior regions were quite comparable in the types and usage rates of evaluation activities, counties from the Bay Area, Central, and Los Angeles regions varied. For instance, while 40-65% of counties from other regions reported collecting participant data to evaluate CPP activities, Los Angeles reported only using discussions or focus groups to evaluate its CPP activities. Only 18% of Central counties reported using discussion or focus groups. Further, for each of the four evaluation activities counties reported using, most counties reported using the information gathered from three of the four activities to improve future CPP processes. However, this excludes counties within the Southern region, 100% of whom reported using information from only one of the evaluation activities to improve their future CPP processes.

County Size: Large counties (*n* = 10) consistently used evaluation activities at greater frequency than counties of other sizes. Additionally, large counties most commonly used discussions or focus groups (60%) to collect evaluation data, while medium (*n* = 12) and small (*n* = 14) counties most frequently collected participant data (42% and 50%, respectively) to evaluate their CPP activities. Further, 100% of large counties that evaluated their CPP activities reported using said data to improve their future CPP processes. This was true for medium counties in all evaluation methods except discussions or focus groups (*n* = 4), of which 25% did not report using the data. Among small counties, evaluation data usage was more sparse, ranging from 50% to 100% usage across the different evaluation measures.

Statewide

Rationale: Further analysis of the County Web-Based Data Request is presented in **Error! Not a valid bookmark self-reference.**. The most common activity counties (*n* = 36) reported using for CPP evaluation was the collection of participant data (47%). This was followed by participant satisfaction surveys (39%), discussion and focus groups (39%), and other activities (33%).

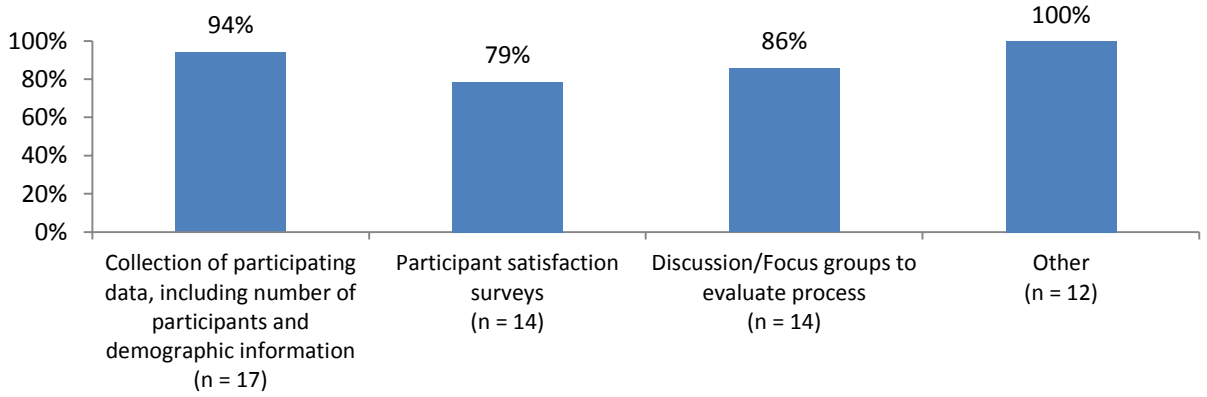
Figure 54: Use of Evaluation Activities to Improve CPP Processes, Statewide ϕ



ϕ *SOURCE*: County Web-Based Data Request

Among the counties that reported using one or more of the above evaluation activities, **Error! Not a valid bookmark self-reference.** shows the proportion of counties that reported using the evaluation results to improve their future CPP activities. While only 33% of counties (*n* = 36) reported using "other" evaluation activities, 100% of them reported using the results in their future CPP processes. Similarly, participant data was used in future CPP planning by 94% of counties that collected participant data as an evaluation activity. While a fair proportion of counties reported using participant satisfaction surveys (39%, *n* = 36), only 79% of those counties reported using information from that activity to improve their future CPP processes.

Figure 55: Percent of Counties that Used Evaluation Results to Improve Future CPP Processes, Statewide ϕ

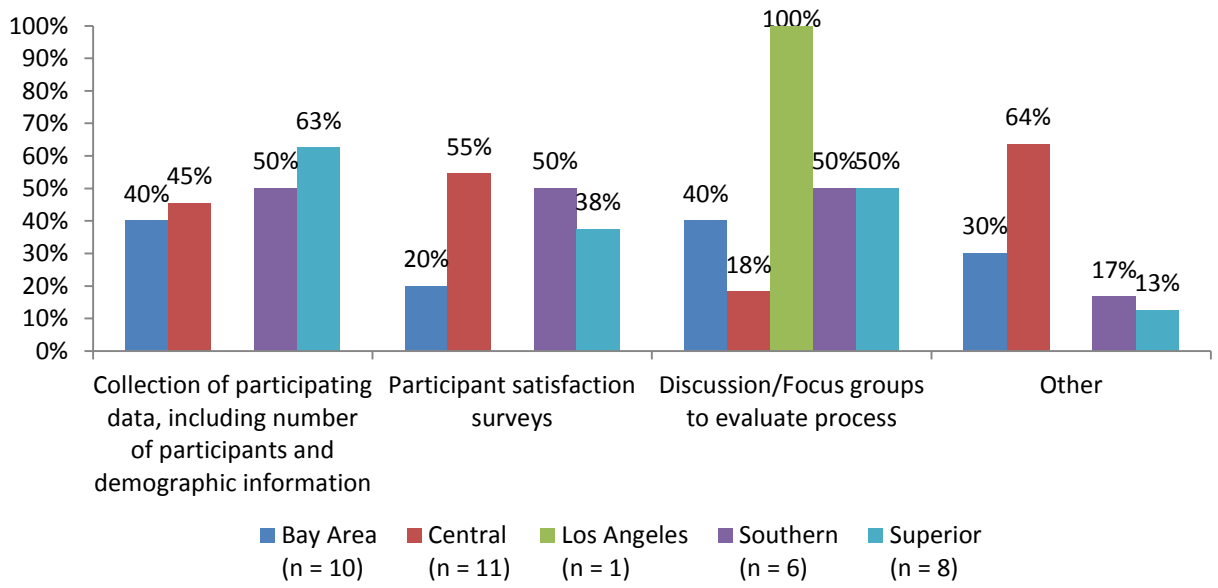


ϕ *SOURCE*: County Web-Based Data Request

CMHDA Region

Rationale: The evaluation method with the most variation of use among CMHDA Regions was "other" activities. Other activities were most common among the Central region (35%) followed by the Bay Area (23%), Southern (10%), and Superior (8%) regions. The Los Angeles region (*n* = 1) only used discussions or focus groups to evaluate its CPP activities, while 18% of Central (*n* = 11) counties reported using discussions or focus groups to evaluate their CPP activities. Meanwhile, the Central region reported most commonly using "other" evaluation activities (64%) whereas the Superior region (*n* = 8) reported using "other" evaluation activities least often (13%). Instead, the Superior region most commonly reported collecting participant data for evaluation (63%).

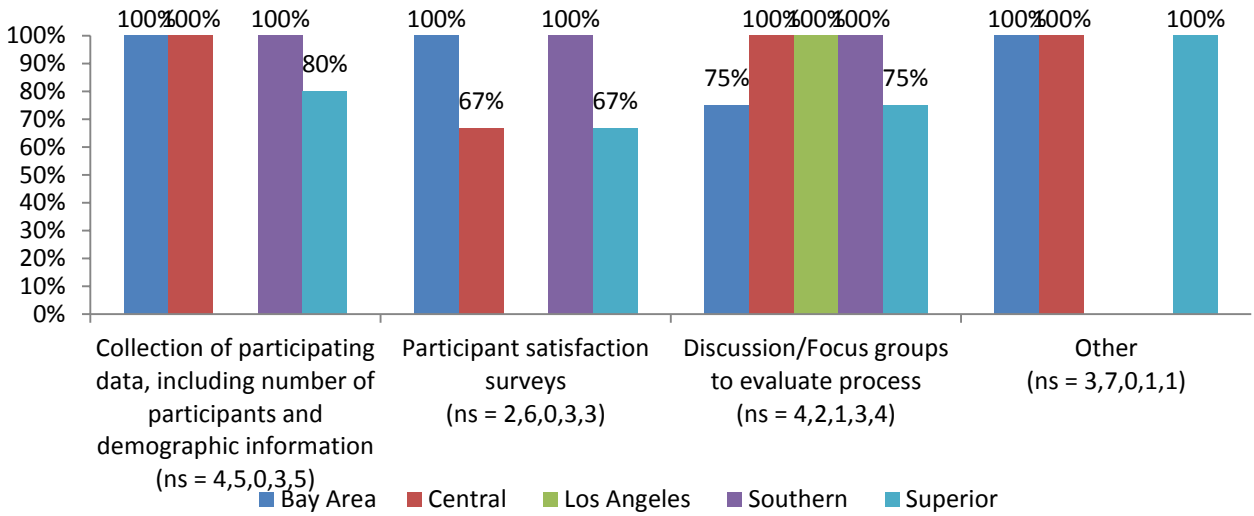
Figure 56: Use of Evaluation Activities to Improve CPP Processes, by CMHDA Region [ϕ]



[ϕ] *SOURCE*: County Web-Based Data Request

Each of the regions reported, to some degree, using information gathered from discussions or focus groups to improve their future CPP processes. Additionally, each region that reported collecting participant data as an evaluation activity had a large majority (80% or 100%) of counties reporting that they used said data to improve their future CPP processes. Beyond that, large inconsistencies of data usage were reported between CMHDA Regions, particularly in using participant satisfaction surveys. While all Bay Area (*n* = 2) and Southern (*n* = 3) counties reported using the participant satisfaction data they collected, only two-thirds (67%) of Central (*n* = 6) and Superior (*n* = 3) counties reported using said data to improve their future CPP processes. Data usage of "other" evaluation activities also varied inconsistently between regions. One hundred percent of Bay Area (*n* = 3), Central (*n* = 7), and Superior (*n* = 1) counties reported using "other" activities, but 0% of Southern counties (*n* = 1).

Figure 57: Counties that Used Evaluation Results to Improve Future CPP Processes, by CMHDA Region ϕ

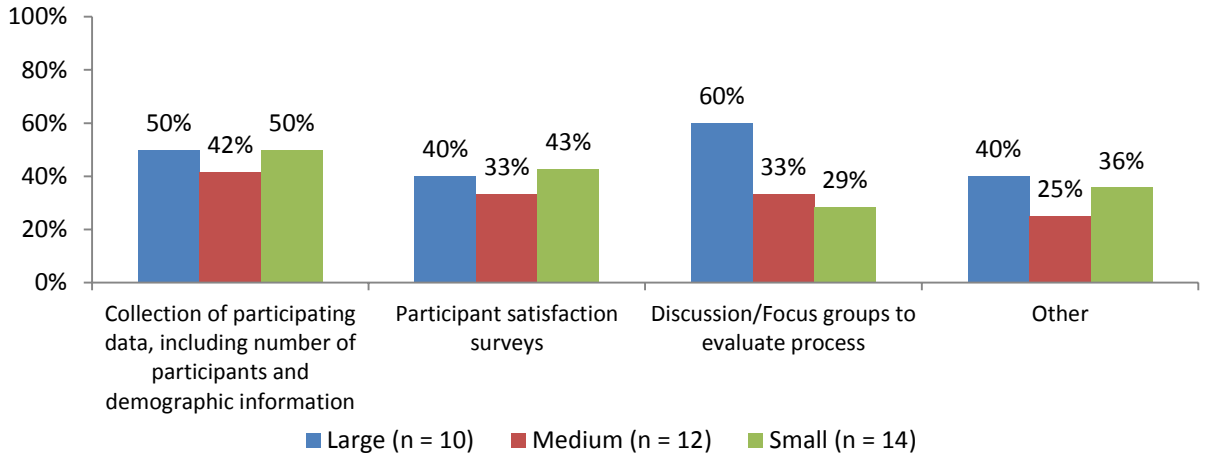


ϕ *SOURCE*: County Web-Based Data Request

County Size

Rationale: Reviewing the County Web-Based Data Request by county size revealed some interesting findings depicted in Figure 58. The responding large counties (*n* = 10) most frequently reported using discussions or focus groups to evaluate CPP activities (60%) while this was something small counties (*n* = 14) did least often (29%). Instead, both small and medium (*n* = 12) counties most frequently collected participant data to evaluate their CPP activities. Additionally, medium counties reported using "other" evaluation methods least frequently (25%).

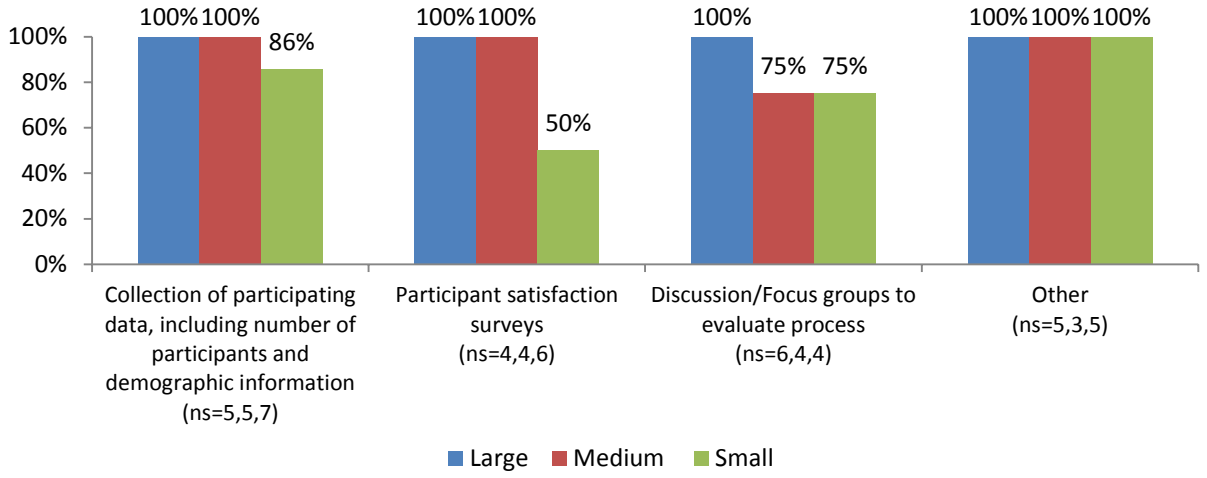
Figure 58: Use of Evaluation Activities to Improve CPP Processes, by County Size ϕ



ϕ *SOURCE*: County Web-Based Data Request

Error! Not a valid bookmark self-reference. examines the counties that reported using specific evaluation methods to determine if the evaluation findings were put into practice. All the large counties reported using the data gathered in each evaluation method to improve their future CPP activities. All medium counties reported using the data gathered in all but one evaluation method to improve their future CPP activities. Utilization of discussion or focus group data remained the exception; 75% of medium counties (*n* = 4) reported using findings to improve future CPP processes. Small counties less frequently used the evaluation data they collected to improve their future CPP activities. While 100% of small counties were able to use evaluation findings from "other" methods (*n* = 5) to improve their future CPP processes, fewer counties were able to use participant data (86%, *n* = 7), discussion or focus group feedback (75%, *n* = 4), and participant satisfaction survey findings (50%, *n* = 6).

Figure 59: Counties that Used Evaluation Results to Improve Future CPP Processes, by County Size [Φ]



[Φ] *SOURCE*: County Web-Based Data Request

Process Outcomes – Outreach

The following section identifies how many stakeholders were outreached to for participation in counties' CPP processes, including the number of items distributed, given, or broadcasted by the type of CPP outreach activity.

PO-01: How many stakeholders are outreached to for participation in the CPP process?

Results

Statewide: Based on the range of data provided by each county (see **Error! Reference source not found.**), the interpretation of how to answer the questions varied significantly. For example, "emails to list-serve" ranged from 1 to 72,000, suggesting that some counties counted the number of emails sent, while others counted the number of email recipients.

CMHDA Region: Because data is unreliable for this question, it is not presented by CMHDA Region.

County Size: Because data is unreliable for this question, it is not presented by county size categories.

Statewide

Rationale: In order to understand how many stakeholders were outreached to for participation in counties' CPP processes, the evaluation team analyzed statewide data from the County Web-Based Data Request. Counties were asked to detail the number of items distributed, given, or broadcasted for each of the various CPP outreach activities that they engaged in. For additional information on the types of outreach activities that counties engaged in, see AC-O1A on Page 23. Based on the range of data provided by each county (see **Error! Not a valid bookmark self-reference.**), the interpretation of how to answer the questions also varied significantly. For example, "emails to listserv" ranged from 1 to 72,000, thus suggesting that some counties counted the number of emails sent, while others counted the number of email recipients. As a result, this data may represent varying assumptions by counties and is therefore not presented in its entirety.

Table 27: Range of Items Distributed, Given, or Broadcast by Type of Outreach Activity, Statewide [β]

	Post flyers/ posters/ brochures (n 37)	Phone calls/ invitations by Mental Health Department staff (n 29)	Emails to list serve (n 34)	Radio/ TV announcements (n 2)	Print announcements (i.e., newspaper) (n 26)	Social media (i.e., Twitter, Facebook) (n 3)	Announcement at meetings (n 38)
Minimum	1	0	1	1	1	5	0
Maximum	4,053	600	72,000	3	52,000	150	2,840

[β] *SOURCE:* County Web-Based Data Request

Process Outcomes – Participant Input

The following section identifies who participates in counties' CPP processes, including their demographics and the stakeholder groups they identify with. This section also discusses whether participation included clients with SMI and/or SED and their family members. Finally, this section discusses the general frequencies of participation and attempts to understand those groups that are *not* participating in counties' CPP processes.

PO-02: Who participates in the CPP process, including the specific stakeholder groups and demographics?

Results

Statewide: Because counties did not consistently report data on their CPP stakeholders, it was not possible to determine the total number of CPP participants engaged, nor the exact breakdowns of their demographics. Additionally, there was not always agreement across county sources or between county and stakeholder sources, presenting limitations in the ability to accurately assess CPP stakeholder participation.

Overall, counties reported participation from all stakeholder groups, with counties and stakeholders identifying mental health consumers, family members, and county mental health department staff among the most commonly represented stakeholder groups.[μ δ] Contracted mental health service providers and advocates, such as NAMI, were also commonly mentioned by MHSA/CPP Coordinators and stakeholders.[β Δ] Stakeholders representing senior services and veteran services were among the least common stakeholder groups reported by counties.[δ] Among stakeholders who indicated that they participated in the CPP process, most were either a family member of a mental health consumer, a mental health client/consumer themselves, or an advocate. The majority of CPP participants identified as being between the ages of 26-59, female, as White/Caucasian, and as speakers of English at home.[δ]

While limited, data from the County Web-based Data Request showed that counties reported participation from stakeholders of all age groups, genders, and racial/ethnic groups, as well as from stakeholders who spoke English and languages other than English as their primary language.[Φ]

CMHDA Region: While there were inconsistencies among data sources with regard to stakeholder affiliation, county and stakeholder sources across CMHDA Regions generally agreed that mental health consumers, family members, county mental health departments, and mental health service providers were the most common participants. A review of county sources suggested that there was less diversity in stakeholder types in the Los Angeles region compared to other CMHDA Regions. In the Southern region, K-12 education providers were also among the most commonly reported stakeholder groups. In the Superior region, members of law enforcement were among the most commonly reported groups.[μ] Advocacy organizations, such as NAMI and homeless advocates, were specifically mentioned by MHSA/CPP Coordinators and stakeholders in all CMHDA Regions except the Bay Area region.[β] Stakeholders, like county sources, noted that contracted mental health service providers were well represented the counties' CPP processes, with two counties noting that the service provider

representatives tended to be from upper-level leadership or management.[Δ] Among Stakeholder Survey respondents who participated in CPP planning processes in the most recent fiscal year, advocates were also among the top three most common stakeholder types in all CMHDA Regions. Mental health community-based organizations (CBOs) were among the top three stakeholder groups in all CMHDA Regions besides the Superior region, while non-mental health CBOs were among the top five in all CMHDA Regions besides the Bay Area region. County mental health department staff members were among the top three in the Bay Area and Superior regions.[δ]

The Central and Southern regions reported participation from stakeholders of all age groups, while the Bay Area and Superior regions did not report participation from stakeholders under age 18. The Southern region reported participation from male and female stakeholders, while the Bay Area, Central, and Superior regions reported that their stakeholders also included transgender individuals. All CMHDA Regions reported participation from all racial and ethnic groups, though the Superior region did not report participation from mixed race individuals. Counties in all CMHDA Regions reported participation from both individuals who spoke English and individuals who spoke languages other than English as their primary language at home.[δ] Counties and stakeholders observed frequent participation from particular racial/ethnic groups, including: Native American (Central, Superior, Southern); Latino (Southern, Superior, Bay Area); Asian/Pacific Islander (Los Angeles, Southern); African American (Southern, Los Angeles), and Hmong (Superior). Counties and stakeholders from the Bay Area region noted that their participants were largely White/Caucasian and English-speaking and had higher levels of education.[β Δ]

Consistent with the statewide results, all CMHDA Regions reported similar distributions of participant age groups, with the vast majority of stakeholders reporting being between the ages of 26 and 59, followed by age 60 or older, and finally between the ages of 18 and 25. While the gender distribution was mostly consistent with the overall statewide result, the Los Angeles region reported fewer females than the statewide average, and the Superior region reported more females than the statewide average. Fairly consistent with statewide results, stakeholders who did not identify as LGBT represented the majority of stakeholders across all CMHDA Regions. The language spoken at home among stakeholders remained fairly consistent across CMHDA Regions. The race/ethnicity distribution varied across CMHDA Regions. Stakeholders identifying as White/Caucasian were the majority across all CMHDA Regions, except Los Angeles, which reported Latino/Hispanic as the predominant race/ethnicity (50%, n = 30). Consistent with statewide results, Asian Pacific Islanders and Tribal/Native Americans were among the least represented race/ethnicities across all CMHDA Regions. Stakeholders identifying as mixed race were represented in three of the five regions, with both the Los Angeles (n = 30) and Superior (n = 112) regions reporting no mixed race stakeholders.[δ]

County Size: Consistent with statewide results, consumers, family members, and mental health providers were among the most commonly reported stakeholder types across county sizes.[μ δ] Large counties appeared to have somewhat lower diversity in their stakeholder types.[μ] Annual Update plans showed that all stakeholder types were represented across all county size categories, with the exception of veteran services which were not reported by any large counties.[μ] Departing from the statewide and regional trends of the most commonly reported groups, children and family services were among the most commonly reported stakeholder groups in small counties (77% in Annual Update plans).[μ] A higher

proportion of medium counties reported participation from consumers (94%) and family members (94%) compared to small and large counties.[μ] In contrast to Annual Update plans, in counties of all sizes, MHSA/CPP Coordinators and stakeholders reported frequent participation from advocates such as NAMI.[β] MHSA/CPP Coordinators and stakeholders from small counties specifically called out participation by mental health boards. Stakeholders from large counties did not specifically call out consumers as frequent stakeholders.[β Δ] Consumers also had lower representation among Stakeholder Survey respondents from medium counties compared to small and large counties. In contrast to data from counties' Annual Update plans, CBOs (including mental health and non-mental health providers) were not among the top five stakeholder groups from Stakeholder Survey participants in small counties; and county mental health department staff was only among the top five stakeholder groups in small counties.[δ]

According to the Annual Update Document Review, counties across all county size categories reported participants from the following stakeholder groups: county mental health department staff, family member of a mental health consumer, and mental health clients/consumers. All stakeholder types were represented across all county size categories, with the exception of veteran services, which were not reported by any large counties. Consistent with statewide results, the age distributions of participants across county size categories remained consistent, with the majority of stakeholders being between the ages of 26 and 59, followed by those aged 60 or older, and finally those between the ages of 18 and 25. Similarly, the distribution of gender across county size categories was fairly consistent with statewide results. Stakeholders that indicated they participated in their counties' CPP processes reported identifying as LGBT at a greater rate in medium and small counties than in large counties. In terms of the primary language spoken at home across county size categories, the vast majority of CPP participants indicated that they spoke English at home. Consistent with statewide results, race/ethnicity category White/Caucasian had the highest representation across all county size categories; however, the proportion of those in this race/ethnicity category decreased as county size increased. Accordingly, large counties showed greater diversity than medium and small counties, with most race/ethnicities increasing their representation as county size increased.[δ]

Statewide

Rationale: In order to understand who participated in counties' CPP processes, statewide data was analyzed from the County Web-Based Data Request, the Annual Update Document Review, and the Stakeholder Survey.

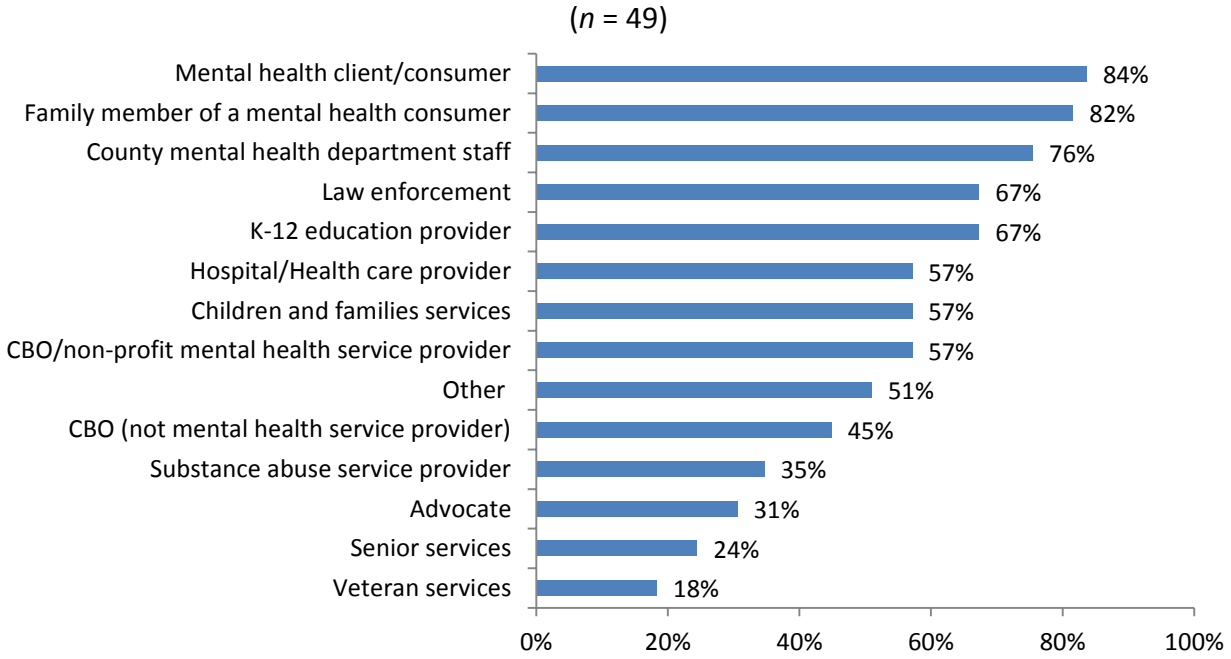
Because counties did not consistently report data on who participated in the CPP process, as was asked in the County Web-Based Data Request, it was not possible to determine the total numbers of participants engaged, nor the exact breakdowns of their demographics. However, data from the Annual Update Document Review and the Stakeholder Survey was available and is presented below.

Stakeholder Affiliation

Data regarding stakeholder affiliation was gathered from both the Annual Update Document Review and the Stakeholder Survey. While these data sources provided conflicting information with regards to the actual percentage that each affiliation accounted for, the general ranking appears to be similar in nature.

According to the Annual Update Document Review (see Figure 60), at least two-thirds of counties (*n* = 49) reported participation from the following stakeholder groups: mental health clients/consumers (84%), family members (82%), county mental health staff (76%), law enforcement (67%), and K-12 education personnel (67%). Close to 60% of counties reported participation from hospital/health care providers (57%), children and family services (57%), and community-based/non-profit mental health service providers (57%). Stakeholders representing advocates (31%), senior services (25%), and veteran services (18%) were among the least commonly reported stakeholder groups.[μ]

Figure 60: CPP Participants Representing Various Stakeholder Groups, Statewide [μ]



[μ] *SOURCE:* Annual Update Document Review

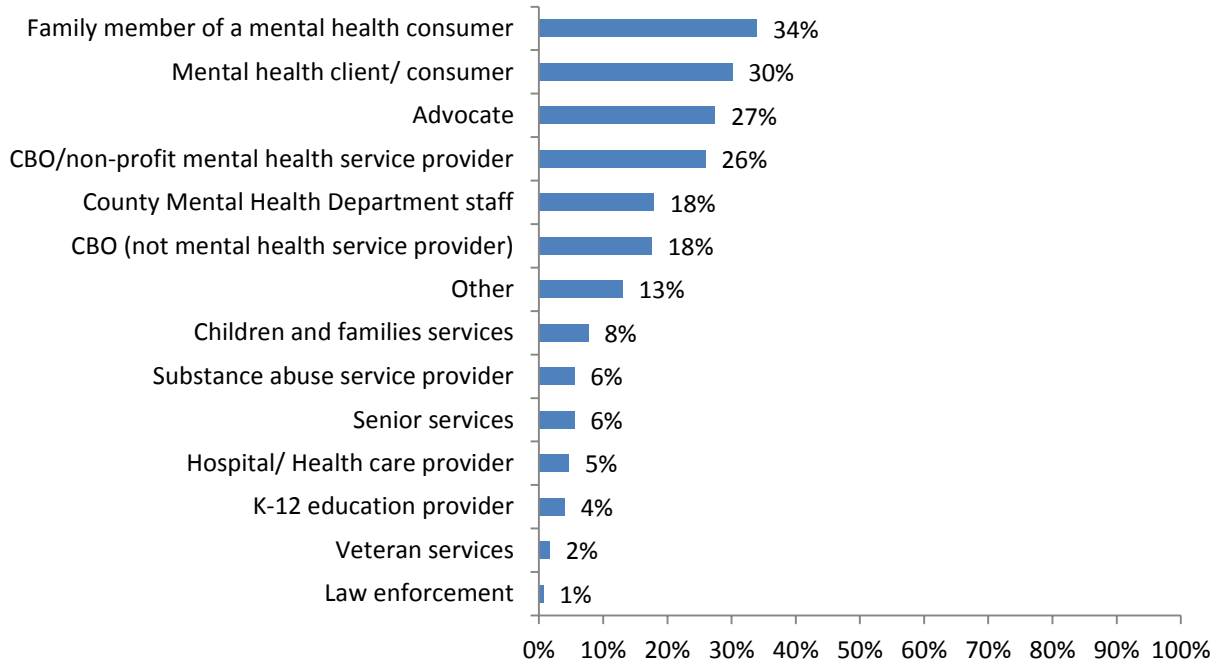
Conversely, when analyzing data from the Stakeholder Survey among respondents who indicated they participated in the CPP process (*n* = 598), the story was somewhat different (see Figure 61).[δ] The following stakeholder groups reported the greatest representation: family member of a mental health consumer (34%), mental health client/consumer (30%), advocate (27%), and CBO/non-profit mental health service provider (26%). Stakeholder groups that were reported the least included: hospital/health care provider (5%), K-12 education provider (4%), veteran services (2%), and law enforcement (1%).[δ]

While these two data sources present varying percentages of stakeholder affiliation, both identified mental health consumers and family members of mental health consumers as the two highest

represented stakeholder groups. Similarly, stakeholders representing veteran services were among the least represented stakeholder affiliation across both data sources.[μ δ]

Figure 61: Stakeholder Affiliation among Participants who Indicated they Participated in CPP Process, Statewide [δ]

(*n* = 598)



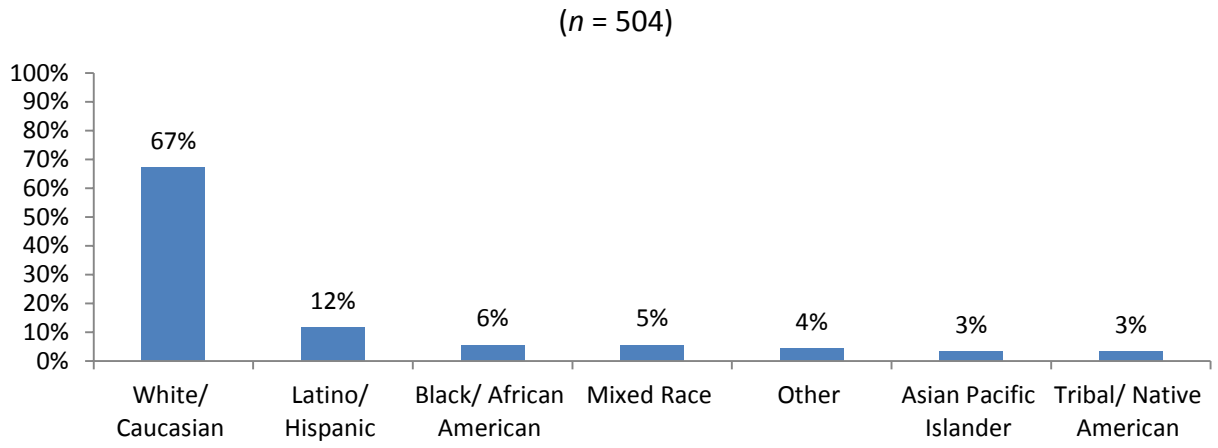
[δ] *SOURCE:* Stakeholder Survey

Stakeholder Demographics

According to data from the Stakeholder Survey, 64% of CPP participants (*n* = 509) were between the ages of 26 and 59, 33% were age 60 or older, and 3% were between 18 and 25 years of age. Just under three-fourths (72%) of CPP participants (*n* = 505) were female, 27% were male, and 1% were transgender/other. The vast majority of CPP participants did not identify as LGBT (91%, *n* = 416), whereas 9% did identify as LGBT. Most CPP participants reported that they spoke English at home (97%, *n* = 490), 5% spoke another language at home, and 2% reported being bilingual (spoke English and another language at home).[δ]

Stakeholders were asked to indicate their race/ethnicity, as shown in Figure 62. Generally speaking, the majority of stakeholders reported being White/Caucasian (67%, *n* = 504), while the remaining six categories each accounted for 12% or less of all stakeholders. Both Asian Pacific Islander and Tribal/Native American accounted for the races/ethnicities with the least representation, each representing 3% of all participating stakeholders.[δ]

Figure 62: Race/Ethnicity among Participants who Indicated they Participated in CPP Process, Statewide [δ]



[δ] *SOURCE:* Stakeholder Survey

CMHDA Region

Rationale: Because counties did not consistently report data on who participated in their CPP processes, as was asked in the County Web-Based Data Request, it was not possible to determine the total number of participants that counties engaged, nor the exact breakdowns of their demographics by CMHDA Region. However, data was available through the Annual Update Document Review and the Stakeholder Survey, which is presented below.

Stakeholder Affiliation

Consistent across all data sources and CMHDA Regions, mental health consumers and their family members were among the top five stakeholder groups represented in counties' CPP processes.[δ μ Δ β]

According to the Annual Update Document Review, most stakeholder groups were reported by at least 20% of counties from all CMHDA Regions, with the exception of Los Angeles (*n* = 1), which reported participation from only five stakeholder groups (see Table 28). Counties across all CMHDA Regions commonly reported participation from mental health client/consumers, county mental health department staff, CBO/non-profit mental health service providers, law enforcement, and hospital/health care providers.[μ] This was consistent with data gathered from MHSA/CPP Coordinators from all CMHDA Regions, which echoed that these stakeholder groups frequently participated in counties' CPP processes.[β] However, according to data from the Stakeholder Survey (see Table 29), counties across all CMHDA Regions commonly reported participation from advocates, CBO/non-profit mental health service providers, family members of a mental health consumer, and mental health clients/consumers.[δ] While the stakeholder groups that participated in counties' CPP processes were generally similar between data sources, law enforcement reported greater representation in the Annual Update Document Review than in the Stakeholder Survey.

Table 28: CPP Participants Representing Various Stakeholder Groups, by CMHDA Region µ

	Bay Area (*n* 11)	Central (*n* 15)	Los Angeles (*n* 1)	Southern (*n* 10)	Superior (*n* 12)
Advocate	55%	20%	0%	30%	25%
Children and families services	64%	73%	0%	30%	58%
CBO (not mental health service provider)	55%	33%	0%	40%	58%
CBO/non-profit mental health service provider	73%	47%	100%	50%	58%
County mental health department staff	91%	73%	100%	60%	75%
Family member of a mental health consumer	91%	87%	0%	90%	67%
Hospital/Health care provider	45%	47%	100%	70%	67%
K-12 education provider	73%	67%	0%	80%	58%
Law enforcement	64%	60%	100%	70%	75%
Mental health client/consumer	91%	80%	100%	90%	75%
Senior services	45%	20%	0%	30%	8%
Substance abuse service provider	45%	27%	0%	20%	75%
Veteran services	27%	20%	0%	0%	25%
Other	27%	67%	0%	80%	33%

µ *SOURCE:* Annual Update Document Review
NOTE: Highlighted values represent the top three categories within each CMHDA Region (some are tied).

Unlike the other CMHDA Regions, Los Angeles did not report participation by family members of mental health consumers in its Annual Update plan.[µ] However, MHSA/CPP Coordinators and stakeholders did report participation by family members, with Los Angeles MHSA/CPP Coordinator and Stakeholder Survey respondents identifying family members as one of its most frequent stakeholder groups.[Δ β]

In the Southern region (see Table 28), K-12 education providers were among the three most commonly reported stakeholder groups (80%, *n* = 10); this stakeholder group was much less common in the Central (67%, *n* = 15) and Los Angeles (0%, *n* = 1) regions.[µ] While most CMHDA Regions did not commonly report participation from advocates (with the exception of the Bay Area region), MHSA/CPP Coordinators and stakeholders observed frequent participation by advocate groups, such as NAMI (this was specifically mentioned by respondents from the Central, Southern, and Superior regions).[Δ β]

While participation by advocates (55%), providers of services for seniors (45%), and providers of veteran services (27%) were more commonly reported in the Bay Area region, these stakeholder groups were still among the least commonly reported stakeholder groups across all CMHDA Regions. Children and families services were reported by a higher proportion of counties in the Bay Area (64%) and Central (73%) regions. While the Superior region more commonly reported participation from substance abuse providers (70%), these providers were generally among the least commonly reported stakeholder groups across all CMHDA Regions.[µ]

Table 29: Stakeholder Affiliation among Participants who Indicated they Participated in CPP Process, by CMHDA Region [δ]

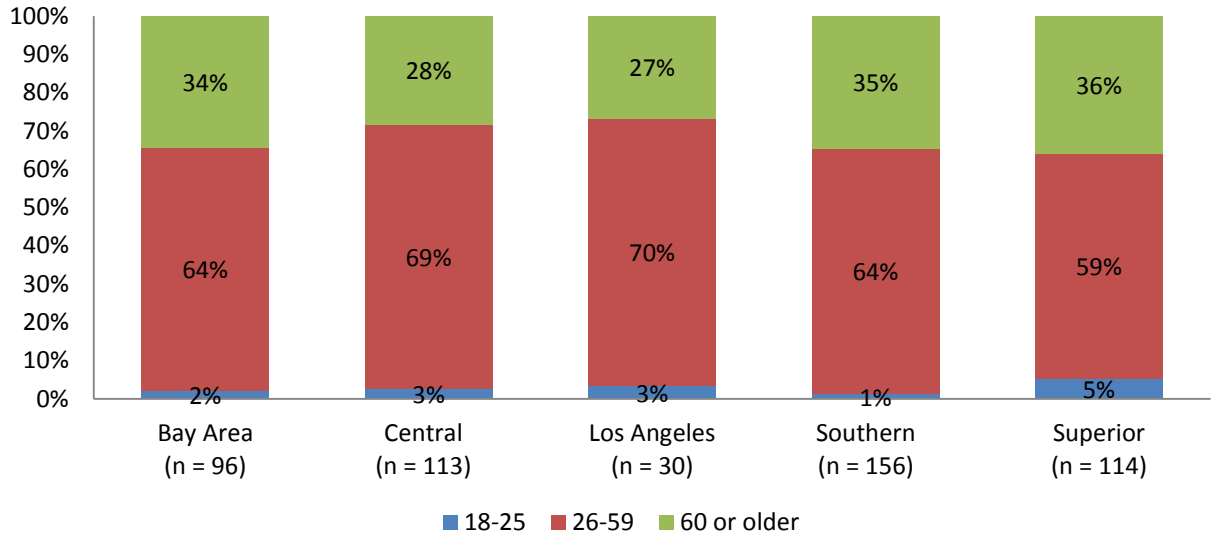
	Bay Area (*n* 112)	Central (*n* 134)	Los Angeles (*n* 34)	Southern (*n* 186)	Superior (*n* 132)
Advocate	34%	28%	24%	30%	20%
Children and families services	4%	8%	12%	7%	11%
CBO (not mental health service provider)	13%	19%	24%	17%	20%
CBO/non-profit mental health service provider	35%	16%	29%	33%	17%
County Mental Health Department staff	19%	14%	9%	16%	26%
Family member of a mental health consumer	36%	40%	32%	35%	24%
Hospital/ Health care provider	4%	4%	0%	5%	6%
K-12 education provider	6%	1%	9%	3%	6%
Law enforcement	1%	0%	3%	1%	0%
Mental health client/ consumer	37%	26%	32%	28%	31%
Senior services	12%	1%	6%	6%	4%
Substance abuse service provider	4%	4%	0%	6%	8%
Veteran services	0%	1%	6%	2%	2%
Other	16%	16%	15%	11%	11%

[δ] *SOURCE:* Stakeholder Survey
NOTE: Highlighted values represent the top three categories within each CMHDA Region (some are tied).

Stakeholder Demographics

Consistent with the statewide results, all CMHDA Regions reported similar distributions of age groups, with the vast majority of stakeholders reporting being between the ages of 26 and 59, followed by age 60 or older, and finally between the ages of 18 and 25 (see Figure 63). The Los Angeles region reported the greatest percentage of participants (70%, *n* = 30) between 26 and 59 years of age, whereas the Superior region reported the least (59%, *n* = 114). Conversely, the Superior region reported the greatest percentage of participants (36%, *n* = 114) age 60 or older, whereas the Los Angeles region reported the least (27%, *n* = 30). All CMHDA Regions reported participation among stakeholders between the age of 18 and 25 as 5% or less.[δ]

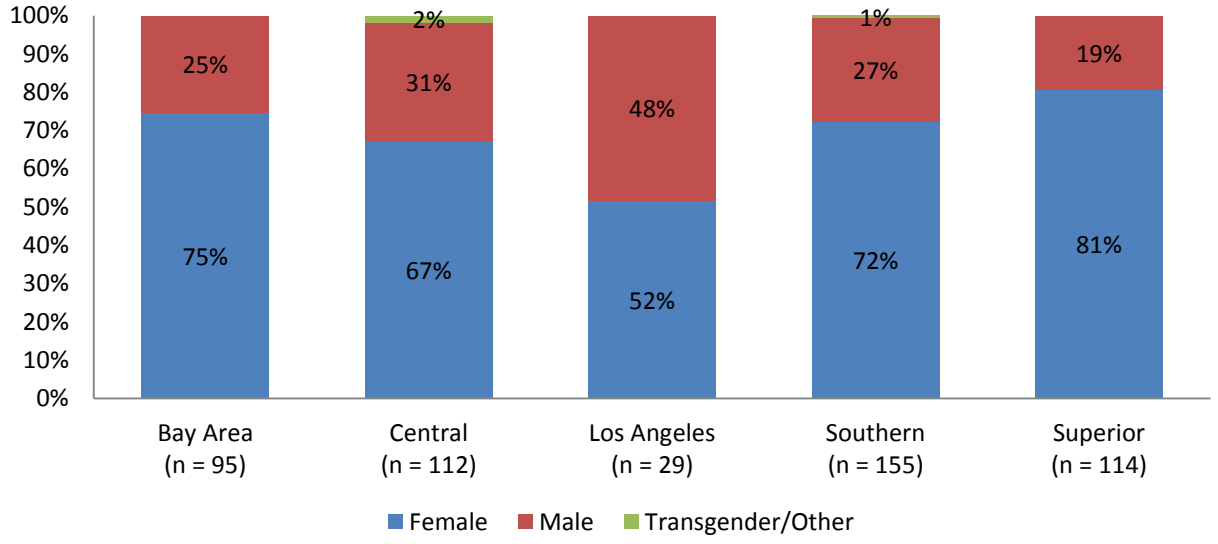
Figure 63: Age among Participants who Indicated they Participated in CPP Process, by CMHDA Region [δ]



[δ] *SOURCE:* Stakeholder Survey

In terms of the gender distribution across CMHDA Regions, the results from the Stakeholder Survey indicated more variation by CMHDA Region, as shown in Figure 64. While the results were mostly consistent with overall statewide results, the Los Angeles region reported fewer females than the statewide average, and the Superior region reported more females than the statewide average. Although representing a small portion of the statewide data, stakeholders identifying as transgender/other were represented in only two of the five CMHDA Regions – Central (2%, n = 112) and Southern (1%, *n* = 155).[δ]

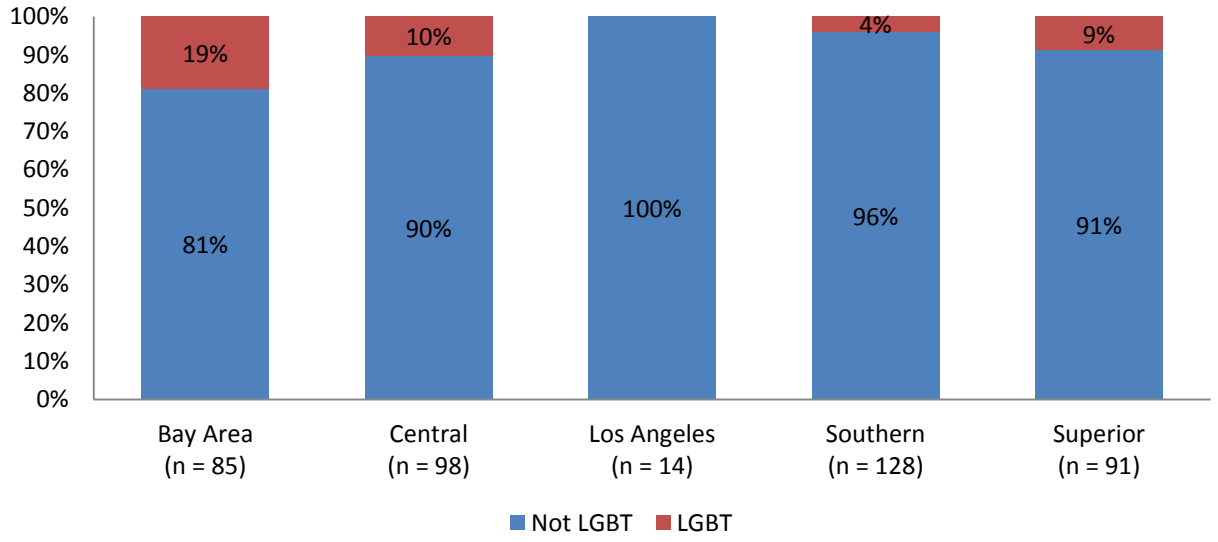
Figure 64: Gender among Participants who Indicated they Participated in CPP Process, by CMHDA Region [δ]



[δ] *SOURCE:* Stakeholder Survey

Fairly consistent with statewide results, LGBT status across all CMHDA Regions was reported at similar rates, with stakeholders who did not identify as LGBT representing the majority of stakeholders. The Bay Area region reported the greatest number of stakeholders identifying as LGBT (19%, *n* = 85), while the Los Angeles region reported the least (0%, *n* = 14).[δ]

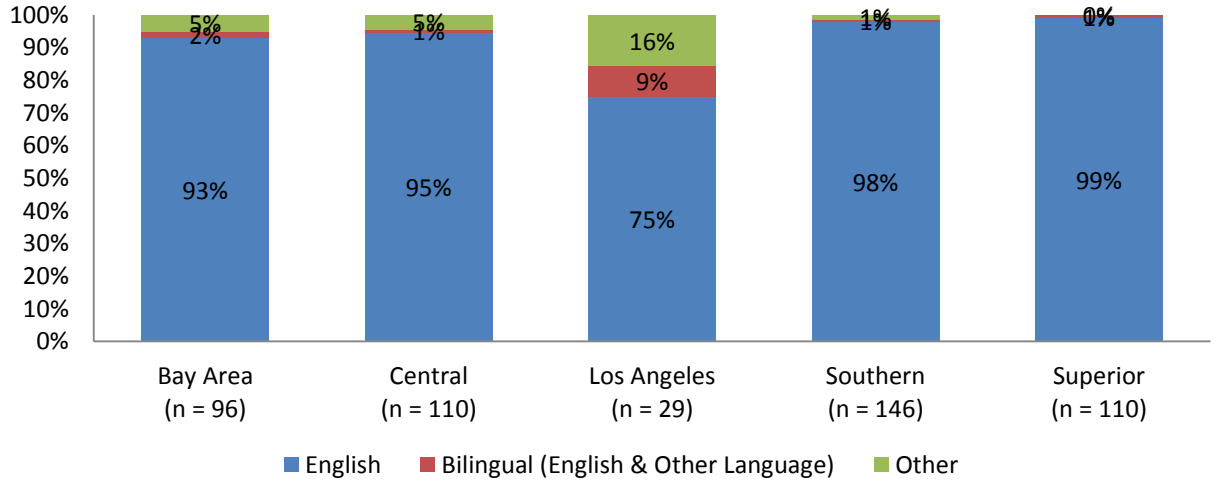
Figure 65: LGBT Status among Participants who Indicated they Participated in CPP Process, by CMHDA Region [δ]



[δ] *SOURCE:* Stakeholder Survey

The language spoken at home among stakeholders remained fairly consistent across CMHDA Regions. Only the Los Angeles region showed a distinct difference in language distribution, with 75% of respondents (*n* = 29) reporting that they speak English at home, 16% (*n* = 29) reporting speaking another language, and 9% (*n* = 29) reporting as bilingual.[δ]

Figure 66: Respondents' Language Spoken at Home, by CMHDA Region [δ]

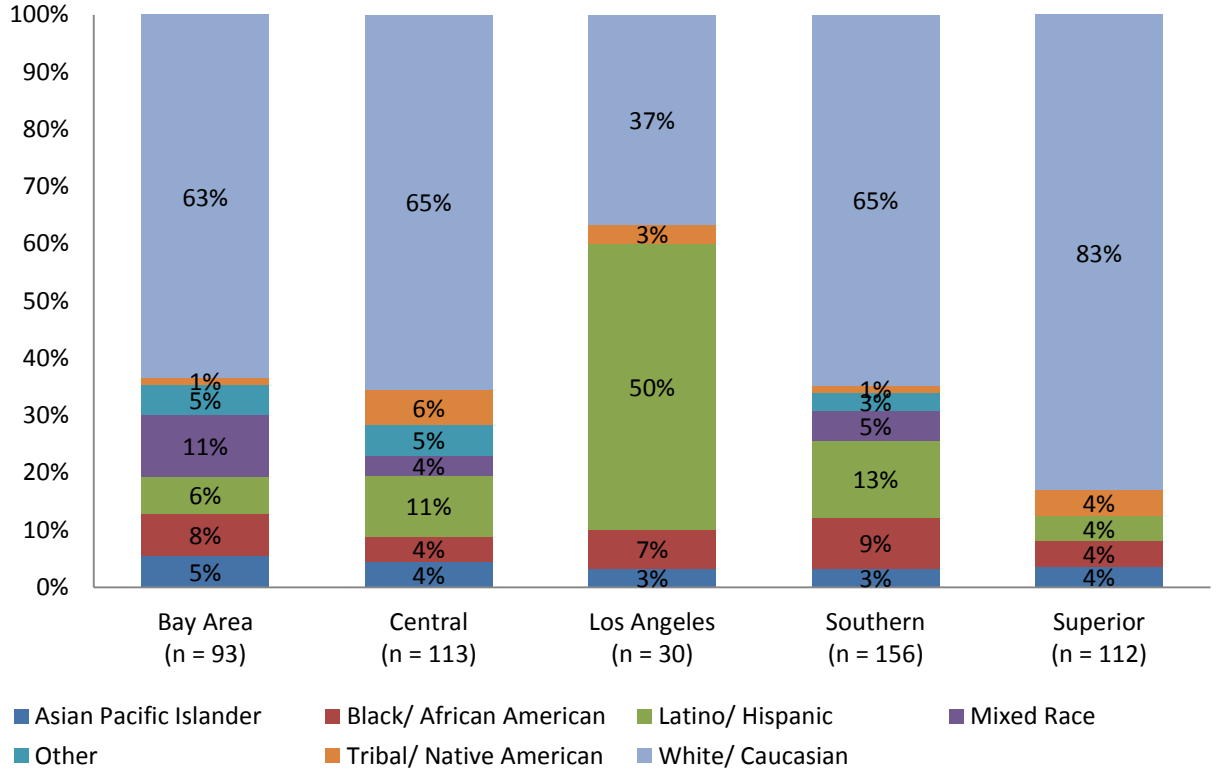


[δ] *SOURCE:* Stakeholder Survey

The race/ethnicity distribution varied across CMHDA Regions, as shown in Figure 67. Stakeholders identifying as White/Caucasian were the majority across all CMHDA Regions, except the Los Angeles region, which reported Latino/Hispanic as the predominant race/ethnicity (50%, *n* = 30). Consistent with statewide results, Asian Pacific Islanders and Tribal/Native Americans were among the least represented race/ethnicities across all CMHDA Regions. Stakeholders identifying as mixed race were represented in three of the five regions, with both the Los Angeles (*n* = 30) and Superior (*n* = 112) regions reporting not having mixed race stakeholders.[δ]

When asked whether any stakeholder groups participated more frequently than others, Bay Area counties and stakeholders observed that their participants were mostly White/Caucasian, with additional representation from Latino populations. In the Southern region, counties observed frequent participation from cultural communities, including Latino, Vietnamese, African American, and Native American. Counties in the Superior region mentioned participation by cultural communities, including Latino, Hmong, and Native American.[Δ β]

Figure 67: Race/Ethnicity among Participants who Indicated they Participated in CPP Process, by CMHDA Region [δ]



[δ] *SOURCE:* Stakeholder Survey

County Size

Rationale: Because counties did not consistently report data on who participated in their CPP processes, as was asked in the County Web-Based Data Request, it was not possible to determine the total numbers of participants that counties engaged or the exact breakdowns of their demographics by county size categories. However, data from the Annual Update Document Review and the Stakeholder Survey is presented below.

Stakeholder Affiliation

According to the Annual Update Document Review, counties across all county size categories reported having participants from the following stakeholder groups: county mental health department staff, family member of a mental health consumer, and mental health clients/consumers. All stakeholder types were represented across all county sizes, with the exception of providers of veteran services, which were not reported by any large counties.[μ]

Children and family services were among the most commonly reported stakeholders in small counties (77%). A higher proportion of medium counties reported participation from consumers (94%) and family members (94%) compared to small and large counties.[μ] County key informants and stakeholders from counties of all sizes observed frequent participation by consumers, family members, providers, and NAMI,[β] though stakeholders from large counties did not specifically call-out consumers as a frequent stakeholders.[Δ]

Table 30: CPP Participants Representing Various Stakeholder Groups, by County Size [μ]

	Large (*n* 11)	Medium (*n* 16)	Small (n 22)
Advocate	18%	44%	27%
CBO (not mental health service provider)	27%	50%	50%
CBO/non-profit mental health service provider	46%	69%	55%
Children and families services	9%	63%	77%
County mental health department staff	64%	81%	77%
Family member of a mental health consumer	73%	94%	77%
Hospital/Health care provider	55%	56%	59%
K-12 education provider	55%	69%	73%
Law enforcement	55%	69%	73%
Mental health client/consumer	82%	94%	77%
Senior services	18%	38%	18%
Substance abuse service provider	9%	44%	41%
Veteran services	0%	25%	23%
Other	64%	56%	41%

[μ] *SOURCE:* Annual Update Document Review
NOTE: Highlighted values represent the top three categories within each CMHDA Region (some are tied).

Consistent with the Annual Update Document Review, among stakeholders who indicated they participated in their counties' CPP processes, family members of consumers were among the top three participants across county size categories. Additionally, in line with county data sources, small counties had a higher proportion of CPP participants from children and family services responding to the Stakeholder Survey.[δ]

There were also some differences in the most common stakeholder groups represented in the Stakeholder Survey compared to counties' Annual Update plans. Unlike the data from the Annual Update Document Review, in the Stakeholder Survey, mental health clients/consumers were not represented in the top three most common stakeholder groups in medium counties. Additionally, county mental health department staff members were not among the top three stakeholder groups in across all county sizes.[μ δ]

Table 31: Stakeholder Affiliation among Participants who Indicated they Participated in CPP Process, by County Size [δ]

	Large (*n* 258)	Medium (*n* 154)	Small (*n* 186)
Advocate	33%	27%	20%
CBO (not mental health service provider)	17%	18%	18%
CBO/non-profit mental health service provider	33%	29%	13%
Children and families services	8%	6%	40%
County Mental Health Department staff	15%	13%	26%
Family member of a mental health consumer	40%	36%	24%
Hospital/ Health care provider	4%	4%	6%
K-12 education provider	2%	6%	5%
Law enforcement	1%	1%	1%
Mental health client/ consumer	31%	10%	30%
Senior services	7%	4%	5%
Substance abuse service provider	6%	3%	8%
Veteran services	2%	1%	2%
Other	13%	15%	11%

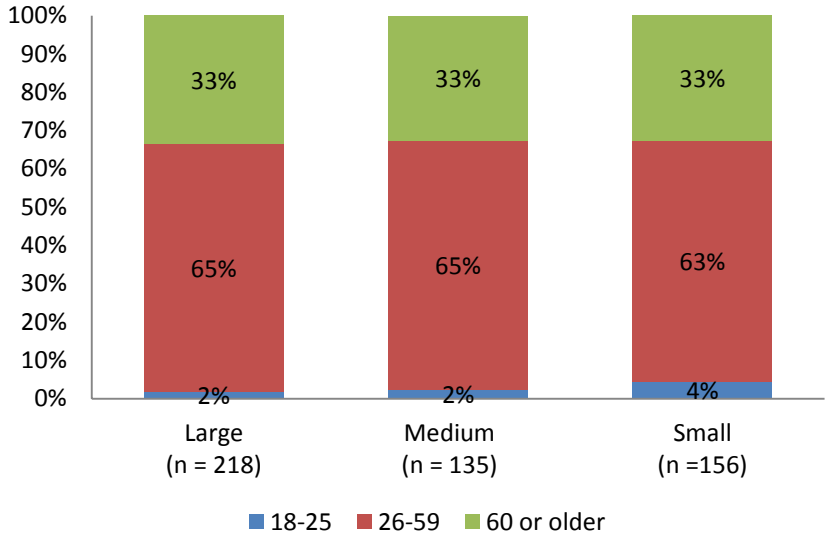
[δ] *SOURCE:* Stakeholder Survey
NOTE: Highlighted values represent the top three categories within each CMHDA Region (some are tied).

Stakeholder Demographics

Consistent with statewide results, the age distribution of participants across county size categories remained consistent, with the majority of stakeholders being between the age of 26 and 59, followed by age 60 or older, and finally between the age of 18 and 25. Little variation in this distribution was seen across county size categories, as shown in

Figure 68.[δ]

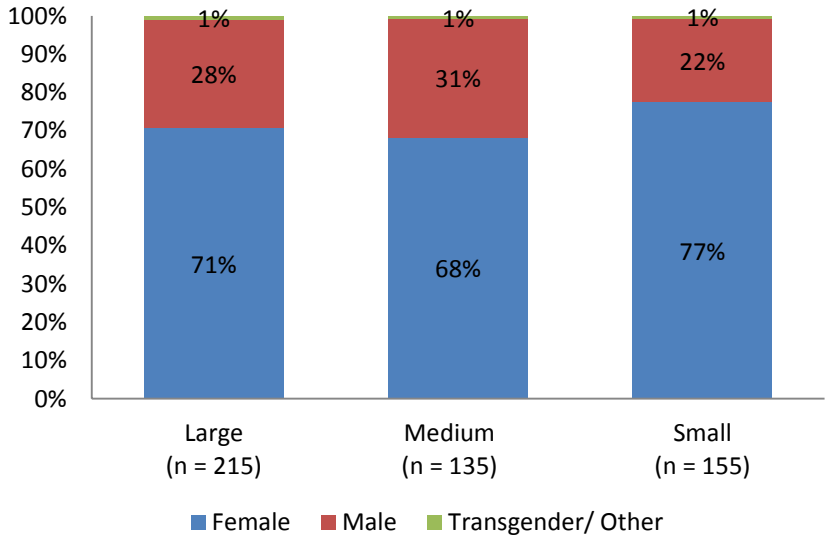
Figure 68: Age among Participants who Indicated they Participated in CPP Process, by County Size δ



δ *SOURCE:* Stakeholder Survey

Similarly, the distribution of gender across county sizes was fairly consistent with statewide results (see Figure 69). However, small counties reported a slightly greater percentage of females (77%, *n* = 155), compared to both large (71%, *n = 215)* and medium counties (68%, *n* = 135).[δ]

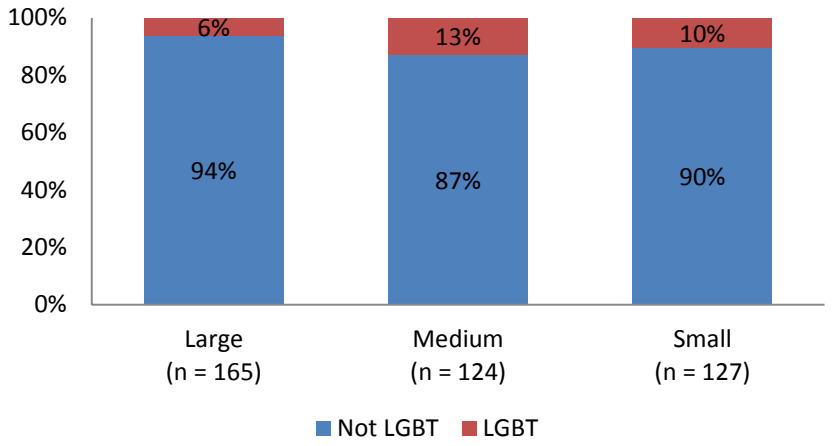
Figure 69: Gender among Participants who Indicated they Participated in CPP Process, by County Size [δ]



δ *SOURCE:* Stakeholder Survey

Of the stakeholders that indicated they participated in their counties' CPP processes, they reported identifying as LGBT at a greater rate in medium (13%, *n* = 124) and small counties (10%, *n* = 124) than in large counties (6%, *n* = 127), as shown in Figure 70.[δ]

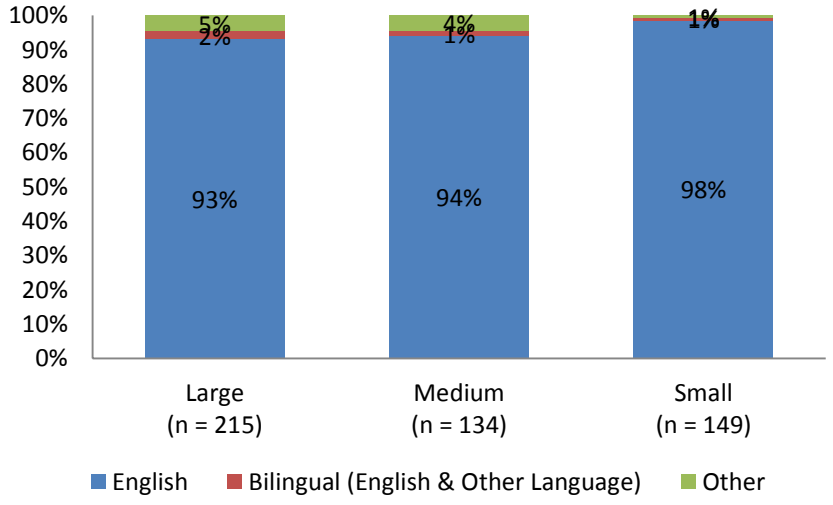
Figure 70: LGBT Status among Participants who Indicated they Participated in CPP Process, By County Size [δ]



[δ] *SOURCE:* Stakeholder Survey

In terms of the language spoken at home across county sizes, the vast majority of CPP participants indicated that they spoke English at home, as shown in Figure 71. However, CPP participants from small counties reported slightly less variation in the languages spoken at home compared to those CPP participants from large and medium counties, in which few participants indicated that they spoke another language (1%, *n* = 149) or were bilingual (1%, *n* = 149).[δ]

Figure 71: Language Spoken at Home among Participants who Indicated they Participated in CPP Process, by County Size [δ]

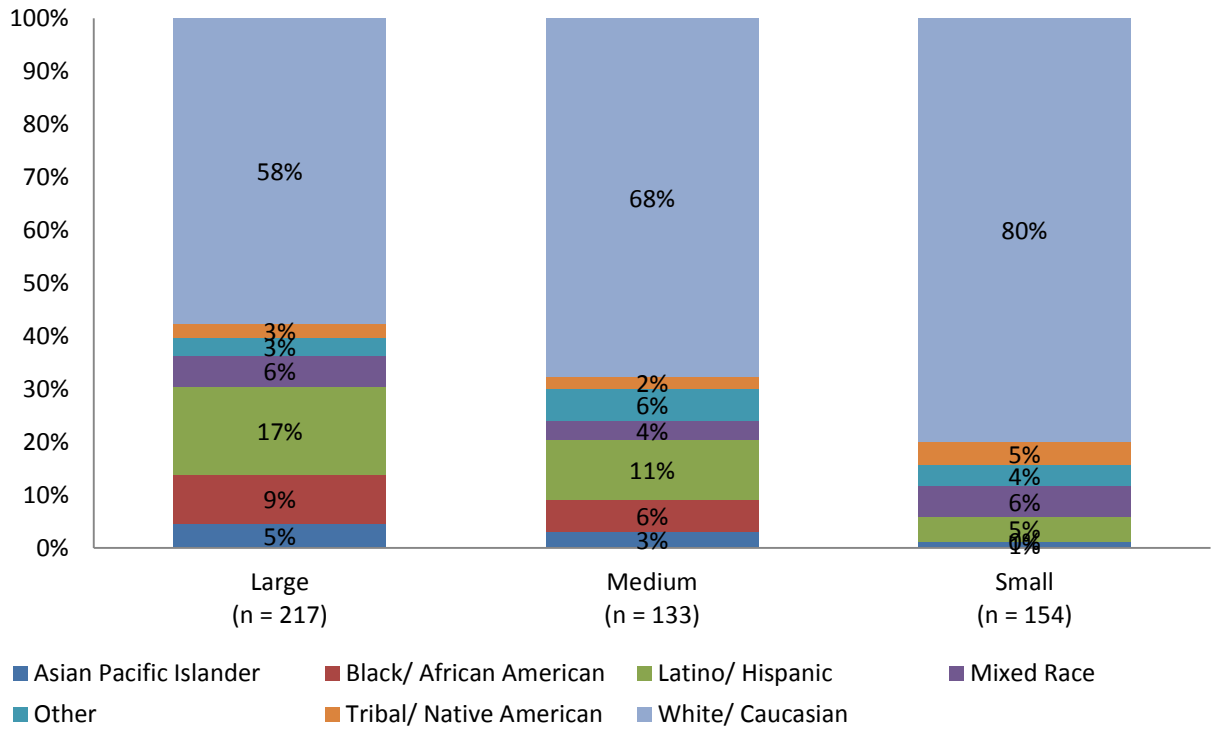


[δ] *SOURCE:* Stakeholder Survey

The distribution of race/ethnicity showed more variation across county size, as shown in Figure 72. Consistent with statewide results, participants identifying as White/Caucasian were the largest race/ethnicity represented across all county size categories, however, its representation decreased as county size increased. Similarly, large counties showed greater diversity than medium and small counties,

with most race/ethnicities increasing their representation as county size increased. However, contrary to that, Tribal/Native Americans showed the greatest representation in small counties (5%, *n* = 154) when compared to medium (2%, *n* = 133) and large counties (3%, *n* = 217).[δ]

Figure 72: Race/Ethnicity among Participants who Indicated they Participated in CPP Process, by County Size [δ]



[δ] *SOURCE:* Stakeholder Survey

PO-03: Does participation include representatives of unserved and underserved populations and their family members?

Because counties did not consistently report data on their CPP stakeholders, it was not possible to determine whether or not participants were from unserved or underserved populations. However, data was available on whether certain activities were used to outreach to unserved and underserved populations (see AC-03 on Page 47), though this data did not capture whether those populations actually participated in their counties' CPP processes.

Similarly, because what it means to be an unserved or underserved population can vary between counties, using demographic data to answer this research question proved to be a challenge. For discussions of the demographic breakdowns of those stakeholders who indicated they participated in the CPP process, see PO-02 on Page 101.

PO-04: Does participation reflect the diversity of the demographics of the county?

Because counties did not consistently report data on who participated in their CPP processes, it was not possible to determine the total number of counties' CPP participants, nor the exact breakdowns of their demographics. Due to the limited nature of this data, comparing the demographics of CPP participants to the overall demographics of the county proved to require more consistently reported and reliable data regarding who participated in counties' CPP processes. As a result, data addressing this research question has been omitted.

However, while not representative of all CPP participants, a general discussion of the demographics of some CPP participants is provided in a previous section (see PO-02 on Page 101).

PO-05: Does participation involve clients with SMI and/or SED, and their family members?

Results

Statewide: At the statewide level, among stakeholders who indicated they participated in the CPP process, 30% identified as being a mental health client/consumer and 34% identified as being a family member of a mental health consumer.

CMHDA Region: Generally speaking, participation among both mental health client/consumers and their family members remained relatively consistent across CMHDA Regions. The Bay Area region had the most participation among mental health clients/consumers (37%), whereas the Central region had the lowest (26%). The Central region had the most participation among family members of mental health consumers (40%), whereas the Superior region had the lowest (24%).

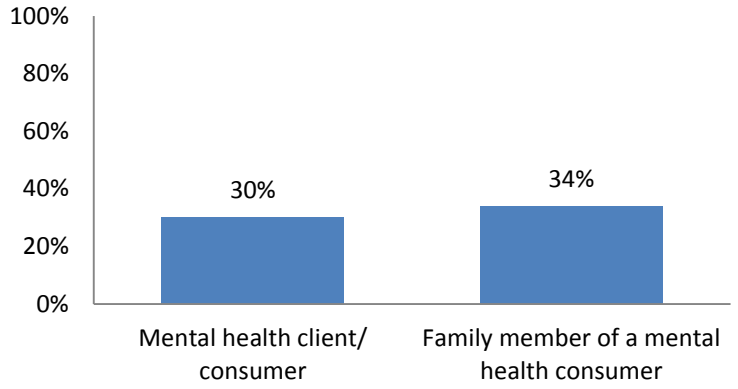
County Size: Both small and large counties reported three times the rates of participation among mental health clients/consumers in counties' CPP processes (30% and 31%, respectively) than medium counties (10%). Participation among family members of a mental health consumer increased as the sizes of counties increased, with small counties reporting 24%, medium counties reporting 36%, and large counties reporting 40%.

Statewide

Rationale: In order to understand whether participation involved clients with SMI and/or SED and their family members, data was analyzed from the Stakeholder Survey. Among stakeholders who reported participating in their counties' CPP processes (as shown in Figure 73), 34% (n = 598) reported being family members of mental health consumers and 30% (n = 598) reported being mental health client/consumers themselves.

Figure 73: Affiliation among Stakeholders Who Indicated They Participated in CPP Process, by Statewide [δ]

(*n* = 598)

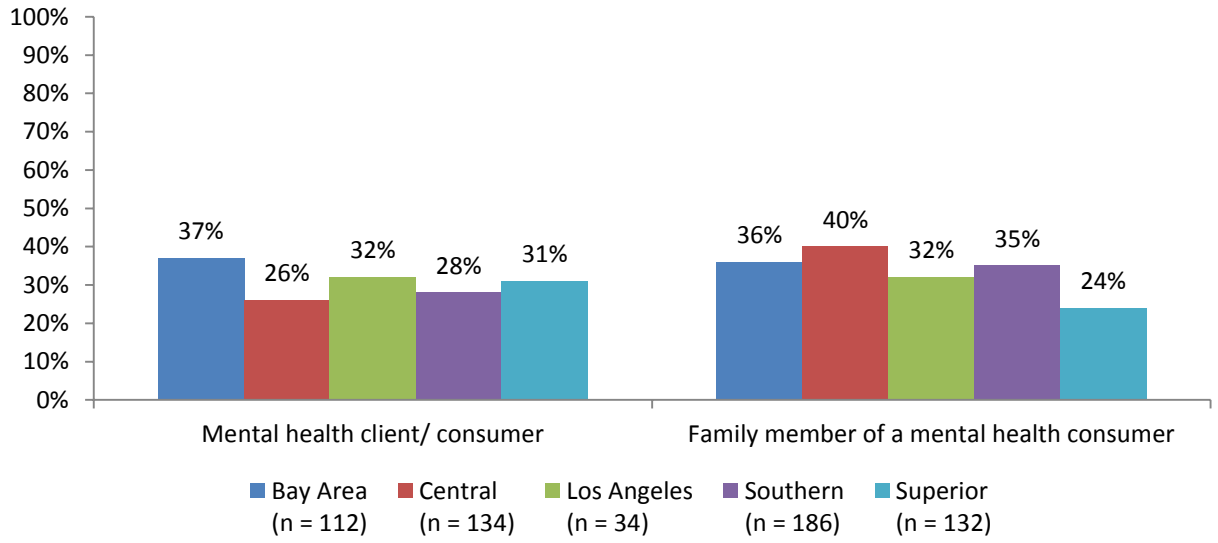


[δ] *SOURCE:* Stakeholder Survey

CMHDA Region

Rationale: Generally speaking, participation among both mental health client/consumers and their family members remained relatively consistent across all CMHDA Regions, as shown in Figure 74. The Bay Area region reported the most participation among mental health clients/consumers (37%, *n* = 112), whereas the Central region had the lowest (26%, *n* = 134). In terms of participation among family members of mental health consumers, the Central region reported the most participation (40%, *n* = 134), whereas the Superior region reported the lowest participation (24%, *n* = 132).

Figure 74: Affiliation among Stakeholders Who Indicated They Participated in CPP Process, by CMHDA Region [δ]

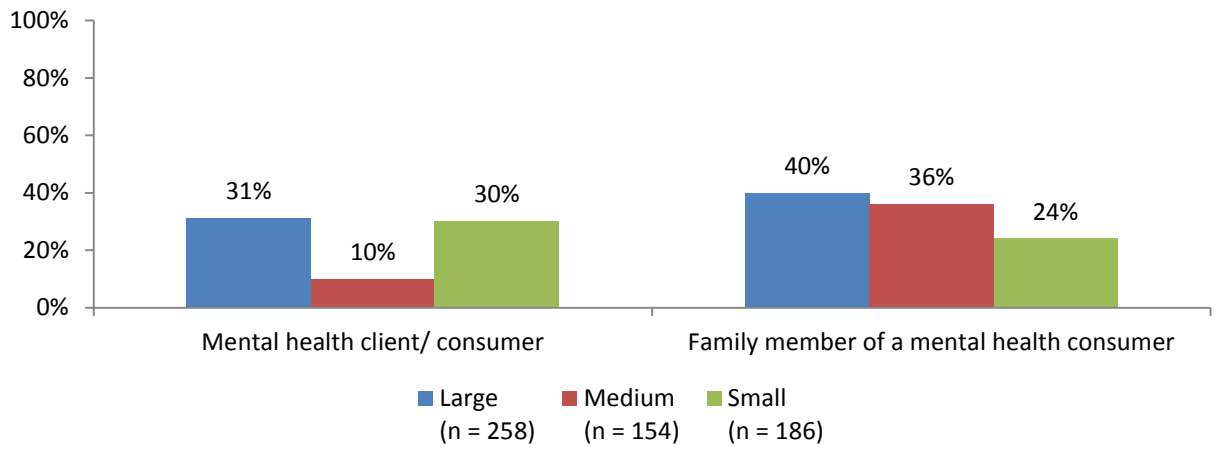


[δ] *SOURCE:* Stakeholder Survey

County Size

Rationale: Both small and large counties reported three times the rates of participation by mental health clients/consumers in their CPP processes (30%, *n* = 186 and 31%, *n* = 258, respectively) than medium counties (10%, *n* = 154), as shown in Figure 75. Participation by family members of a mental health consumer increased as county size increased, with small counties reporting 24% (n=186), medium counties 36% (*n* = 154), and large counties 40% (*n* = 258).

Figure 75: Affiliation Type among Stakeholders who Reported Participating in the CPP Process, by County Size [δ]



[δ] *SOURCE:* Stakeholder Survey

PO-06: How long and with what frequency do people participate?

Results

Statewide: The majority of stakeholders reported they have participated in CPP processes for more than three years (56%, *n* = 590). Additionally, about one-third of stakeholders said they did not take part in monthly activities, but they did participate in more than one activity per year.

CMHDA Region: The Bay Area region had the highest percentage of stakeholders who participated for more than three years (64%). However, the Bay Area region also reported the highest percentage of stakeholders that participated in one activity per year (17%). Thus, more Bay Area region stakeholders participated longest, but they participated less frequently. On the other hand, the Central region had the highest percentage of stakeholders who participated for less than one year (21%), but was one of the regions that had the highest percentage of stakeholders who participated in more than one CPP activity per year (41%). Thus, a high proportion of Central region stakeholders participated in CPP activities for a short amount of time, but a high proportion also reported participating in more than one activity per year. The Superior region also had a high proportion of stakeholders participating in more than one CPP activity per year (41%). Stakeholders from the Los Angeles and Southern regions frequently engaged in CPP activities, reporting attendance at 1-2 events per month (27% and 35%, respectively).

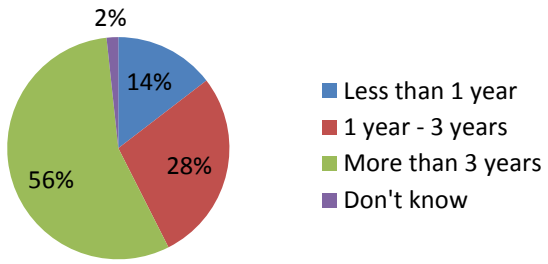
County Size: Across county size categories, the majority of stakeholders had participated in the CPP processes for more than three years. Large counties had the highest percentage of stakeholders (33%) who participated in CPP activities 1-2 times per month, while approximately 40% of small and medium county stakeholders participating in less than one CPP activity per month but more than one per year.

Statewide

Rationale: To understand how long and with what frequency stakeholders participate in the CPP process, data was analyzed from Stakeholder Surveys. Figure 76 shows the length of time stakeholders have participated in the MHSA CPP process. The majority of participants reported they had participated in their counties' CPP processes for three or more years (56%, *n* = 590).

Figure 76: Length of Time Stakeholders Participated in CPP Process, Statewide [δ]

(*n* = 590)



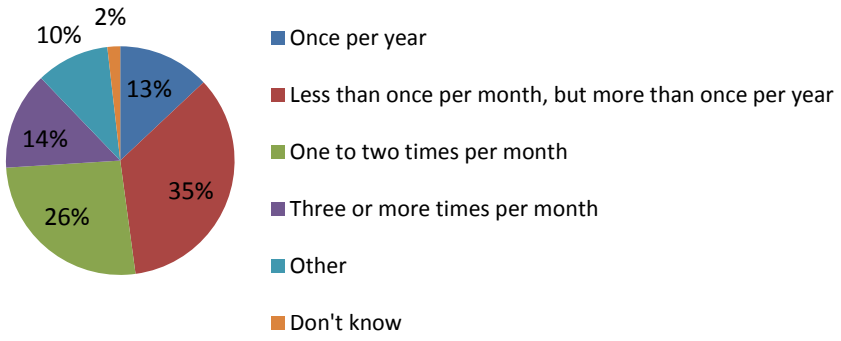
[δ] *SOURCE*: Stakeholder Survey

Stakeholders were also asked how frequently they participated in their counties' CPP processes. Approximately one-third of respondents (35%, *n* = 589) said they participated less than once per month and more than once per year. Approximately a quarter participated 1-2 times per month (26%, *n* = 589) (see

Figure 77).

Figure 77: Frequency of Participation in CPP Activities, Statewide [δ]

(*n* = 589)

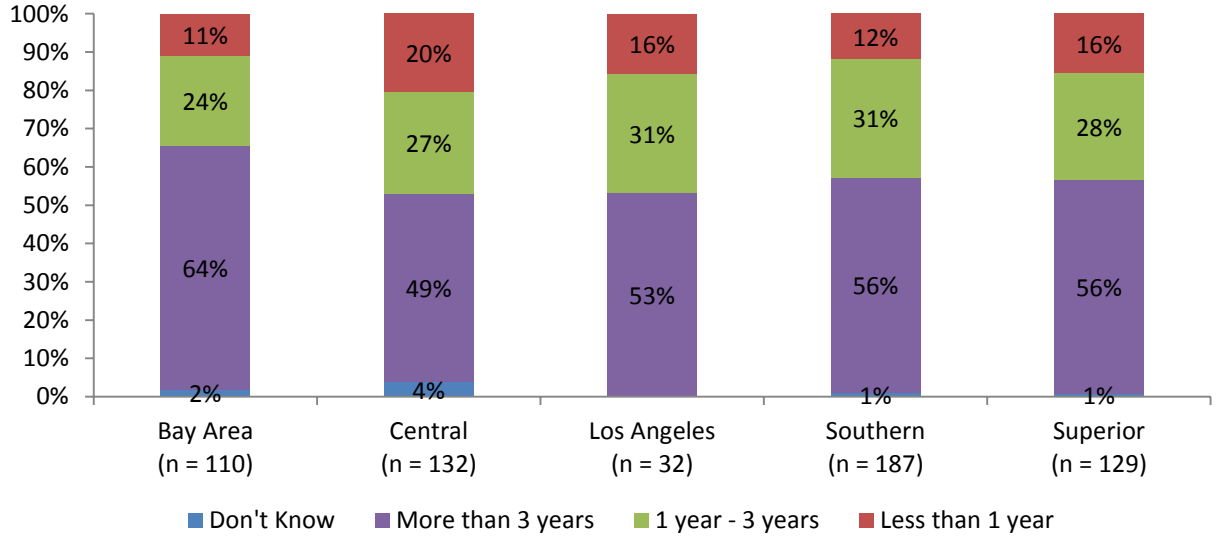


[δ] *SOURCE*: Stakeholder Survey

CMHDA Region

Rationale: Across CMHDA Regions, the majority of stakeholders reported participating in their counties' CPP processes for more than three years, as shown in Figure 78. The Bay Area region had the highest percentage of stakeholders who had participated in their counties' CPP processes for more than three years (64%, *n* = 110). The Central region had the highest percentage of stakeholders who had participated in their counties' CPP processes for less than one year (21%, *n* = 132).

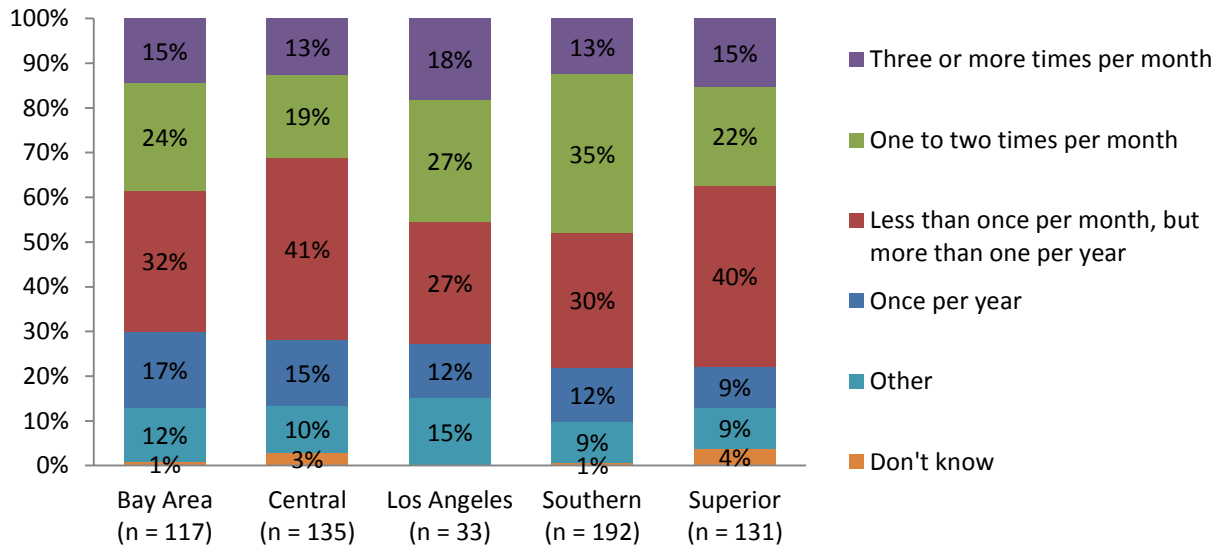
Figure 78: Length of Time Stakeholders Participated in CPP Process, by CMHDA Region [δ]



[δ] *SOURCE*: Stakeholder Survey

Stakeholders were also asked the frequency with which they participated in CPP activities, as shown in Figure 79. The majority of stakeholders in the Bay Area, Central, and Superior regions reported attending more than one CPP activity per year, but less than one per month (32%, *n* = 117; 41%, *n* = 135; and 41%, *n* = 131, respectively). The Central and Superior regions had the highest percentages of stakeholders (41%, *n* = 135 and 41%, *n* = 131, respectively) who participated in more than one CPP activity per year, but less than one per month. The majority of Southern region stakeholders participated in 1-2 activities per month (35%, *n* = 192), while an equal proportion of Los Angeles region stakeholders participated in 1-2 activities per month or less than one per month (27%, *n* = 33), but more than one per year (27%, *n* = 33).

Figure 79: Frequency of Participation in CPP Activities, by CMHDA Region [δ]



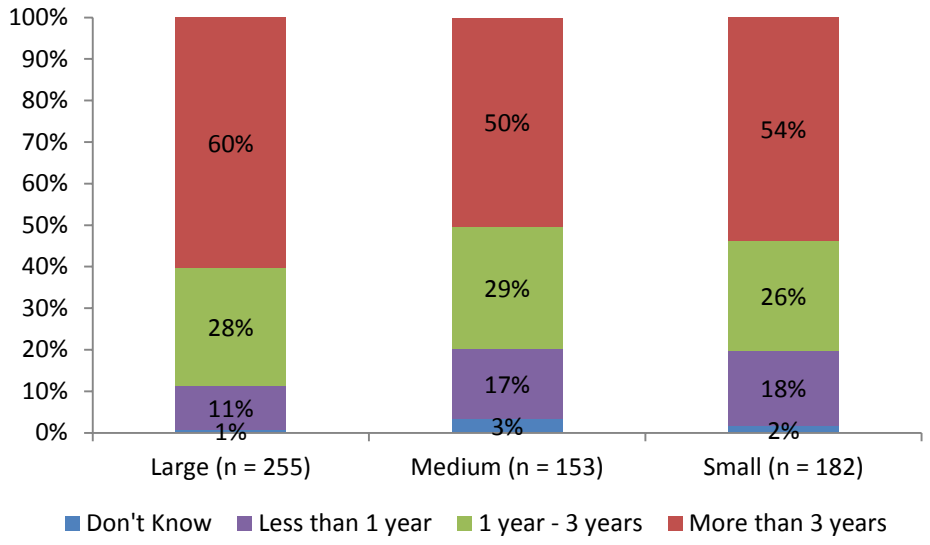
[δ] *SOURCE*: Stakeholder Survey

County Size

Rationale: Across county size categories, the majority of stakeholders participated in their counties' CPP processes for more than three years, with large counties having the highest percentage of participation (60%, *n* = 255). Small counties had the highest percentage of stakeholders who have participated for less than one year (18%, *n* = 182) (see

Figure 80).

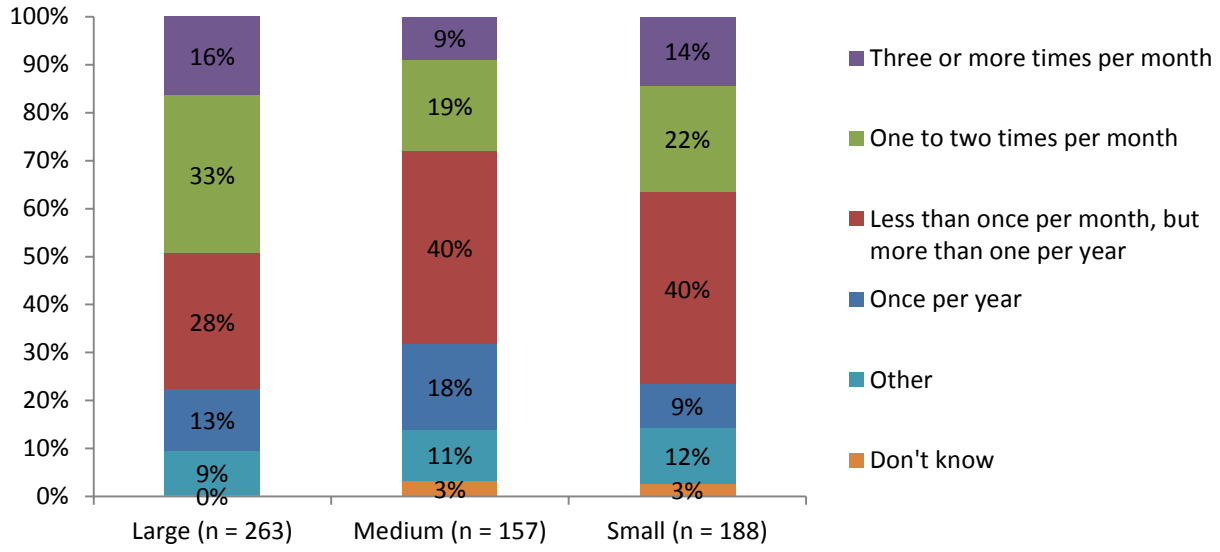
Figure 80: Length of Time Stakeholders Participated in CPP Process, by County Size [δ]



[δ] *SOURCE*: Stakeholder Survey

Regarding the frequency with which stakeholders reported they participate in CPP activities, large counties had the highest percentage of stakeholders (33%, *n* = 263) who participated in CPP activities one to times per month. Approximately 40% of stakeholders in medium (*n* = 157) and small (*n* = 188) counties participated in less than one CPP activity per month, but more than one activity per year (see Figure 81).

Figure 81: Frequency of Participation in CPP Activities, by County Size [δ]



[δ] *SOURCE*: Stakeholder Survey

PO-07: Who is not participating in the CPP process, and why not?

Result

Statewide: Counties and stakeholders agreed that the following stakeholder populations were underrepresented in their counties' CPP processes: 1) all communities of color, 2) youth/TAY, 3) parents of children diagnosed with serious emotional disturbance (SED), 4) veterans, and 5) LGBT. In addition to these specific populations, data indicated that rural communities and geographically isolated communities were not sufficiently represented in counties' CPP processes. Counties and stakeholders reported a need for more participation by stakeholders with other community affiliations – law enforcement, criminal justice, K-12 education, and the faith-based community emerged as key sectors based on the County Key Informant Interviews and Stakeholder Focus Groups.

Counties and stakeholders agreed that transportation and geography were the key barriers preventing stakeholder participation in counties' CPP activities. Geographic barriers had to do with counties that were spread-out but had pockets of isolated rural and/or desert communities, and thus prevented stakeholders from attending CPP activities. Stigma and accessibility issues were also frequently cited by both counties and stakeholders. However, counties and stakeholders differed in their understanding of accessibility. Counties described "accessibility" largely in terms of structural issues, such as inconvenient meeting times and locations, stakeholders busy work schedules, and stakeholders disinterest due to lack of knowledge about CPP and/or the mental health system. Stakeholders, on the other hand, defined "accessibility" in terms of the CPP culture. For instance, stakeholders often spoke about unwelcoming environments as one of the key accessibility issues that prevented stakeholders from participating in their counties' CPP activities. Unwelcoming environments included: uninviting staff and environment, overuse of technical jargon and charts/graphs, too much arguing, long meetings, and overly bureaucratic cultures.

Stakeholder Survey data was inconsistent with Key Informant Interview and Stakeholder Focus Group data. Based on Stakeholder Survey data, the majority of stakeholders reported that there were no barriers to participating in their counties' CPP processes (55.8%, n = 573). Other than the stakeholders that noted not having any barriers to CPP participation, the primary factor preventing stakeholder participation was inconvenient meeting times.

CMHDA Region: In general, county and stakeholder data did not vary significantly when analyzed by CMHDA Region. Nonetheless, respondents from the Superior and Southern regions discussed underrepresentation by rural and isolated desert communities, primarily due to accessibility issues. Stigma was a key barrier in the Superior region.

Relative to other CMHDA Regions, a significant proportion of Bay Area region stakeholders (16%, n = 109) reported not enough training/knowledge prevented them from meaningfully participate in their counties' CPP processes. Language was a significant barrier for stakeholders from the Los Angeles region (16%, n = 32). In addition to inconvenient meeting times, stigma was the second most frequently cited barrier by stakeholders from the Superior region (10%, n = 124). This last result *does* align with the stakeholder focus group data.

County Size: In general, county and stakeholder data did not vary significantly when analyzed by county size categories. Both counties and stakeholders in small counties identified mono-lingual Spanish speakers and tribal communities as insufficiently represented in their counties' CPP activities. Regarding barriers that prevented stakeholders from participating in CPP activities, small counties often discussed transportation and geographic barriers together; specifically, stakeholders commented on transportation challenges for those who lived in rural or isolated communities where the counties are geographically spread-out. Stigma was a second significant barrier in small counties; stakeholders reported unease in attending CPP activities due to the lack of anonymity.

Stakeholder Survey data reflected statewide data when analyzed by county size categories, but was inconsistent with County Key Informant and Stakeholder Focus Group data.

Statewide

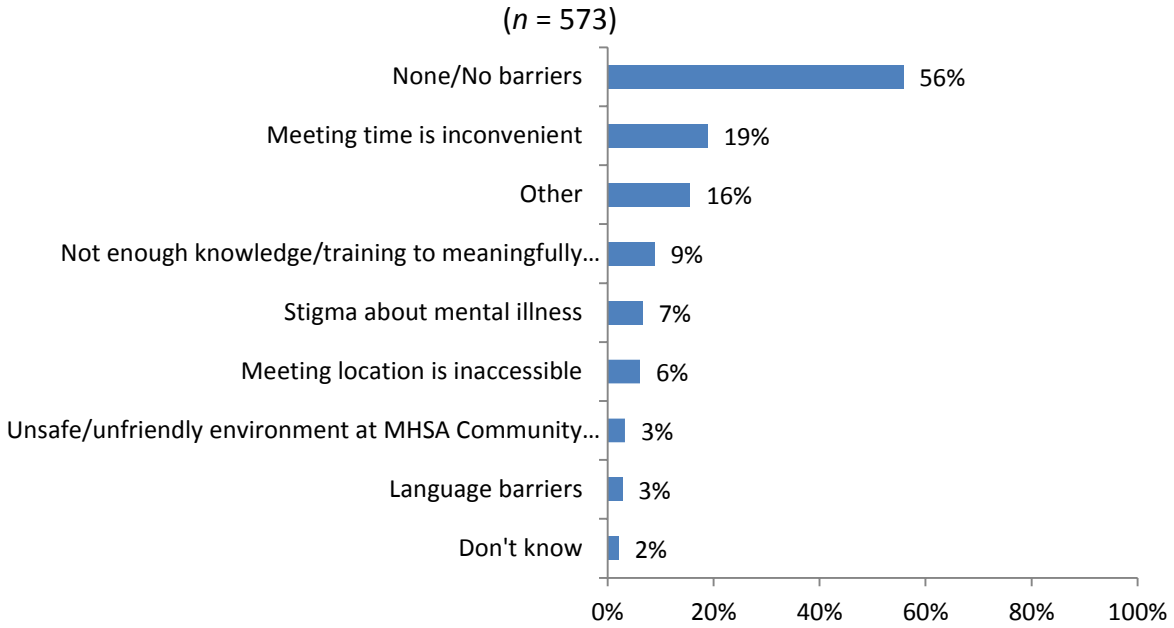
Rationale: To answer this question at the statewide level, data was analyzed from the County Key Informant Interviews, Stakeholder Focus Groups, and Stakeholder Surveys. Overall, county and stakeholder data were in agreement that the following populations were underrepresented in counties' CPP processes: 1) communities of color, 2) youth/TAY, 3) parents of children diagnosed with SED, 4) veterans, and 5) LGBT. Data also indicated that rural communities as well as geographically isolated communities were not sufficiently participating in their counties' CPP processes. Along with specific populations, counties and stakeholders also discussed the need for more participation from stakeholders from other sectors, in particular K-12 education, law enforcement, and the faith-based communities.

Regarding barriers to stakeholder participation in counties' CPP processes, data from the Key Informant Interviews and Stakeholder Focus Groups corresponded on some barriers while disagreed on other identified barriers. Data from the Stakeholder Survey was inconsistent between the Key Informant Interview and Stakeholder Focus Group data – both sets of data pointed to transportation and county geography as key barriers to stakeholders participating in CPP processes. Geographic barriers had to do with counties that were spread-out but had pockets of rural/desert communities that were isolated and thus prevented stakeholders from attending CPP activities. Additional barriers counties and stakeholders identified were: 1) language/cultural, 2) childcare, 3) stigma, and 4) accessibility issues.

Counties and stakeholders differed in what they considered to be "accessibility" issues. For counties, concerns pertaining to accessibility included: meeting times and locations, stakeholders busy work schedules, and stakeholders disinterest due to lack of knowledge about CPP and/or the mental health system. Stakeholders, on the other hand, highlighted the unwelcoming environment as one of the key accessibility issues that prevented stakeholders from participating in counties' CPP activities. The unwelcoming environments were described as: uninviting staff and environment, overusing technical jargon and charts/graphs, too much argument, having long meetings, and overly bureaucratic cultures. Where MHSA/CPP Coordinators focused on structural barriers, stakeholders elaborated on the organizational culture as accessibility issues that prevented stakeholders from participating in their counties' CPP processes.

Based on Stakeholder Survey data, the majority of stakeholders reported that there were no barriers to participating in their counties' CPP processes (56%, *n* = 573). Nineteen percent of stakeholders (*n* = 573) checked inconvenient meeting times was a barrier to participating in their counties' CPP activities. Inconvenient meeting times were the primary factor preventing stakeholder CPP participation (see Figure 82).

Figure 82: Barriers to Participation in the CPP Process, Statewide [δ]



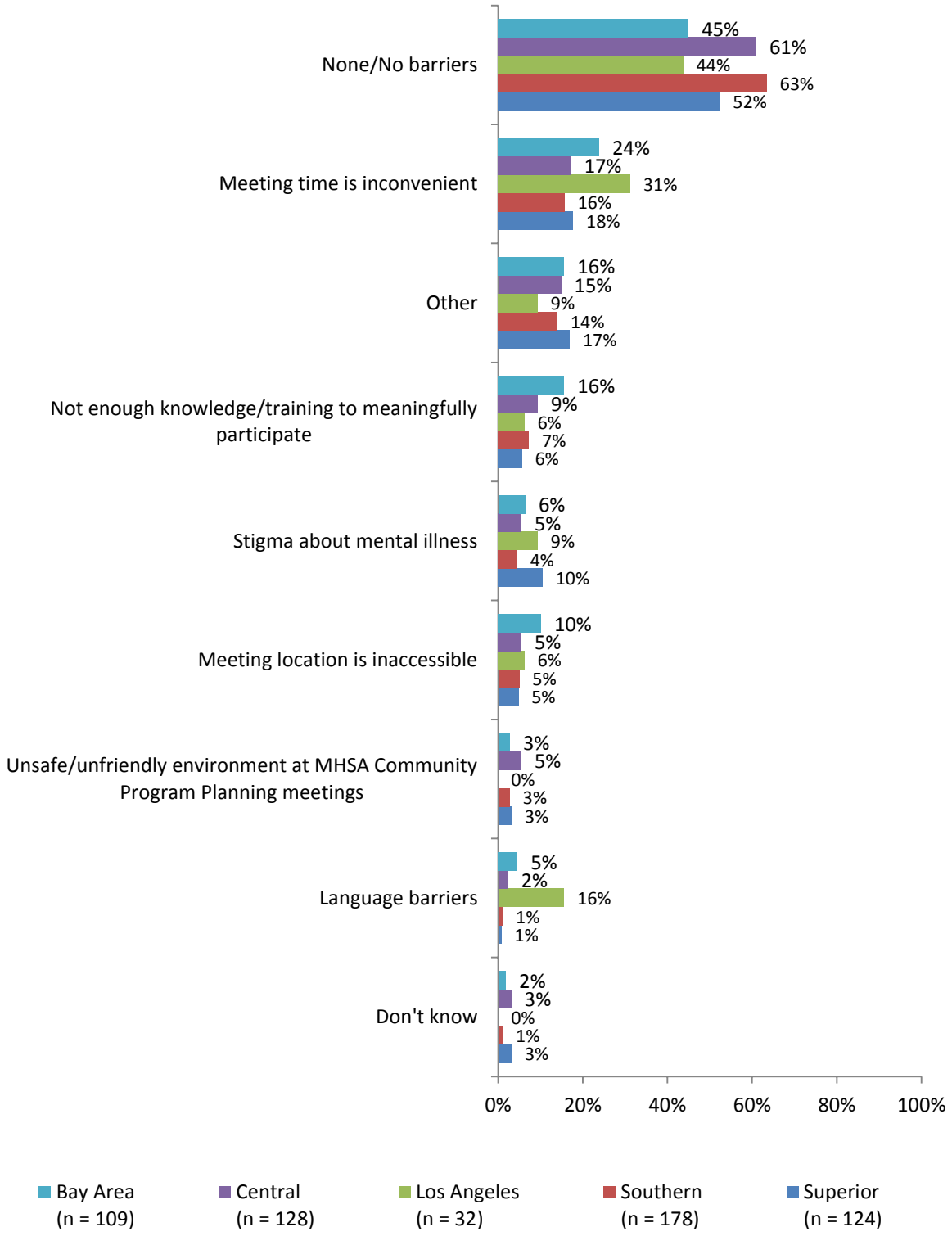
[δ] *SOURCE*: Stakeholder Survey

CMHDA Region

Rationale: County and stakeholder data did not vary significantly when analyzed by CMHDA Region. Similar to statewide data, counties and stakeholders felt that all communities of color were underrepresented in their counties' CPP processes. Superior and Southern regions discussed underrepresentation among rural and isolated desert communities, primarily due to accessibility issues. Stigma was a key barrier in the Superior region.

Stakeholder survey data indicated that the majority of stakeholders reported no barriers from participating in their counties' CPP processes. The second most frequently cited barrier was inconvenient meeting times. Relative to other CMHDA Regions, a significant proportion of Bay Area region stakeholders (16%, *n* = 109) reported that not having enough training/knowledge prevented them from meaningfully participating in their counties' CPP processes. Relative to other CMHDA Regions, language was a significant barrier for the Los Angeles region (16%, *n* = 32). In addition to inconvenient meeting times, stigma was the second most frequently cited barrier for the Superior region (10%, *n* = 124), which corresponded with the Stakeholder Focus Group data.

Figure 83: Barrier to Participation in CPP Process, by CMHDA Region [δ]



[δ] *SOURCE*: Stakeholder Survey

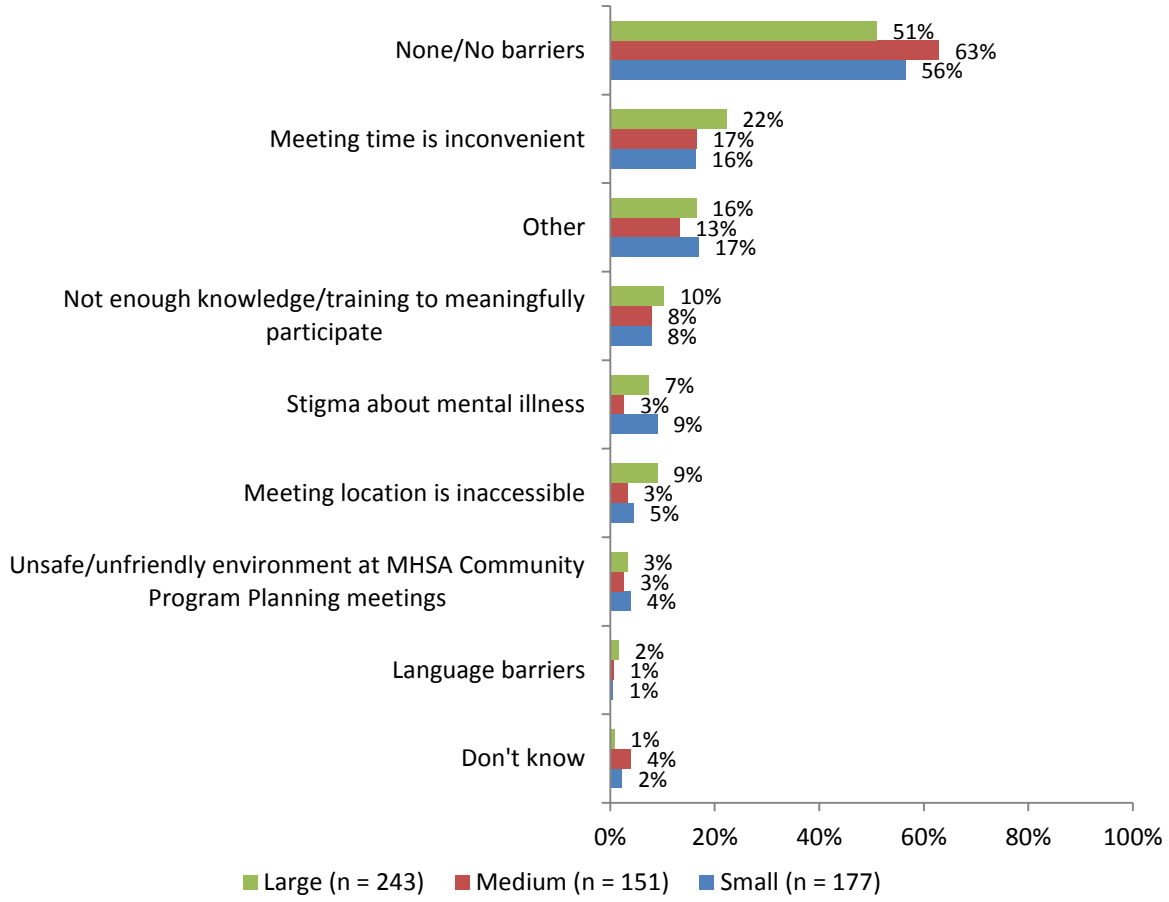
County Size

Rationale: County and stakeholder data did not significantly vary when analyzed by county size categories. However, counties and stakeholders from small counties identified mono-lingual Spanish speakers and tribal communities as insufficiently represented communities in their counties' CPP activities.

County and stakeholder qualitative data generally supported the key barriers identified at the statewide level. Nonetheless, some differences emerged for small counties. For instance, small counties often discussed transportation and geographic barriers together. Stakeholders commented on transportation challenges for those who lived in rural or isolated communities where the counties were geographically spread out. Stigma was a second significant barrier in small counties. Stakeholders reported unease in attending CPP meetings due to the lack of anonymity in smaller counties.

Overall, Stakeholder Survey data reflected statewide data for this item. Across county size categories, the majority of stakeholders replied that there were no barriers to participating in their counties' CPP processes, as shown in Figure 84.

Figure 84: Barriers to Stakeholder Participation in the CPP Process, by County Size [δ]



[δ] *SOURCE*: Stakeholder Survey

Process Outcomes – Training

The following section identifies how many participants are trained to better participate in the CPP process and the frequency of that training.

PO-08: How many participants are trained to better participate in the CPP process? With what frequency?

Results

Statewide: At the statewide level, the methods of CPP training or education that received the greatest number of participants included: 1) offer professional development or continuing education credits, with an average of 300 participants (*n* = 1); 2) support for participants to attend training not sponsored by the county, with an average of 105 participants (*n* = 3); and 3) county-specific trainings on participation in the local stakeholder planning process, with an average of 74 participants (*n* = 10). While the frequency of CPP training or education varied across each method, "as needed" was consistently reported as the most common frequency of trainings.

CMHDA Region: Across all CMHDA Regions, "providing county-specific trainings on participation in the local stakeholder planning process" was the primary method used to train and educate CPP participants; however, the average number of total participants ranged from 10 (Los Angeles region) to 300 (Superior region). Due to the limited nature of data regarding the number of participants trained to better participate in counties' CPP processes (*n* = 30), analyzing the data based on CMHDA Region artificially created high and low counts of the number of participants who were trained to participate in counties' CPP processes. Similarly, due to the limited nature of data regarding the frequency of training or education that CPP participants received (*n* = 32), analyzing the data based on CMHDA Region artificially created high and low percentages of the frequency of training or education.

County Size: Across all county sizes, "providing county-specific trainings on participation in the local stakeholder planning process" and "produce and distribute CPP educational materials" were the primary methods used to train and educate CPP participants. However, the average number of participants that received county-specific trainings ranged from 10 (large counties) to 300 (small counties), and the average number of participants that received CPP educational materials ranged from 10 (small counties) to 250 (large counties). While "offering professional development or continuing education credits" appeared to be an effective method for training or educating a large number of CPP participants, this method was only used within small counties.

Statewide

Rationale: Based on available data at the statewide level, there were limited opportunities for CPP participants to receive training or education about how to better participate in their counties' CPP processes (*n* = 30). However, among those counties that did provide training or education for CPP participants, as shown in Table 32, the methods of training or education that received the greatest number of participants included: 1) offer professional development or continuing education credits, with an average of 300 participants (*n* = 1); 2) support for participants to attend training not sponsored by the

county, with an average of 105 participants (*n* = 3); and 3) county-specific trainings on participation in the local stakeholder planning process, with an average of 74 participants (*n* = 10). However, there was significant variation across counties in the range of participants that each training or education method received. For example, while support for participants to attend trainings not sponsored by the county received an average of 105 participants, the minimum was 5 participants and the maximum was 300 participants.

Table 32: Number of CPP Process Participants that Received Training or Education, Statewide [ϕ]

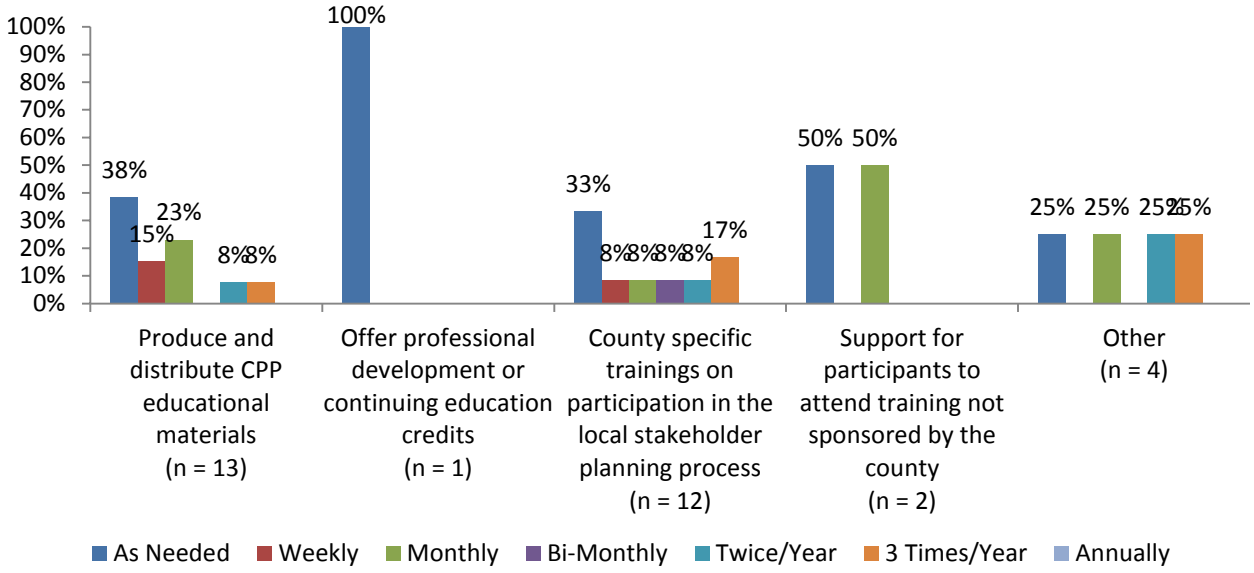
		Produce and distribute CPP educational materials (*n* 13)	Offer professional development or continuing education credits (*n* 1)	County specific trainings on participation in the local stakeholder planning process (*n* 10)	Support for participants to attend training not sponsored by the county (*n* 3)	Other (*n* 3)
Statewide	*Average*	71	300	74	105	53
	Minimum	10	300	6	5	4
	Maximum	250	300	300	300	100

[ϕ] *SOURCE:* County Web-Based Data Request

Generally speaking, the frequency of CPP training or education varied across each method. However, as shown in

Figure 85, "as needed" was consistently reported as the most common or among the most common frequency of trainings. The CPP training or education method that occurred at the highest frequency included: 1) produce and distribute CPP educational materials, with 28% of counties (*n* = 13) distributing materials on at least a monthly basis; and 2) countyspecific trainings on participation in the local stakeholder planning process, with 24% of counties (*n* = 12) providing trainings on at least a bi-monthly basis.

Figure 85: Frequency of Training/Education CPP Participants Received by Training or Education Type, Statewide ϕ



ϕ *SOURCE:* County Web-Based Data Request

CMHDA Region

Rationale: Across all CMHDA Regions, "providing county-specific trainings on participation in the local stakeholder planning process" was the primary method used to train and educate CPP participants; however, the average numbers of total participants ranged from 10 (Los Angeles region) to 300 (Superior region), as shown in Table 33**.** While "offering professional development or continuing education credits" appeared to be an effective method for training or educating a large number of CPP participants, this method was only used within the Superior region.

Within the Bay Area region, the method that averaged the greatest number of CPP participants was "other" (52 participants) and "produce and distribute CPP educational materials" (45 participants). Within the Central region, only two methods were reported as being used to train or educate CPP participants: "providing county specific trainings on participation in the local stakeholder planning process" (average of 87 participants, *n* = 4) and "produce and distribute CPP educational materials" (average of 85 participants, *n* = 5). The Los Angeles region only reported utilizing "county-specific trainings on participation in the local stakeholder planning process" (10 participants). Within the Southern region, the method that averaged the greatest number of CPP participants was "produce and distribute CPP educational materials" (77 participants) and "other" (56 participants). Within the Superior region, the methods that averaged the greatest numbers of CPP participants were "offer professional development or continuing education credits" (300 participants), "county specific trainings on participation in the local stakeholder process" (300 participants), and "support for participants to attend training not sponsored by the county" (300 participants).

Due to the limited nature of data regarding the frequency of training or education that CPP participants received (*n* = 32), analyzing the data based on CMHDA Region artificially created high and low percentages of the frequency of CPP training or education.

Table 33: Number of CPP Process Participants that Received Training or Education, by CMHDA Region ϕ

		Produce and distribute CPP educational materials	Offer professional development or continuing education credits	County specific trainings on participation in the local stakeholder planning process	Support for participants to attend training not sponsored by the county	Other
Bay Area	*Average*	45	N/A	19	5	52
	Minimum	10	N/A	6	5	4
	Maximum	80	N/A	31	5	100
	N-Value	2	0	3	1	2
Central	*Average*	85	N/A	87	N/A	N/A
	Minimum	20	N/A	20	N/A	N/A
	Maximum	250	N/A	250	N/A	N/A
	N-Value	5	0	4	0	0
Los Angeles	*Average*	N/A	N/A	10	N/A	N/A
	Minimum	N/A	N/A	10	N/A	N/A
	Maximum	N/A	N/A	10	N/A	N/A
	N-Value	0	0	1	0	0
Southern	*Average*	77	N/A	25	10	56
	Minimum	15	N/A	25	10	56
	Maximum	115	N/A	25	10	56
	N-value	3	0	1	1	1
Superior	*Average*	60	300	300	300	N/A
	Minimum	12	300	300	300	N/A
	Maximum	150	300	300	300	N/A
	N-value	3	1	1	1	0

ϕ SOURCE: County Web-Based Data Request

County Size

Rationale: Across all county sizes, "providing county-specific trainings on participation in the local stakeholder planning process" and "produce and distribute CPP educational materials" were the primary methods used to train and educate CPP participants, as shown in Table 34. However, the average number of participants that received county-specific trainings ranged from 10 (large counties) to 300 (small

counties), and the average number of participants that received CPP educational materials ranged from 10 (small counties) to 250 (large counties). While "offering professional development or continuing education credits" appeared to be an effective method for training or educating a large number of CPP participants, this method was only used within small counties.

Within large counties, the methods that averaged the greatest numbers of CPP participants were "produce and distribute CPP educational materials" (112 participants) and "providing county specific trainings on participation in the local stakeholder planning process" (95 participants). Within medium counties, the methods that averaged the greatest numbers of CPP participants were "other" (78 participants) and "produce and distribute CPP educational materials" (29 participants). Within small counties, the methods that averaged the greatest numbers of CPP participants were "offer professional development or continuing education credits" (300 participants) and "support for participants to attend training not sponsored by the county" (300 participants).

Due to the limited nature of data regarding the frequency of training or education that CPP participants received (*n* = 32), analyzing the data based on county size categories artificially created high and low percentages of the frequency of training or education.

Table 34: Number of CPP Process Participants that Received Training or Education, by County Size [ϕ]

		Produce and distribute CPP educational materials	Offer professional development or continuing education credits	County specific trainings on participation in the local stakeholder planning process	Support for participants to attend training not sponsored by the county	Other
Large	*Average*	112	N/A	95	N/A	4
	Minimum	15	N/A	10	N/A	4
	Maximum	250	N/A	250	N/A	4
	N-Value	5	0	3	0	1
Medium	*Average*	29	N/A	27	7.5	78
	Minimum	20	N/A	20	5	56
	Maximum	37	N/A	37	10	100
	N-value	2	0	4	2	2
Small	*Average*	52	300	115	300	N/A
	Minimum	10	300	6	300	N/A
	Maximum	150	300	300	300	N/A
	N-Value	6	1	3	1	0

[ϕ] *SOURCE:* County Web-Based Data Request

Process Outcomes – Stakeholder Perceptions and Satisfaction

This section presents several aspects of CPP participants' perceptions of how well their counties' CPP processes aligned with MHSA principles and values. This section also analyzes CPP participants' satisfaction with their counties' CPP processes, including the aspects that participants liked most and least.

PO-09: To what extent do stakeholders feel that the CPP activities are accessible?

Results

Statewide: The majority of stakeholders who participated in FY 2012-13 CPP activities agreed that efforts by counties to make CPP meetings more accessible were successful.

CMHDA Region: Consistent with statewide findings, the majority of stakeholders from different CMHDA Regions agreed that the efforts that counties made to increase CPP accessibility were successful. Out of the five CMHDA Regions, the Bay Area region had the lowest percentage of stakeholders who felt that CPP meetings were accessible.

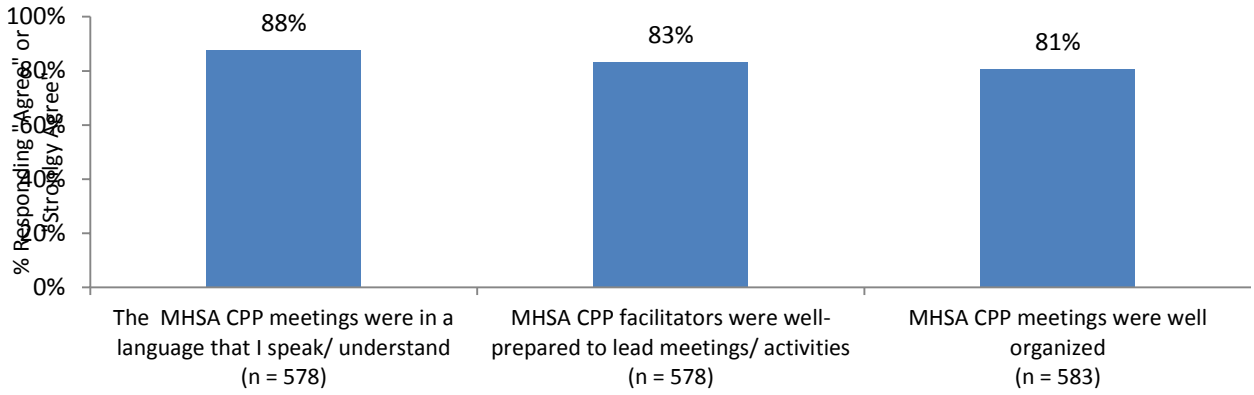
County Size: Consistent with statewide findings, the majority of stakeholders from counties of different sizes agreed that efforts counties made to increase CPP accessibility were successful. Respondents from large counties tended to agree at slightly lower levels, while respondents from medium counties agreed at slightly higher levels.

Statewide

Rationale: In the Stakeholder Survey, the majority of respondents who participated in FY 2012-13 CPP activities (*n* = 578) agreed that CPP meetings were especially accommodating in terms of being in a language stakeholders understood (88%) and that CPP facilitators were well prepared to lead CPP meetings and activities (83%), as shown in

Figure 86. Moreover, over three-fourths (81%) of responding CPP participants (*n* = 583) agreed that their counties' CPP meetings were well organized.

Figure 86: Stakeholder Perception of CPP Process Accessibility, Statewide [δ]



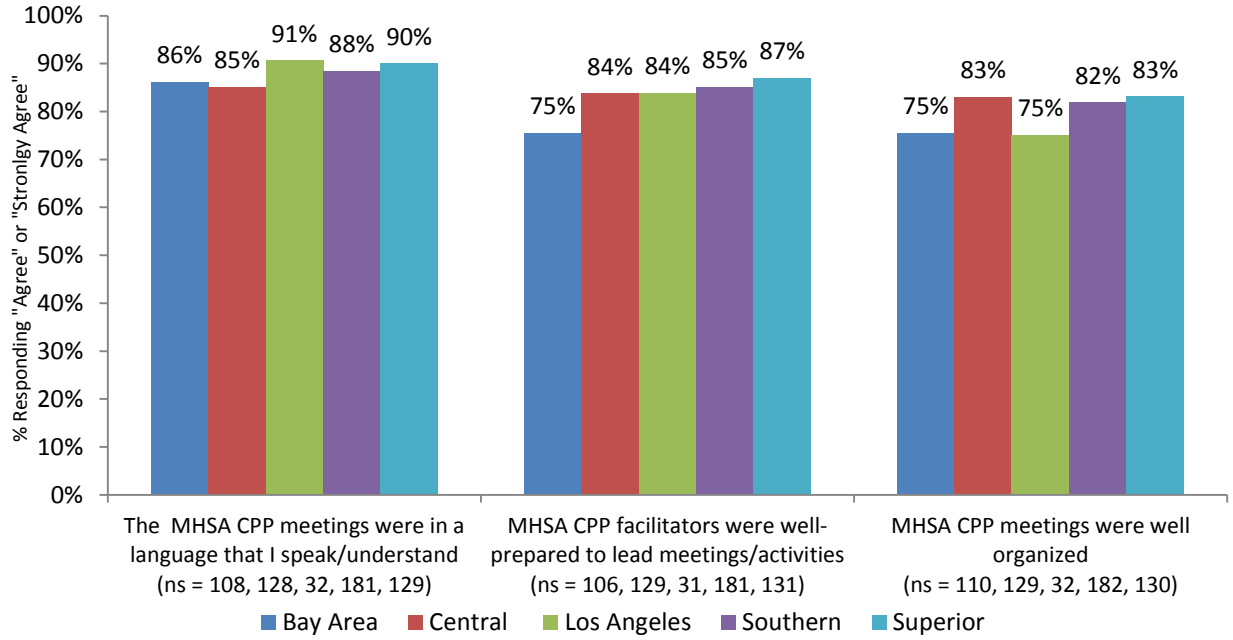
[δ] *SOURCE*: Stakeholder Survey

CMHDA Region

Rationale: Further analysis revealed few differences in how participants rated CPP accessibility across CMHDA Regions (see

Figure 87). Respondents from the Bay Area region consistently agreed with accessibility statements at lower levels than respondents from other CMHDA Regions, while respondents from the Superior region consistently agreed at slightly higher levels. The greatest difference in ratings was in how well prepared CPP facilitators were in leading CPP meetings and activities – only 75% of Bay Area region respondents (*n* = 106) agreed with this statement while 87% of Superior region respondents (*n* = 131) agreed.

Figure 87: Stakeholder Perception of CPP Process Accessibility, by CMHDA Region [δ]



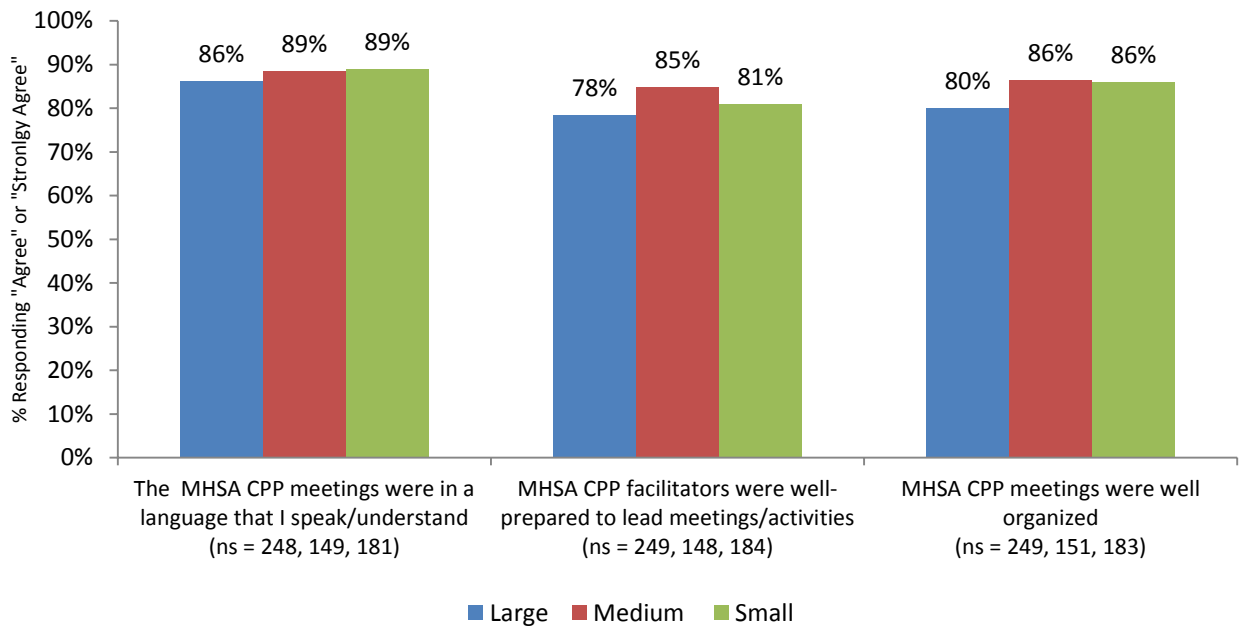
[δ] *SOURCE*: Stakeholder Survey

County Size

Rationale: Further analysis revealed few differences in how CPP participants rated CPP accessibility across counties of different sizes (see

Figure 88). Respondents from large counties agreed with accessibility statements at consistently lower levels while respondents from the medium counties consistently agreed at slightly higher levels. However, the differences in agreement were never greater than 7% of respondents.

Figure 88: Stakeholder Perception of CPP Process Accessibility, by County Size δ



δ *SOURCE*: Stakeholder Survey

PO-10: To what extent do stakeholders feel that the CPP process is consistent with the philosophy, principles, and practices of the Recovery Vision? (WIC, §5813.5d).

Results

Statewide: Nearly three-quarters (71%) of responding stakeholders who participated in FY 2012-13 CPP activities (*n* = 575) agreed that their counties' CPP processes were recovery oriented.

CMHDA Region: There was moderate variation among CMHDA Regions as to the extent to which stakeholders felt that their counties' CPP processes were recovery oriented. Again, respondents from the Bay Area region (*n* = 109) were in least agreement with whether or not CPP processes were recovery oriented (60%). Additionally, respondents from the Los Angeles region (*n* = 31) comprised the largest proportion of stakeholders agreeing that its region's CPP processes were recovery oriented (84%).

County Size: Large counties yielded the greatest proportion (74%) of responding CPP participants (*n* = 246) who agreed that the CPP activities were recovery oriented.

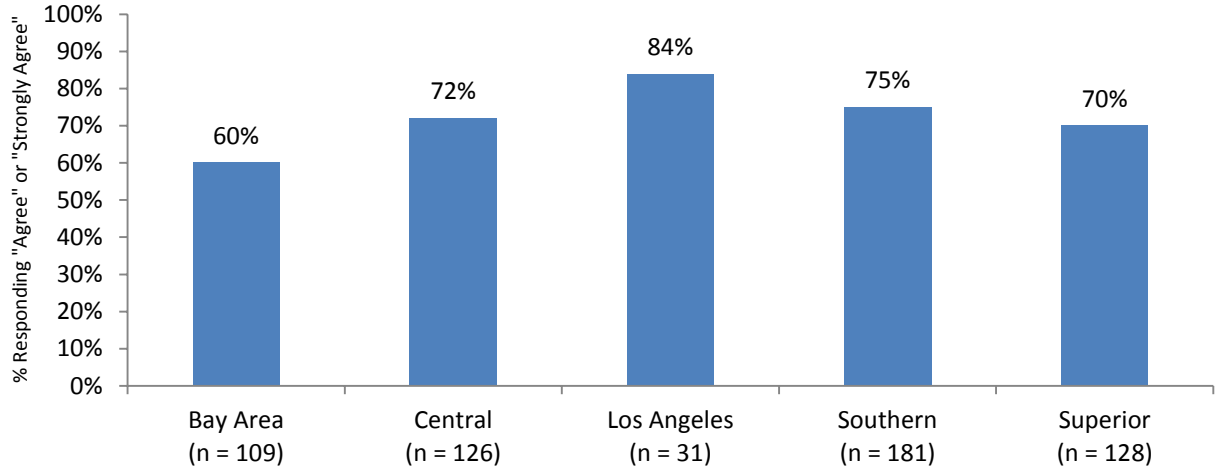
Statewide

Rationale: Based on data from the Stakeholder Survey, 71% of the respondents who participated in CPP activities (*n* = 575) "agreed" or "strongly agreed" with the statement, "The CPP process was recovery oriented." There was not consistent descriptive data obtained from the Stakeholder Focus Groups to produce statewide findings on whether counties' CPP processes were consistent with the philosophy, principles, and practices of the recovery vision.

CMHDA Region

Rationale: Stakeholders were asked to rate how consistent the CPP process was with the MHSA recovery vision, as shown in Figure 89. The greatest proportion of stakeholders who agreed that the CPP process was recovery oriented was from the Los Angeles region (84%), while the smallest proportion was from the Bay Area region (60%). Slight differences in agreement were reported among stakeholders from the Central (72%), Southern (75%), and Superior (70%) regions.

Figure 89: Stakeholder Perception of CPP Consistency with the Recovery Vision, by CMHDA Region [δ]



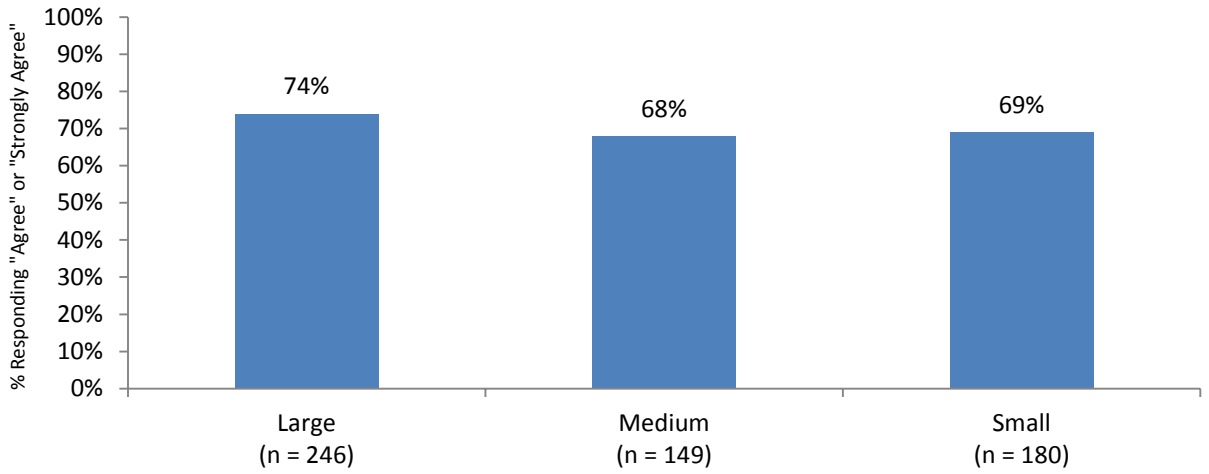
[δ] *SOURCE*: Stakeholder Survey

County Size

Rationale: While more respondents from large counties (*n* = 246) agreed that the CPP process was recovery oriented (74%), this was not a substantial difference from the proportion of respondents from medium counties (68%, *n* = 149) or small counties (69%, *n* = 180), as shown in

Figure 90.

Figure 90: Stakeholder Perception of CPP Consistency with the Recovery Vision, by County Size [δ]



[δ] *SOURCE*: Stakeholder Survey

PO-11: To what extent do participants feel that the CPP environment is safe and free from stigma, discrimination, and retaliation?

Results

Statewide: The majority of stakeholders reported that they felt safe participating in CPP processes.

CMHDA Region: While over 80% of all responding stakeholders who participated in the CPP process in the Central, Southern, and Superior regions felt safe and supported in the CPP process, noticeably fewer stakeholders in the Los Angeles and Bay Area regions felt similarly.[δ] These findings were reflected in the Stakeholder Focus Groups as well.

County Size: Findings across the two stakeholder feedback tools in this area were less conclusive. A consistent finding across the measures was that fewer stakeholders from large counties reported feeling safe and supported in their counties' CPP processes.

Statewide

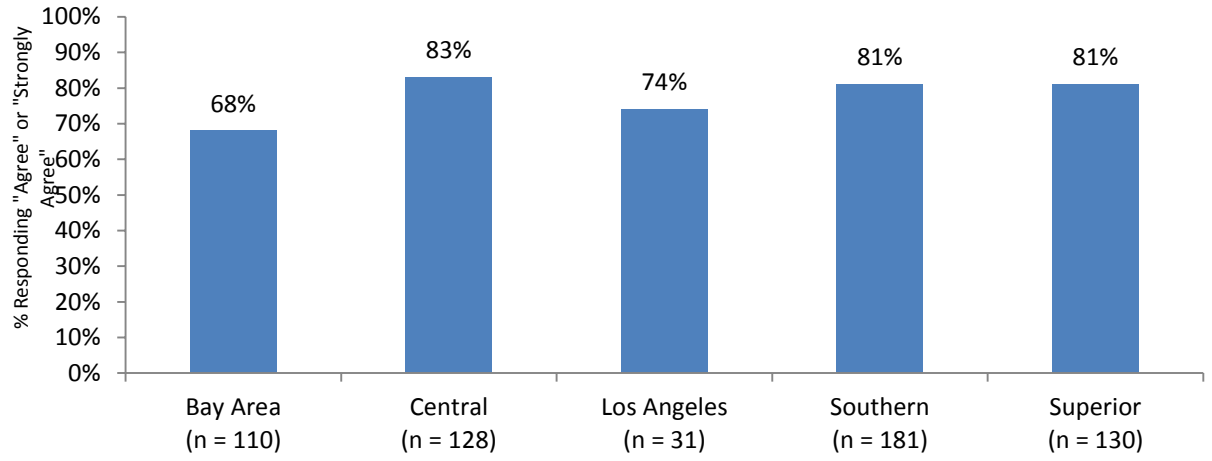
Rationale: In the Stakeholder Survey, 79% of respondents who participated in FY 2012-13 CPP activities (*n* = 580) reported that they felt safe participating in their counties' CPP processes. Among counties that conducted Stakeholder Focus Groups (*n* = 47), 62% of focus groups reported feeling safe and supported while participating in CPP meetings. They most commonly identified safety agreements, communication agreements, and peer-driven committees as sources of safety and support.

CMHDA Region

Rationale: In the Stakeholder Survey, the Central region yielded the greatest percentage (83%) of stakeholders who felt safe participating in their counties' CPP meetings, followed by the Southern (81%), Superior (81%), and Los Angeles (74%) regions (see Figure 91). As with previous measures of stakeholder

perceptions, the Bay Area region yielded the smallest proportion (68%) of stakeholders who reported feeling safe participating in CPP processes.

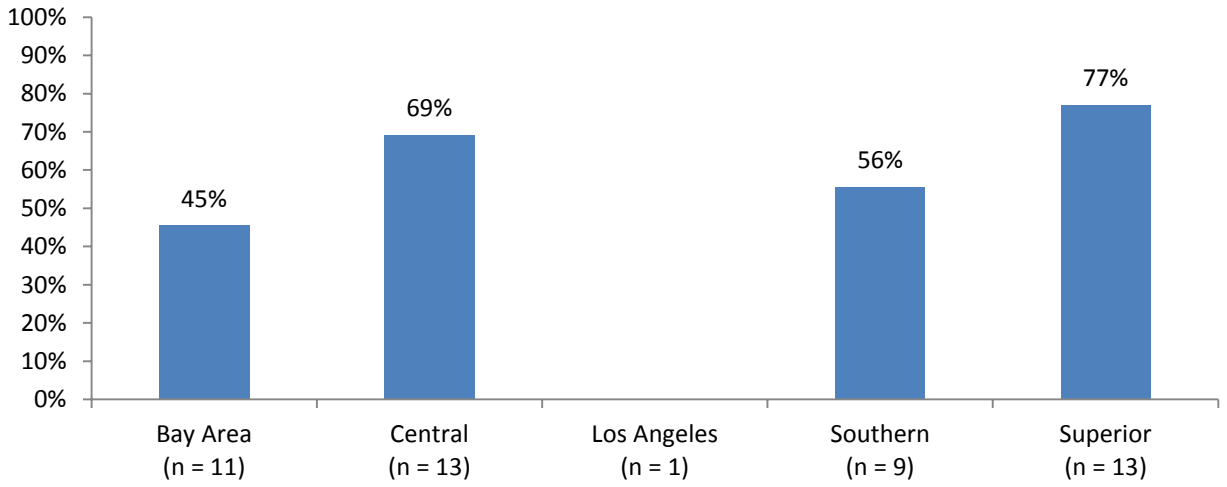
Figure 91: Stakeholder Perception of Safety in the CPP Processes, by CMHDA Region [δ]



[δ] *SOURCE*: Stakeholder Survey

Similarly, the Superior (77%) and Central (69%) regions contained the greatest proportions of Stakeholder Focus Groups that reported feeling safe and supported in CPP participation, as shown in Figure 92. Meanwhile, the Bay Area (45%) regions yielded the smallest proportions of focus groups that reported feelings of safety and support in their CPP participation. The one stakeholder focus group conducted in the Los Angeles region did not report feeling safe or supported in CPP participation.

Figure 92: Stakeholder Perception of Safety and Support in CPP Participation, by CMHDA Region[Δ]



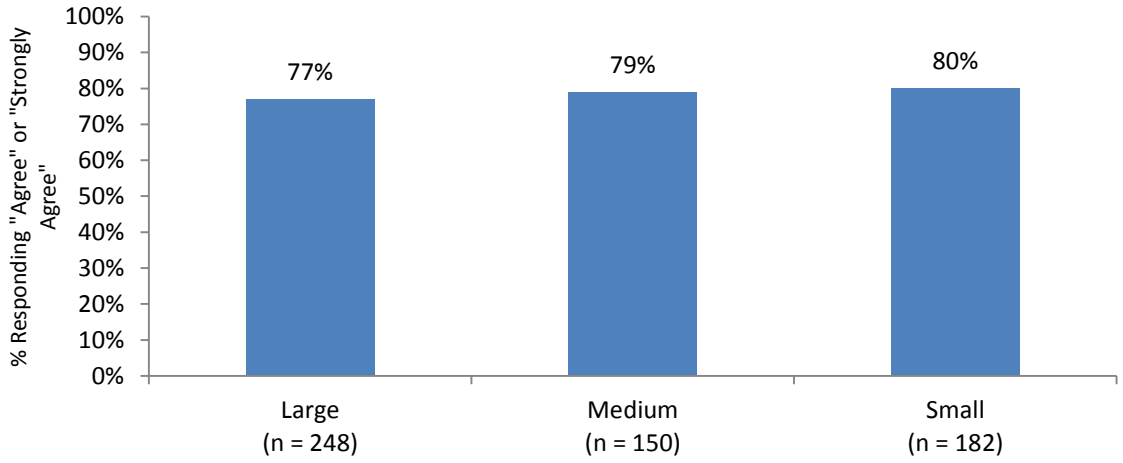
[Δ] *SOURCE*: Stakeholder Focus Groups

County Size

Rationale: According to the Stakeholder Survey, there were very slight differences between county size categories and stakeholders' agreement with the statement, "I felt safe participating in the MHSA CPP

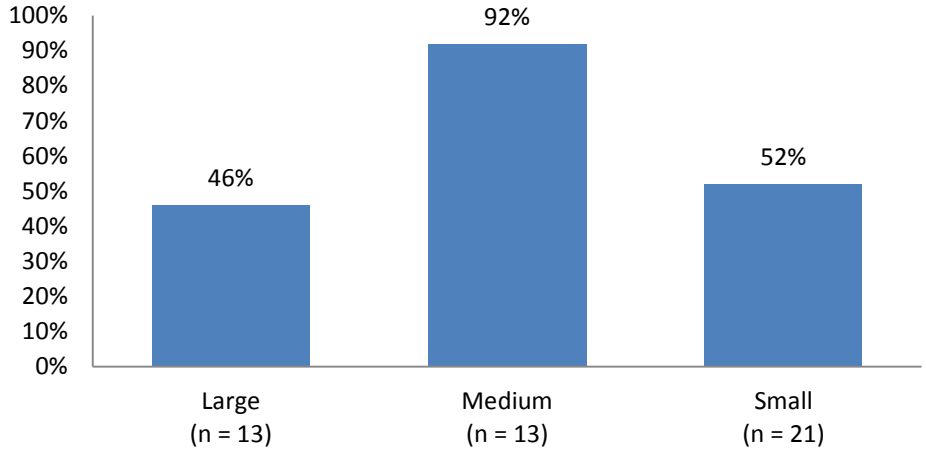
process" (see Figure 93). However, the Stakeholder Focus Groups revealed greater differences in the same indicator (see Figure 94). While the magnitude of difference can be attributed to having smaller n-values, or participant pools, when comparing the two data sources, one consistent finding was that smaller proportions of stakeholders from large counties (77% and 46%, respectively) agreed with feeling safe and supported in their CPP participation.

Figure 93: Stakeholder Perception of Safety in the CPP Processes, by County Size [δ]



[δ] *SOURCE*: Stakeholder Survey

Figure 94: Stakeholder Perception of Safety and Support in CPP Participation, by County Size [Δ]



[Δ] *SOURCE*: Stakeholder Focus Groups

PO-12: To what extent do participants feel that they have the training, knowledge, and support needed to meaningfully participate in the CPP process? (CCR, 9 CA ADC § 3300)

Results

Statewide: The majority of responding CPP participants (70%, *n* = 576) reported that they received enough training to meaningfully participate in their counties' CPP processes. Additionally, only 17% of Stakeholder

Focus Groups (*n* = 47) mentioned that a lack of training hindered their ability to take part in their counties' CPP activities.

CMHDA Region: About 72% of stakeholders from Central, Los Angeles, Southern, and Superior counties felt they received enough training to meaningfully participate in the CPP process. Meanwhile, only 59% of Bay Area stakeholders felt that they received enough training to meaningfully participate in their counties' CPP processes.

County Size: The differences in stakeholders' rates of agreement with the statement, "I received enough training to meaningfully participate," were within 1% across respondents from counties of different sizes.

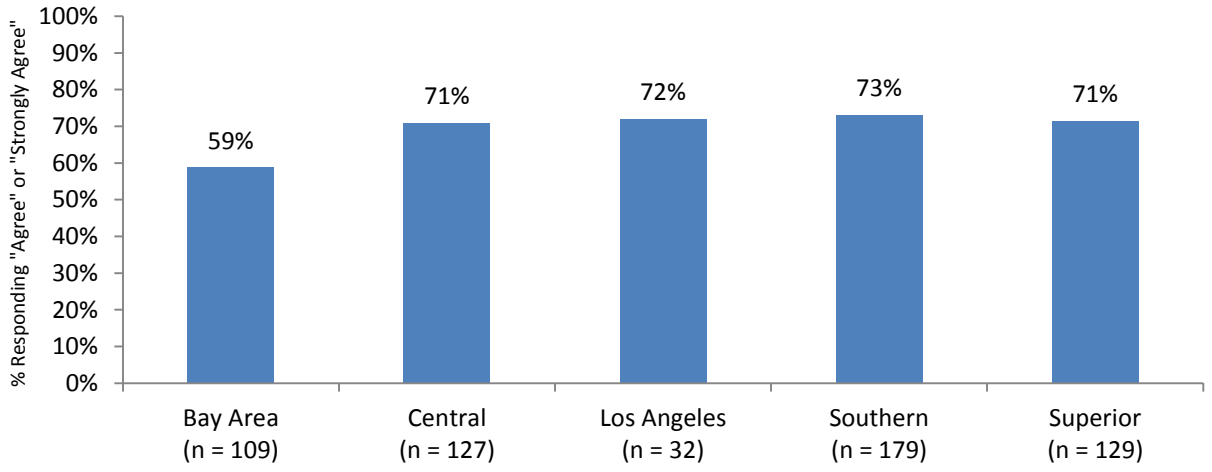
Statewide

Rationale: According to the Stakeholder Survey, 70% of the respondents who participated in FY 2012-13 CPP activities (*n* = 576) indicated that they received enough training to meaningfully participate in their counties' CPP processes. The 17% of Stakeholder Focus Groups that raised the lack of training as a barrier to participation most often stated that they were not sure how to effectively participate.

CMHDA Region

Rationale: Further analysis of the Stakeholder Survey (*n* = 576) showed little or no difference in CPP participants' level of agreement with receiving sufficient training between the Central (71%), Los Angeles (72%), Southern (73%), and Superior (71%) regions, as shown in Figure 95. However, as with previous measures of satisfaction, respondents from the Bay Area region reported a much lower rate of agreement (59%) than responding CPP participants from other regions. Interestingly, among Stakeholder Focus Groups that reported a lack of training on how to meaningfully participate, more than half were from counties in the Southern region (5 out of 8).

Figure 95: Stakeholder Perception of the Amount of Training Received to Meaningfully Participate in CPP Processes, by CMHDA Region [δ]

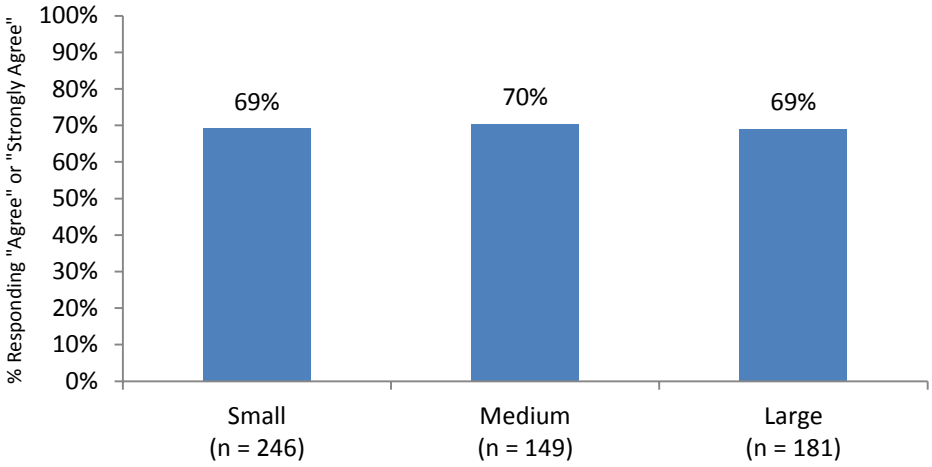


[δ] *SOURCE*: Stakeholder Survey

County Size

Rationale: Across counties of similar sizes, there were nearly imperceptible differences in the proportions of stakeholders who felt that they had received enough training to meaningfully participate in their counties' CPP processes (see Figure 96). About 69% of Stakeholder Survey respondents from small counties (*n* = 246), 70% of respondents from medium counties (*n* = 149), and 69% from large counties (*n* =181) reported that they received enough training. However, among the Stakeholder Focus Groups that raised a lack of training on how to effectively participate in CPP process as a challenge, 6 out of 8 focus groups were from large counties.

Figure 96: Stakeholder Perception of the Amount of Training Received to Meaningfully Participate in CPP Processes, by County Size [δ]



[δ] *SOURCE*: Stakeholder Survey

PO-13: To what extent do participants feel that they contribute to program planning? (WIC, §5848a)

Results

Statewide: Nearly three-fourths (72%) of responding CPP participants (*n* = 580) felt that stakeholder input was taken into account for planning mental health services in their counties.

CMHDA Region: In all five CMHDA Regions, a majority of stakeholders felt that their input was taken into account in planning mental health services in the county, with two-thirds of the respondents from the Bay Area and Los Angeles regions (59% and 65%, respectively) reporting agreement and about three-fourths of respondents from the Central, Southern, and Superior regions (73%, 78%, and 73%, respectively) reporting agreement.

County Size: The proportions of responding CPP participants who felt that their input was taken into account in their counties' mental health services planning did not significantly vary (2% difference) between small, medium, and large counties.

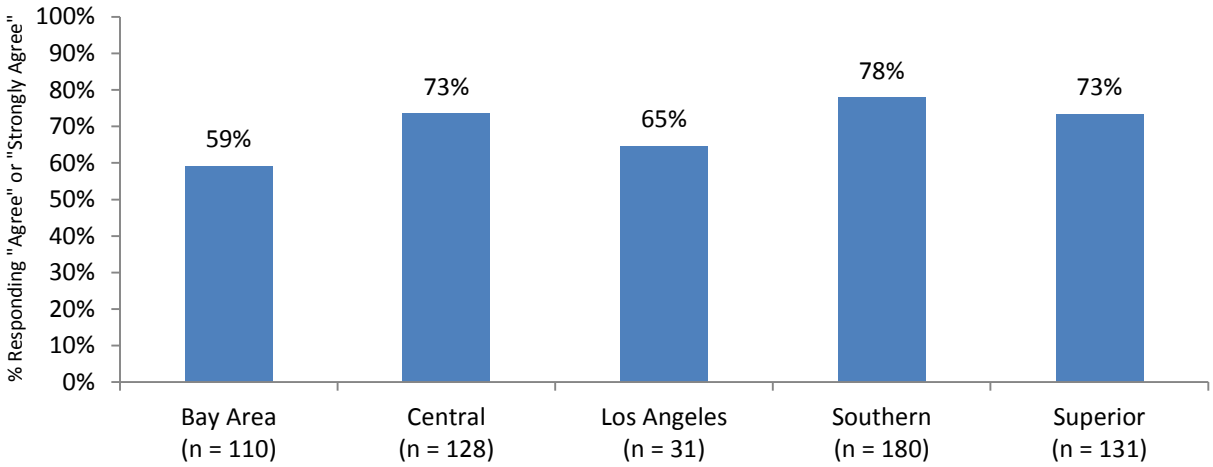
Statewide

Rationale: In the Stakeholder Survey, respondents who reported participating in FY 2012-13 CPP activities (*n* = 580) were asked to report their levels of agreement with the statement, "Stakeholder input was taken into account for planning mental health services in the county." About 72% of these respondents reported "agree" or "strongly agree."

CMHDA Region

Rationale: Respondents from the Southern region (*n* = 180) comprised the largest stakeholder group that agreed with this statement (78%), as shown in Figure 97. Agreement among respondents from the Central (*n* = 128) and Superior (*n* = 131) regions was also high at 73%. However, the rate of agreement was less noticeable among respondents from the Los Angeles (*n* = 31) and Bay Area (*n* = 110) regions. Further, the Bay Area region (*n* = 110) had the smallest proportion of respondents (59%) who felt that stakeholder input was considered in their counties' mental health services planning.

Figure 97: Stakeholder Perceptions of their Contribution to Program Planning, by CMHDA Region [δ]

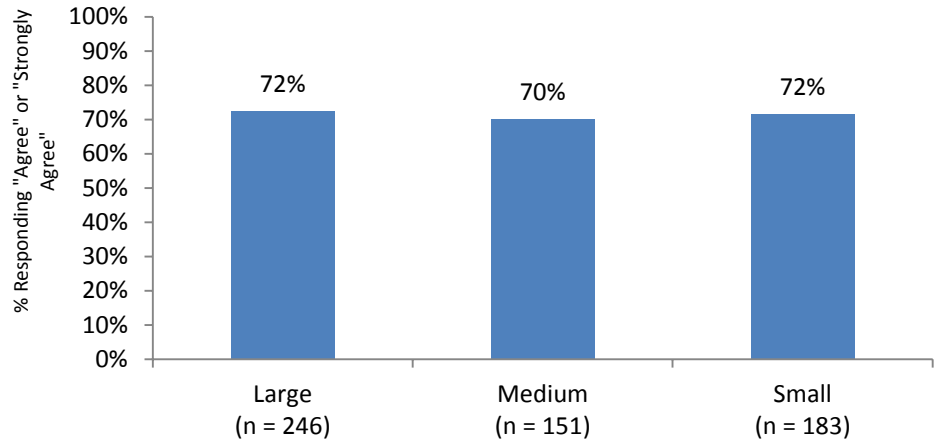


[δ] *SOURCE*: Stakeholder Survey

County Size

Rationale: In large (*n* = 246) and small (*n* = 183) counties, 72% of responding CPP participants felt that they contributed to planning of mental health services in their counties (see Figure 98). In medium counties (*n* = 151), the rate of agreement was slightly lower at 70%.

Figure 98: Stakeholder Perceptions of their Contribution to Program Planning, by County Size [δ]



[δ] *SOURCE*: Stakeholder Survey

PO-14: To what extent do participants feel that their opinions and perspectives are respected?

Results

Statewide: Over three-quarters of responding CPP participants reported that their opinions were respected and listened to during the CPP process and that CPP facilitators respected their culture.

CMHDA Region: In each of the CMHDA Regions, over 70% of respondents felt that their opinions and perspectives were listened to during their counties' CPP processes. A majority of stakeholders in each of the CMHDA Regions also felt that their CPP facilitators were respectful of their cultures. While rates of agreement varied minimally across the Central, Los Angeles, Southern, and Superior regions, the levels of agreement among Bay Area region respondents were perceptibly lower on both measures of feeling respected.

County Size: Across counties of different sizes, responding CPP participants reported consistent levels of agreement that their opinions and cultures were respected, with no more than a 4% difference in the rates of agreement between counties of different sizes.

Statewide

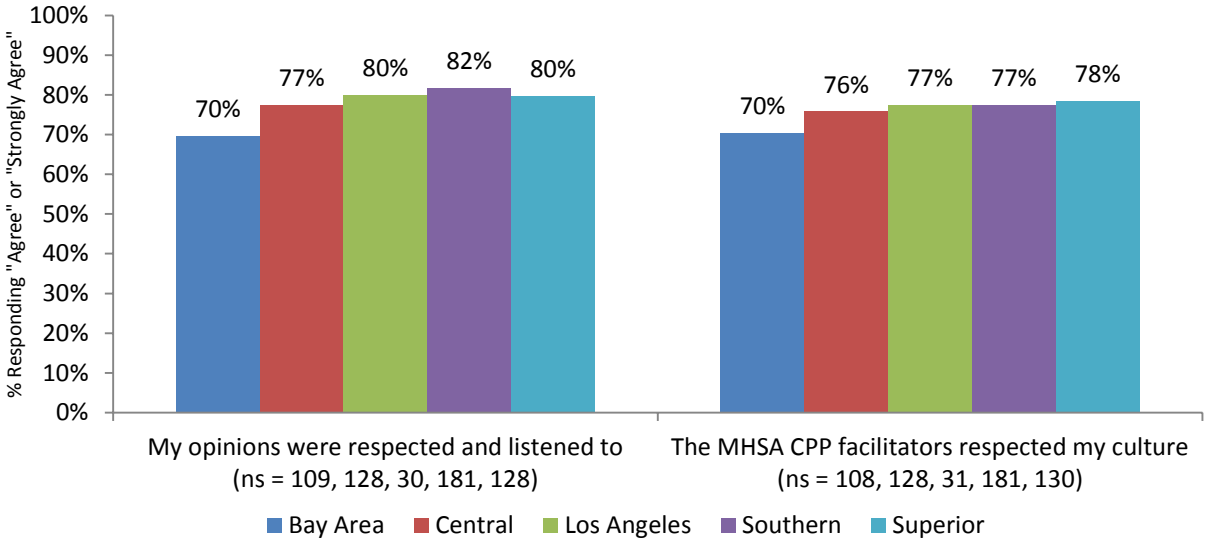
Rationale: From the Stakeholder Survey, respondents who reported participating in FY 2012-13 CPP activities were asked to rate their agreement with the statements, "My opinions were respected and listened to" and "The MHSA CPP facilitators respected my culture." About 78% of the respondents (*n* = 576) reported that their opinions were respected and listened to during their counties' CPP processes, and 76% (*n* = 578) reported that CPP facilitators respected their cultures.

CMHDA Region

Rationale: Among four of the five CMHDA Regions, there was a small amount of variation in the percentage of stakeholders (5% maximum difference) who felt that their opinions and perspectives were respected and listened to, as shown in Figure 99. Similarly, among the same four regions, there was even

smaller variation in the percentage of stakeholders (2% maximum difference) who felt CPP facilitators respected their cultures. The Bay Area region had the lowest percentage of stakeholders (70%) who felt that their opinions and perspectives were respected and listened to as well as the lowest percentage of stakeholders (70%) who felt CPP facilitators respected their cultures.

Figure 99: Stakeholder Perceptions that their Opinions and Perspectives are Respected and Listened to at CPP Meetings, by CMHDA Region [δ]



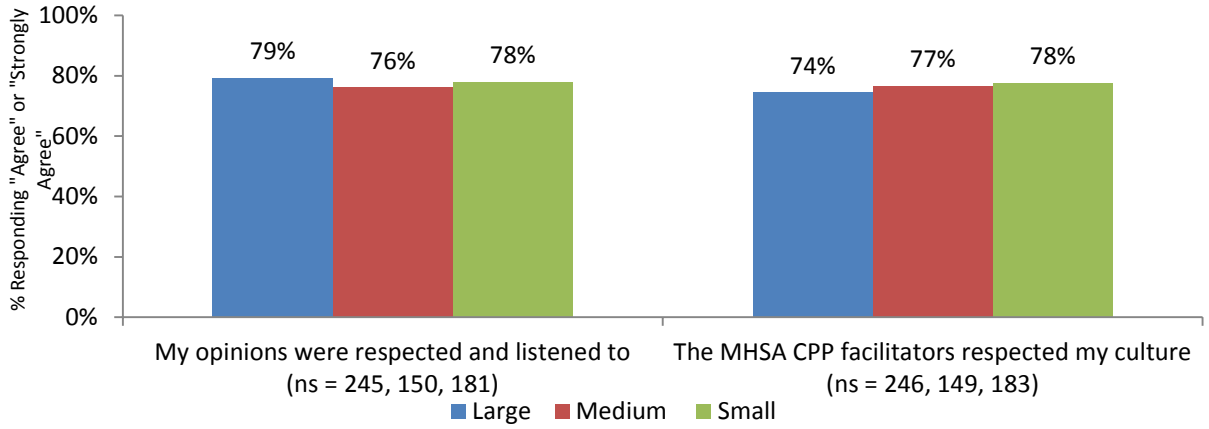
[δ] *SOURCE*: Stakeholder Survey

County Size

Rationale: There was a maximum difference of 3% between counties of different sizes in the proportion of their responding CPP participants who reported that their opinions and perspectives were respected and listened to (see

Figure 100). On this item, large counties (*n* = 245) yielded the greatest levels of agreement at 79% of stakeholders. There was also little variation among counties of different sizes in the proportions of their responding CPP participants who reported that their opinions and perspectives were respected and listened to, yielding a maximum difference of 4%. On this item, small counties (*n* = 183) had the greatest level of agreement at 78%.

Figure 100: Stakeholder Perceptions that their Opinions and Perspectives are Respected and Listened to at CPP Meetings, by County Size [δ]



[δ] *SOURCE*: Stakeholder Survey

PO-A: How did the county's CPP process change since it was first used to develop plans for the Three-Year Program and Expenditure Report (FY 05/06, 06/07, 07/08)?

Results

Statewide: Overall, counties reported that the areas of their counties' CPP processes that had changed since they were first used to develop plans for Three Year Program and Expenditure Reports were "responsibility and roles of staff to implement the CPP process" (24%), "the focus of the planning (20%), "the degree to which [the] CPP process was comprehensive and representative" (17%), and "strategies used to encourage stakeholder involvement" (17%).

CMHDA Region: Generally speaking, there was limited variation across CMHDA Regions with regards to how counties' CPP processes had changed since the development of Three Year Program and Expenditure Reports. However, while 100% of the Los Angeles region responses reported that "the responsibility and roles of staff to implement the CPP process" had changed, the other four CMHDA Regions had more similar proportions of responses, ranging from 14% (Southern region) to 29% (Central region) of each region. Similarly, while the Los Angeles region reported that "the focus of the planning" had changed for itself, the other four CMHDA Regions again reported more similar proportions of responses, ranging from 14% (Central and Southern regions) to 25% (Bay Area region) of each region.

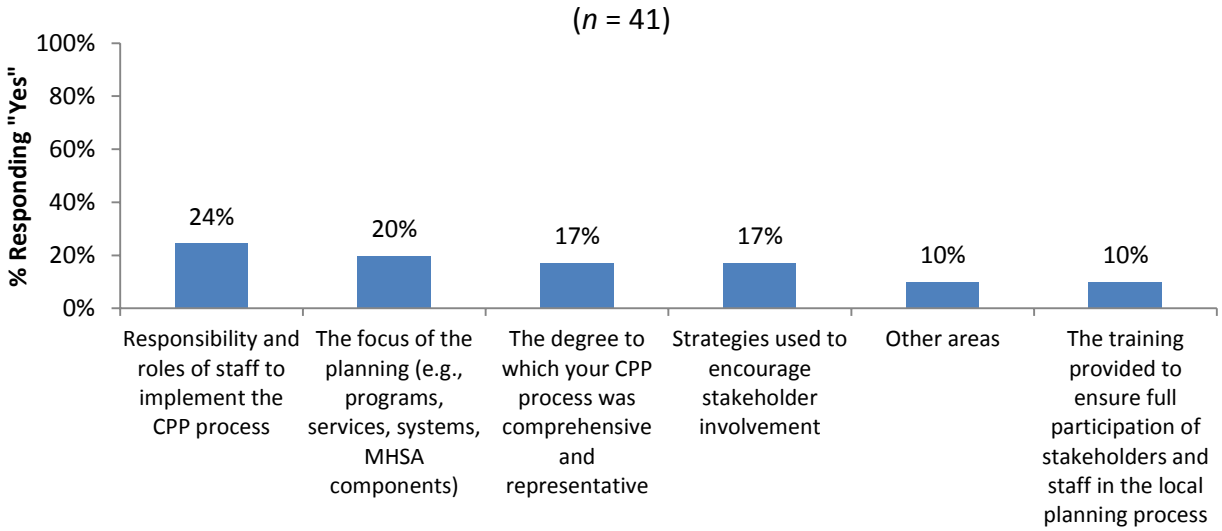
County Size: While both large and small counties reported changes to the "responsibility and roles of staff to implement the CPP process" since the development of Three Year Program and Expenditure Reports (both 57%), medium counties reported this change at nearly half the rate (29%). Changes to "the training provided to ensure full participation of stakeholders and staff in the local planning process" item appeared to decrease as county size decreased. For example, 17% of large counties reported that "the training provided to ensure full participation of stakeholders and staff in the local planning process" changed since it was first used to develop plans for the Three Year Program and Expenditure Reports, whereas 67% of medium counties and 100% of small counties indicated that that aspect of the process had changed.

Statewide

Rationale: In order to understand how each county's CPP process changed since it was first used to develop plans for the Three-Year Program and Expenditure Reports, the evaluation team analyzed data from the County Web-Based Data Request.

Overall, counties reported that the areas of their CPP processes that had changed since they were first used to develop plans for the Three Year Program and Expenditure Reports (see Figure 101) were "responsibility and roles of staff to implement the CPP process" (24%; *n* = 41), "the focus of the planning" (20%; *n* = 41), "the degree to which [the] CPP process was comprehensive and representative" (17%; *n* = 41), and "strategies used to encourage stakeholder involvement" (17%; *n* = 41).

Figure 101: Percentage of Counties Indicating Changes to CPP Process since Development of Three Year Program and Expenditure Report, Statewide ϕ



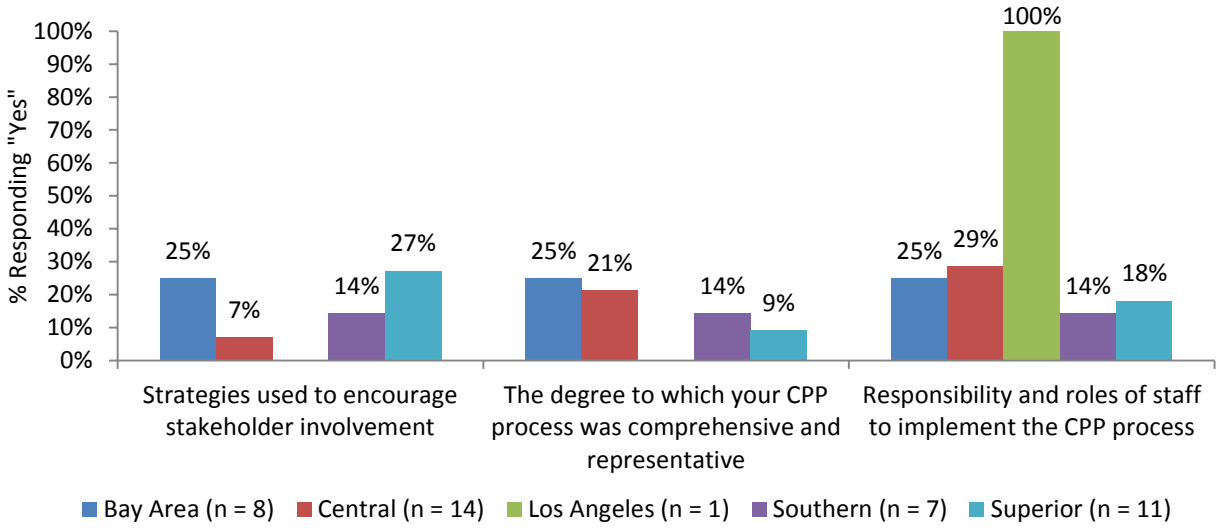
ϕ *SOURCE:* County Web-Based Data Request

CMHDA Region

Rationale: Generally speaking, there was limited variation across CMHDA Regions with regards to how counties' CPP processes had changed since the development of the Three Year Program and Expenditure Reports (see

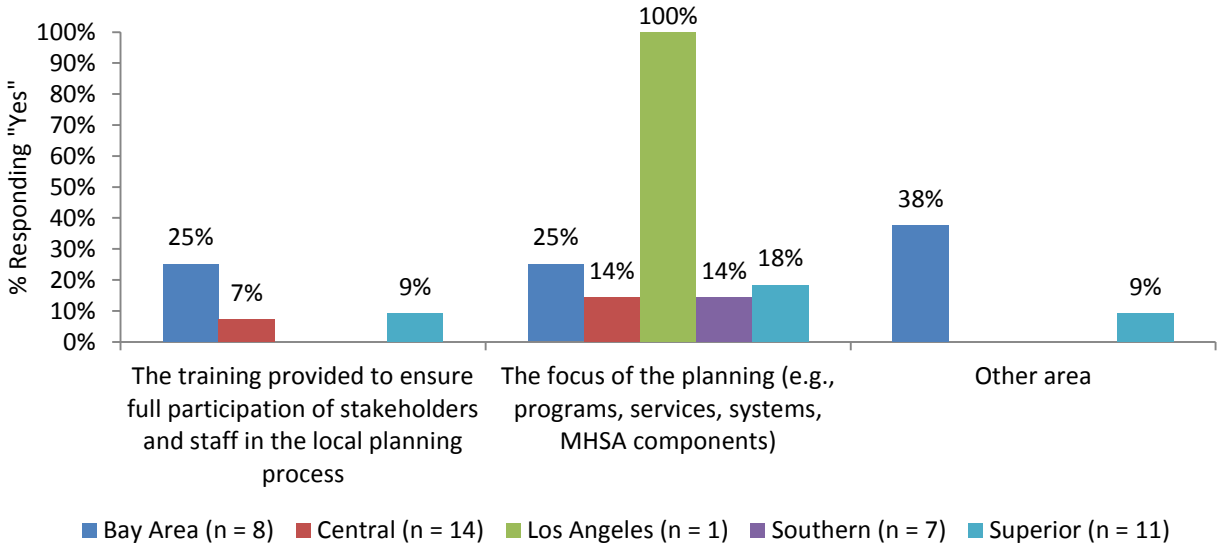
Figure 102 and Figure 103). However, while the Los Angeles region reported that "the responsibility and roles of staff to implement the CPP process" had changed (100%, *n* = 1), the other four regions reported more similar proportions of responses, ranging from 14% (Southern region) to 29% (Central region). Similarly, while the Los Angeles region reported that "the focus of the planning" had changed (100%, *n* = 1), the other four CMHDA Regions again reported more similar proportions of responses, ranging from 14% (Central and Southern regions) to 25% (Bay Area region).

Figure 102: Percentage of Counties Indicating Changes to CPP Process since Development of Three Year Program and Expenditure Report, by CMHDA Region (1 of 2) ϕ



ϕ *SOURCE:* County Web-Based Data Request

Figure 103: Percentage of Counties Indicating Changes to CPP Process since Development of Three Year Program and Expenditure Report, by CMHDA Region (2 of 2) ϕ



ϕ *SOURCE:* County Web-Based Data Request

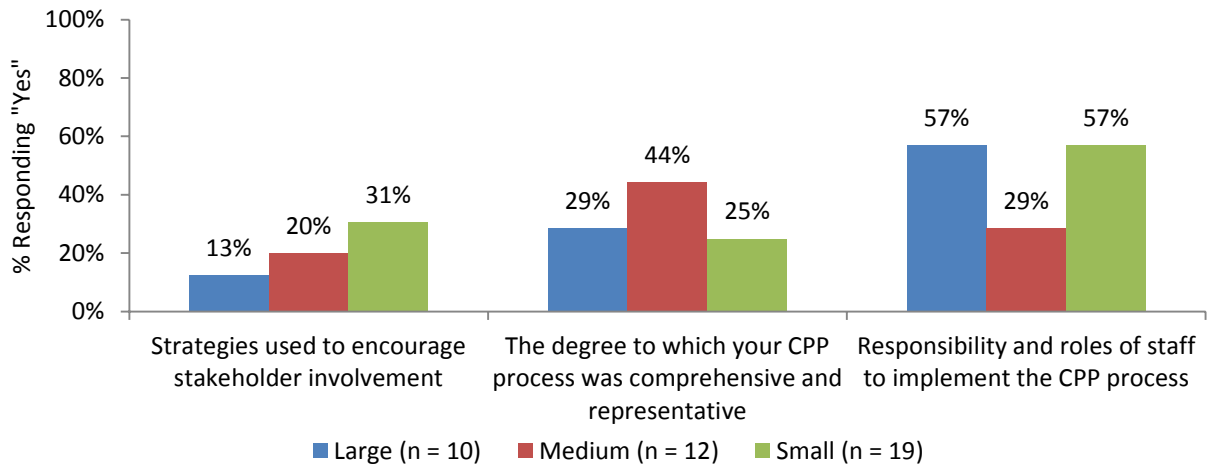
County Size

Rationale: While all counties reported changes to the "responsibility and roles of staff to implement the CPP process" since the development of the Three Year Program and Expenditure Reports, large and small counties reported these changes at a rate of 57%, and medium counties reported this change at nearly half that rate (29%, *n* = 12), as shown in Figure 104 and Figure 105. Conversely, while medium counties

reported changes to "the degree to which the CPP process was comprehensive and representative" at a rate of 44% (*n* = 12), both large and small counties reported this change at a lower rate (29% and 25%, respectively).

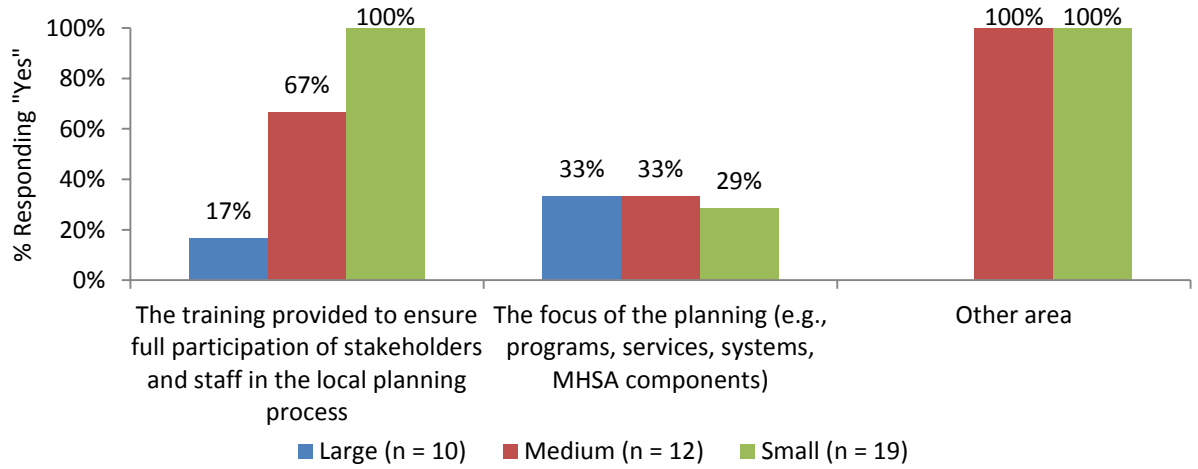
Changes to "the training provided to ensure full participation of stakeholders and staff in the local planning process" appear to decrease as county size decreases. For example, 17% of large counties (*n* = 10) reported that "the training provided to ensure full participation of stakeholders and staff in the local planning process" were changed since it was first used to develop plans for the Three Year Program and Expenditure Reports, whereas 67% of medium counties (*n* = 12) and 100% of small counties (*n* = 19) indicated that aspect of the process had changed.

Figure 104: Percentage of Counties Indicating Changes to CPP Process since Development of Three Year Program and Expenditure Report, by County Size (1 of 2) ϕ



ϕ *SOURCE:* County Web-Based Data Request

Figure 105: Percentage of Counties Indicating Changes to CPP Process since Development of Three Year Program and Expenditure Report, by County Size (2 of 2) ϕ



ϕ *SOURCE:* County Web-Based Data Request

PO-B: What did stakeholders like most about the CPP process? What about the CPP process were stakeholders satisfied with?

Results

Statewide: In 79% of counties (*n* = 47*)* throughout the state, stakeholders expressed satisfaction with the CPP process. Stakeholders in nearly one-quarter (24%) of counties were satisfied with their counties' CPP processes because they felt it supported their counties in better serving their communities. Twenty-one percent of stakeholders were satisfied with the CPP process because they felt it resulted in improvements in services. Stakeholders in 16% of counties were satisfied because they felt their counties' CPP processes increased collaboration among providers. In 11% of counties, stakeholders described an increase in mental health providers as the reason for being satisfied with CPP processes. Stakeholders in one county (3%) were satisfied with its CPP process because they felt it resulted in improved mental health outcomes. Stakeholders in three counties described being satisfied because their counties' CPP processes had shown them how hard their counties work. Stakeholders from five counties felt that their counties' CPP processes resulted in improvements in services because of increased capacities for their counties to deliver services to certain racial and ethnic groups as well as underserved populations.

Stakeholder survey responses indicated that what they liked most about their counties' CPP processes were their attempts to bring together and collect input from diverse groups of stakeholders to provide them a voice in mental health policy and planning. Knowing that their input contributed to creating programs and addressing mental health needs in the community affected stakeholders' sense of empowerment and overall wellness. Additionally, stakeholders noted that what they found most satisfying about their counties' CPP processes were well-structured meetings led by knowledgeable and respectful facilitators as well as smaller events that were more interactive and consumer-friendly.

CMHDA Region: In each of the CMHDA Regions, a majority of stakeholders felt satisfied with their counties' CPP processes. All stakeholders from counties in the Superior (100%, *n* = 13) and Los Angeles (100%, *n* = 1) regions said they felt satisfied with their counties' CPP processes. Similarly, large majorities of stakeholders from counties in the Southern (78%), Bay Area (73%), and Central (62%) regions said they were satisfied with the CPP processes in their counties.

Stakeholders from counties in different CMHDA Regions were satisfied with their counties' CPP processes for a variety of reasons. Stakeholders from the Bay Area region were satisfied with their counties' CPP processes mostly because they felt that they supported their counties in better serving their communities and stakeholders (56%) as well as improved services (22%). Stakeholders in the Central region reported being satisfied with their counties' CPP processes, but only small percentages of stakeholders from Central counties explained why they were satisfied. Stakeholders in three Central counties felt satisfied because they felt that their counties' CPP processes supported their counties in better serving their communities. Stakeholders from the Los Angeles region did not provide any reasons for their satisfaction; however, they did describe being very satisfied. A majority of stakeholders from counties in the Southern region felt satisfied with their counties' CPP processes due to improvements in services resulting from CPP (71%) and increased collaboration among stakeholders (57%). A majority of stakeholders from counties in the

Superior region felt satisfied with their counties' CPP processes because they felt that CPP supports the counties in better serving their communities (69%) and because CPP had resulted in improvement in services (62%). Stakeholders from the Superior region often mentioned satisfaction because of increased collaboration among stakeholders (46%) and an increase in the number of mental health providers in counties (31%).

County Size: The percentage of stakeholders that said they were satisfied with their counties' CPP processes varied based on county size. In medium counties, 92% of stakeholders said they were satisfied with CPP processes. In small counties, 82% of Stakeholders said they were satisfied with CPP processes. Though still a majority, a much lower percentage of stakeholders in large counties (52%) said they were satisfied with their counties' CPP processes.

Similar to results from the CMHDA Regions, the reasons that stakeholders felt satisfied varied based on the size of the county. Stakeholders from large counties were satisfied with CPP processes for two reasons. In large counties, 25% of stakeholders said they felt satisfied with the CPP process due to CPP processes supporting counties in better serving their communities. A smaller percent of stakeholders (13%) from large counties said that they were satisfied because they felt that their counties' CPP processes resulted in improved services.

Nearly a third of stakeholders from medium counties (31%) said that they were satisfied with their counties' CPP processes because they supported counties in better serving their communities. Additionally, 15% of stakeholders from medium counties said they were satisfied with their counties' CPP processes because they resulted in improved outcomes.

Over a third of stakeholders from small counties said that they were satisfied with their counties' CPP processes because of improvements in services that resulted from CPP processes (35%) as well as an increase in collaboration among stakeholders (35%). Eighteen percent of stakeholders in small counties said they were satisfied with CPP processes because the CPP process supported their counties in better serving their communities.

Statewide

Rationale: To answer this question, statewide data was analyzed from the Stakeholder Focus Groups and Stakeholder Surveys. Responses from the Stakeholder Surveys were analyzed at the statewide level, but not according to CMHDA Region or county size.

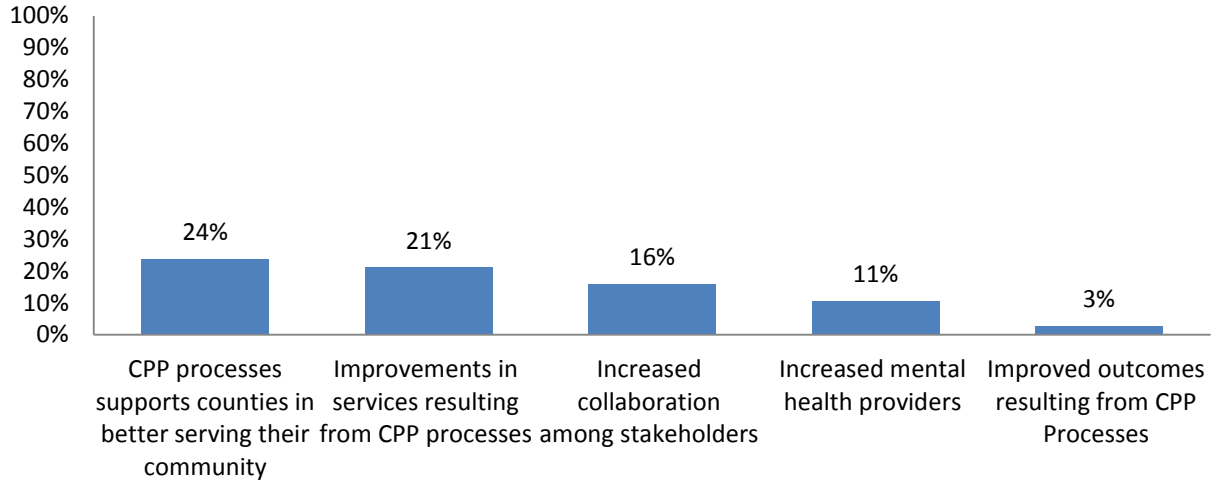
Stakeholders expressed satisfaction with their counties' CPP processes in 77% of the counties that conducted Stakeholder Focus Groups (*n* = 47*).* Stakeholders had a variety of reasons for satisfaction, as depicted in

Figure 106. Of the stakeholders that indicated that they were satisfied with their counties' CPP processes, 24% felt satisfied because their counties' CPP processes supported their counties in better serving their communities. Twenty-one percent (21%) of stakeholders felt satisfied with their counties' CPP processes because they felt that they had resulted in improvements in services. Stakeholders in 16% of counties

were satisfied because they felt their counties' CPP processes increased collaboration among providers. In 11% of counties, stakeholders described an increase in mental health providers as the reason for being satisfied with their counties' CPP processes. Stakeholders in one county (3%) were satisfied with its county's CPP process because they felt it resulted in improved mental health outcomes.

Figure 106: Reasons for Stakeholder Satisfaction with the CPP Process, Statewide [Δ]

(*n* = 38)



[Δ]*SOURCE:* Stakeholder Focus Group

Stakeholder Survey feedback indicated that stakeholders most frequently cited what they appreciated most about their counties' CPP processes to be the following: 1) the counties' sincere efforts to be inclusive and engage a diverse range of stakeholders, 2) well-organized CPP meetings with direct presentations and, more importantly, informed and respectful facilitators, 3) the opportunity to have a voice and be heard as well as learn other stakeholders' perspectives, resulting in a greater sense of empowerment and social connectedness, and 4) the potential to make a positive impact on the mental health system as well as raise public awareness around mental health. Stakeholder Survey responses were analyzed according to the following nine general domains and are presented below.

Inputs

Stakeholders did not comment on issues related to county resources designated for CPP, such as staffing and staff training on the CPP process.

Outreach

Fourteen stakeholders from the Stakeholder Surveys reported an appreciation for county outreach activities during their counties' CPP processes, while outreach activities were not discussed by stakeholders during the Stakeholder Focus Groups. Primarily, large and small counties discussed their counties' sincere attempts to include stakeholders throughout their counties.

Participant Input

Stakeholder survey and focus group data show that Participant Input was one of the primary domains that they liked about their counties' CPP processes. In other words, stakeholders appreciated counties' sincere attempts to be inclusive and culturally-sensitive when trying to bring together diverse groups of stakeholders. A stakeholder reported, "Every effort was made to open the process to everyone who might have a stake in mental health services." Stakeholders frequently cited counties' *proactive* attempts to seek stakeholder input. One stakeholder's comment underscores this point: "I love that the County is ASKING for feedback, not only asking but really trying to encourage folks to give feedback and get involved in their care from all angles. This is what recovery is about." The diversity of stakeholders invited to the table was greatly appreciated, and stakeholders noted that this had the potential to represent a wide array of community-based concerns and recommendations.

Training

Stakeholder survey and focus group data was consistent. Only two stakeholders mentioned training as one of the activities they liked about the CPP process. However, training was not identified by stakeholders during the Stakeholder Focus Groups.

Evaluation

Stakeholder survey and focus group data was consistent. Only one stakeholder from a large county found the evaluation activities interesting when asked what they liked most about the CPP process, while no comments were made about evaluation during the stakeholder focus groups.

Stakeholder Perceptions and Satisfaction

Stakeholder comments regarding what they liked the most about their counties' CPP processes primarily related to stakeholder perceptions and satisfaction. Both the Stakeholder Survey and Stakeholder Focus Group data supported this result.

A large proportion of Stakeholder Survey data and Focus Group data discussed the *processes* that made for an effective CPP activity. In both the Stakeholder Survey and Stakeholder Focus Group data, stakeholders frequently cited liking well-prepared and informed CPP facilitators that were respectful and listened well to everyone's opinions. Stakeholders that reported having a strong facilitator frequently also reported that they felt they were in safe environments to provide feedback and that their opinions were valued.

Stakeholders also discussed liking CPP meetings that were well structured and presented information in clear and direct manners that were free of technical jargon and heavy use of statistics. Some stakeholders noted that they liked smaller meetings or when breakout sessions were incorporated into larger activities. In addition, participants in the Stakeholder Focus Groups indicated that they liked CPP activities that were more social, such as dinner and movie night and BBQs, because these activities were more personal and consumer-friendly. In general, stakeholders reported meetings and events that were more interactive were valued.

Participant Impacts

Stakeholders frequently identified having their voices heard and having their voices make a difference as what they enjoyed the most about their counties' CPP processes. In particular, stakeholders discussed the senses of empowerment and hope that came with knowing that their input contributed to creating and/or improving programs and services. Many stakeholders also reported enjoying the opportunities to connect with people, hearing from diverse constituencies, and sharing information. As such, social connectedness emerged as a key factor for those people who most liked the personal impacts of the CPP process on their wellness and recovery. In addition, stakeholders found CPP activities to be very informative opportunities to learn about current programs and mental health.

Mental Health System Impacts

Participants in both the Stakeholder Survey as well as Stakeholder Focus Groups reported that they liked their counties' CPP processes because they knew their input would contribute to system-wide changes. As one stakeholder described, "[I like the] chance to share my experience with mental health clients to make things better. Such a chance is historically significant." Stakeholders appreciated the opportunity to provide substantial input on the allocation of resources, advocate for particular programs, and address specific needs. Other stakeholders discussed liking their counties' CPP processes for fostering inter-agency partnerships and dialogue between the county and community, resulting in greater transparency in the mental health system.

Perceptions of the Broader Community Impacts

Several stakeholders from the Stakeholder Survey reported that they enjoyed CPP's impact on raising public awareness around mental health. For instance, one stakeholder commented how they appreciated his/her county's effort to engage the community in education around mental health. Another stakeholder reported they liked that his/her county was proactively working to reduce stigma and raise public awareness around mental health. Finally, several stakeholders appreciated the CPP process in its entirety. These stakeholders noted the very fact that the community participatory planning process exists was valuable in itself.

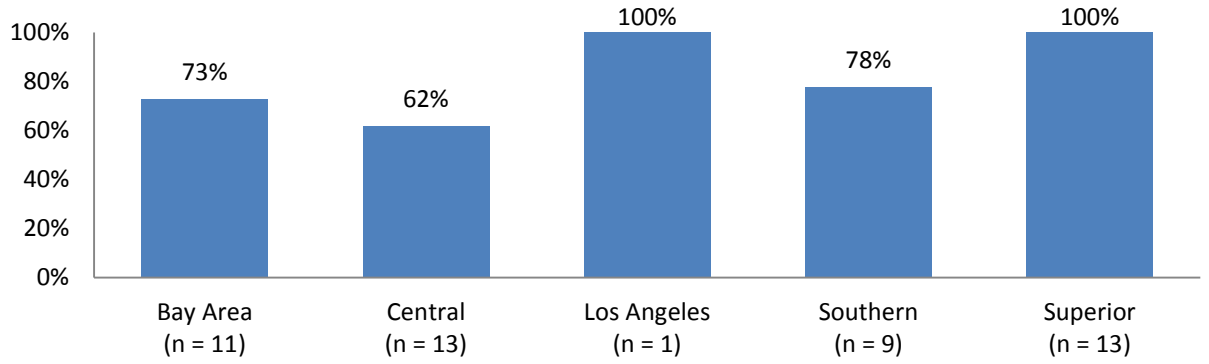
CMHDA Region

Rationale: Although the percentages of satisfied stakeholders varied among counties in each of the CMHDA Regions, overall, large majorities of stakeholders in each CMHDA Region said they were satisfied.

Figure 107 illustrates the percentages of stakeholders from counties in each CMHDA Region. One-hundred percent of stakeholders from the Los Angeles and Superior regions said that they were satisfied with their counties' CPP processes. Similarly, large majorities of stakeholders from counties in the Southern (78%, *n*= 9), Bay Area (73%, *n* = 11), and Central (62%, *n* = 13) regions reported satisfaction with the CPP processes in their counties.

Figure 107: The Percent of Stakeholders Who Were Satisfied with the CPP Process, by CMHDA Region

Δ

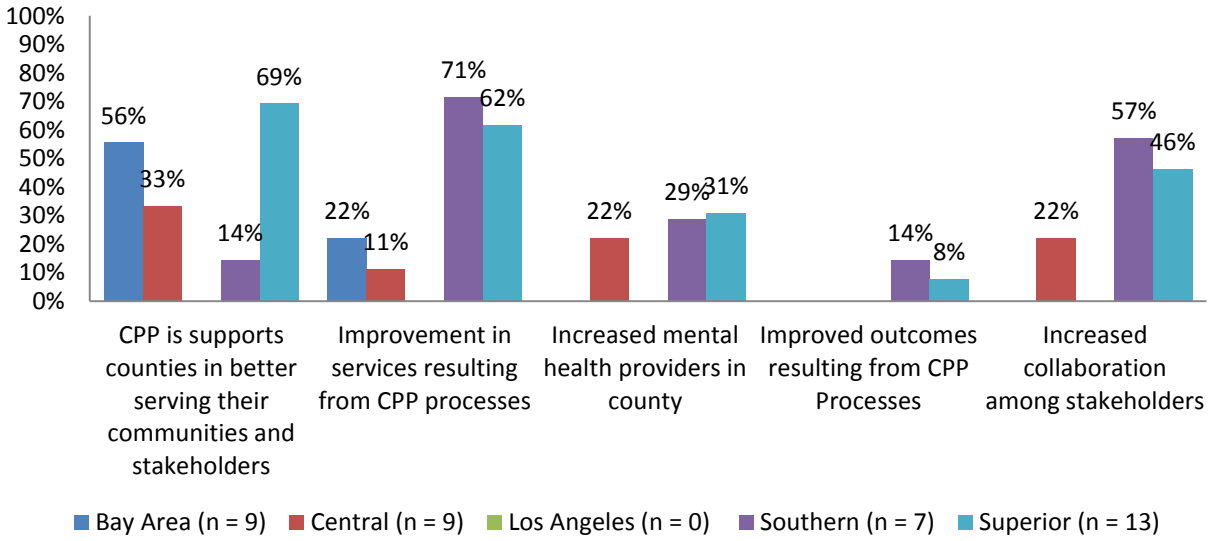


[Δ] *SOURCE*: Stakeholder Focus Group

Stakeholders were satisfied with the CPP process for a variety of reasons, as shown in

Figure 108. Stakeholders from the Bay Area region were satisfied with their counties' CPP processes mostly because they felt that their counties' CPP processes supported counties in better serving their communities and stakeholders (56%, *n* = 9) as well as led to improvements in services resulting from CPP processes (22%, *n* = 9).

Figure 108: Reasons for Stakeholder Satisfaction with the CPP Process, by CMHDA Region [Δ]



[Δ] *SOURCE*: Stakeholder Focus Group

Stakeholders from counties in the Central region were satisfied with their counties' CPP processes, but only a small number of stakeholders from Central region counties explained why they were satisfied. One-third of stakeholders from the Central region (*n* =9) felt satisfied with their counties' CPP processes because they felt CPP supports their counties in better serving their community, while smaller percentages of stakeholders felt satisfied with their counties' CPP processes because of increased mental health providers in their counties (22%, *n* = 11), increased collaboration among stakeholders (22%, *n* = 11), and improvements in services that resulted from CPP planning efforts (11%, *n* = 11).

Los Angeles region stakeholders reported feeling satisfied with their county's CPP process, but did not specify why or what about their county's CPP process they were most satisfied with.

Stakeholders from counties in the Southern region felt satisfied with their counties' CPP processes for many reasons. A majority of stakeholders from counties in the Southern region felt satisfied with their counties' CPP processes because of improvements in services resulting from CPP (71%, *n* =9) and increased collaboration among stakeholders (57%, *n* = 9).

A smaller percentage of stakeholders from Southern region counties reported satisfaction due to feeling that their counties' CPP processes had supported counties in better serving their communities (14%, *n* = 13) and because stakeholders felt CPP had improved their health outcomes.

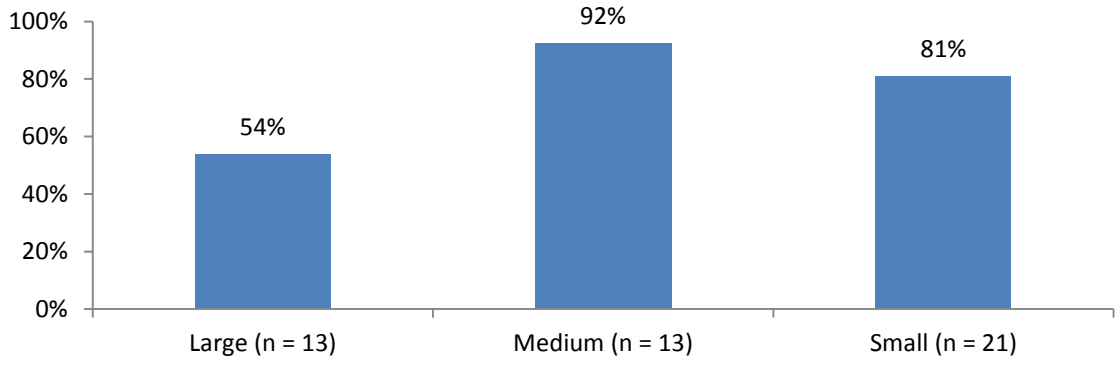
A majority of stakeholders from counties in the Superior regions felt satisfied with their counties' CPP processes because they felt CPP supports counties in better serving their communities (69%, *n* = 13) and because CPP had resulted in improvement in services (62%, *n* = 13). Stakeholders from Superior region counties often mentioned satisfaction because of increased collaboration among stakeholders (46%, *n* = 13) and an increase in the number of mental health providers in the county (31%, *n* = 13). Stakeholders from one Superior county said that they were satisfied because of improved outcomes resulting from his/her county's CPP process.

County Size

Rationale: The percentage of stakeholders that said they were satisfied by CPP processes varied based county size.

Figure 109 depicts stakeholder satisfaction based on the size of the county. Ninety-two percent of stakeholders from medium counties said they were satisfied with their counties' CPP processes. Eighty-two percent of stakeholders in small counties said they were satisfied with their counties' CPP processes. Though still a majority, a much lower percentage, 52%, of stakeholders in large counties said they were satisfied.

Figure 109: The Percent of Stakeholders who were Satisfaction with the CPP Process, by County Size [Δ]

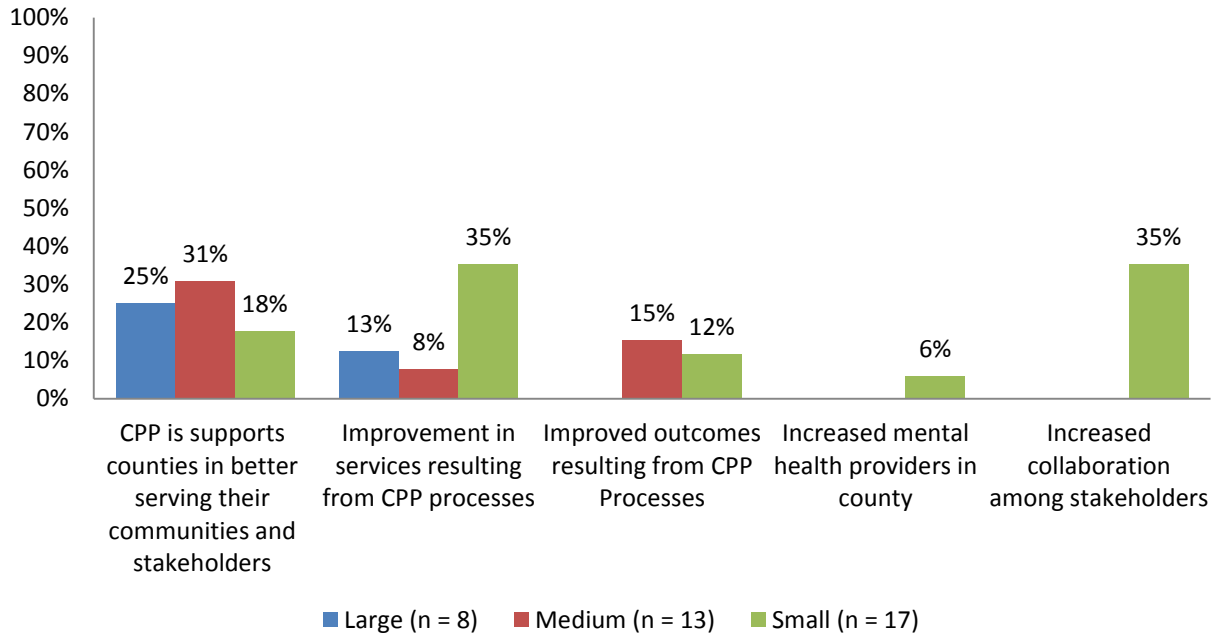


[Δ]*SOURCE:* Stakeholder Focus Group

Similar to results across CMHDA Regions, the reasons stakeholders said they were satisfied with the CPP process varied based on the size of the county.

Figure 110 illustrates the different reasons stakeholder said they were satisfied with their counties' CPP processes based on county size categories.

Figure 110: Reasons for Stakeholder Satisfaction with the CPP Process, by County Size [Δ]



[Δ] *SOURCE:* Stakeholder Focus Group

In large counties, 25% of stakeholders (*n* = 8) said they felt satisfied with their counties' CPP processes for reasons related to CPP processes supporting counties in better serving their communities. A smaller percent (13%, *n* = 8) of stakeholders from large counties said they were satisfied because they felt CPP processes resulted in improved services.

Nearly a third of stakeholders from medium counties (31%, *n* = 13) said they were satisfied with their counties' CPP processes because they supported counties in better serving their communities. Fifteen percent of stakeholders from medium counties said they were satisfied with their counties' CPP processes because CPP resulted in improved outcomes. Stakeholders from one medium county reported satisfaction because of improvements in services that resulted from CPP processes.

Over a third of stakeholders from large counties said they were satisfied with their counties' CPP processes because of improvements in services that resulted from them (35%, *n* = 8). Eighteen percent of stakeholders in large counties said they were satisfied with their counties' CPP processes because they supported their counties in better serving their communities. Smaller percentages of stakeholders from small counties said they were satisfied with their counties' CPP processes because of improved outcomes resulting from CPP processes (12%, *n* = 17) and an increase in mental health providers in the counties (6%, *n* = 17).

PO-C: What did stakeholders like least about the CPP process? How could the county's CPP process be improved for the future?

Results

Statewide: Across the state, stakeholders (*n* = 311) most commonly disliked various components of the CPP meeting itself. More specifically, stakeholders mentioned disliking the location and time of the meeting, the length of meeting, and the way information was shared at the meeting. Similar to results regarding transportation barriers to participation, stakeholders also described disliking travel related to attending CPP activities and made suggestions related to improving travel. Some stakeholders disliked how their input was used because many felt that their counties already had a plan regardless of what suggestions were made at CPP meetings. A portion of stakeholders also disliked stakeholder representation at CPP meetings and felt that counties could do a better job of conducting outreach to diverse stakeholders.

Stakeholders from counties across the state (*n* = 47) suggested a variety of improvements that could be made to their counties' CPP processes. Stakeholders in many counties provided suggestions to improve stakeholder CPP outreach and increase the diversity of stakeholders who participated in CPP processes. Forty-five percent of stakeholders suggested that counties improve their county's CPP outreach efforts. In the same regard, stakeholders from 26% of counties suggested that counties take measures to increase the diversity of those participating in their counties' CPP processes, including consumer and family member participation, while 19% of stakeholders suggested increased involvement of consumers.

Stakeholders were also concerned with accessibility and the participation structure of CPP meetings. Thirty-four percent of stakeholders from counties suggested improvements related to meeting structure, while 30% suggested improvements related to meeting accessibility. A smaller percentage of stakeholders (15%) from across the state wanted to see more CPP trainings for stakeholders to improve their capacities to participate. Twenty-six percent of stakeholders suggested that counties improve their communication and transparency as a way to improve their CPP processes.

Suggestions provided by counties to improve their future CPP processes aligned with stakeholders' suggestions in terms of the types of suggestions and the percent of counties (*n* = 54) that made each suggestion. In addition to the suggestions offered by both stakeholders and counties, five counties (9%) also suggested providing more evaluation and input collection activities in their CPP processes. Counties also suggested more training and education opportunities (19%); they spoke of this not only in terms of training stakeholders on how to participate, but also more opportunities for community education about CPP processes in other counties.

CMHDA Region: Stakeholders from each CMHDA Region agreed and disagreed on things that they disliked about CPP processes. Stakeholders from counties in each CMHDA Region also disliked certain CPP activities; however, the type of activities stakeholders disliked differed in each CMHDA Region.

Stakeholders in each CMHDA Region offered various suggestions for improving future CPP processes. A large portion of stakeholders from all CMHDA Regions suggested increasing stakeholder outreach. Among stakeholders from counties in the Bay Area region, 45% suggested increasing consumer involvement, while only 23% of stakeholders from Central region counties and 11% of stakeholders from counties in the Southern region made that suggestion. In addition, about a third of stakeholders from counties in the Bay Area (36%) and Southern (33%) regions suggested increasing stakeholder diversity, while only 15% of stakeholders in the Central and Superior regions made suggestions related to increasing stakeholder diversity.

Suggestions regarding CPP participation and accessibility varied among stakeholders in different CMHDA Regions. Similar percentages of stakeholders in the Bay Area (27%), Central (31%), Southern (22%), and Superior (31%) regions made suggestions related to improving meeting accessibility as a way to improve future their CPP meetings. Suggestions related to improvements in the participation structure of CPP meetings were made by 100% of stakeholders from the Los Angeles region and 62% of stakeholders from the Superior region; however, smaller percentages of stakeholders from counties in the Southern (33%), Bay Area (18%), and Central (15%) regions noted the same sentiment. More stakeholders from counties in the Bay Area (27%) and Southern (22%) regions suggested increased training for stakeholder participation than stakeholders from the Central (8%) and Superior (8%) regions.

Suggestions to improve communication and transparency from the county were offered by 33% of the responding stakeholders from counties in the Southern region, 31% of stakeholders from counties in the Central region, 23% of stakeholders from counties in the Superior region, and 9% of stakeholders from counties in the Bay Area region.

All of the stakeholders from the Los Angeles region (*n* = 1) offered suggestions relating to increasing stakeholder outreach, improved meeting participation structure, improved accessibility, increased stakeholder diversity, and improved communication and diversity.

Counties made similar suggestions on how to improve their future CPP processes to those offered by stakeholders from the same CMHDA Regions. Counties differed from stakeholders in several instances. The only suggestion provided by the Los Angeles region was increased CPP evaluation and input collection activities. Unlike stakeholders, counties also made suggestions related to evaluation and other activities.

Eighteen percent (18%) of counties in the Central region suggested increasing evaluation and input collection activities at CPP meetings as well as 11% of counties in the Southern region, 7% in the Superior region, and 8% in the Bay Area region. One county from the Bay Area region and one county from the Central region both suggested providing more resources at CPP meetings in the form of increased staff members.

County Size: There was some variation in what stakeholders liked about their counties' CPP processes based on the sizes of their counties. Overall, stakeholders disliked activities that did not allow them to fully participate or understand the information. Stakeholders from large and small counties disliked traveling to meetings. Stakeholders from differently sized counties also described disliking specific CPP activities; however, the type of activities that stakeholders disliked varied.

Stakeholders offered different kinds of suggestions based on the sizes of the counties that they were from. Overall, a higher percentage of stakeholders from large counties made suggestions than stakeholders from medium and small counties.

Suggestions related to increasing stakeholder outreach varied based on county size categories. Many stakeholders from large counties (62%) suggested increasing stakeholder outreach while only 38% of stakeholders in medium and small counties made the same suggestion. In similar regards, more stakeholders from large counties (46%) suggested increasing stakeholder diversity than in medium (23%) and small (14%) counties. Smaller portions of stakeholders in large (23%), medium (19%), and small (15%) counties suggested increasing the involvement of consumers.

Stakeholders from counties of different sizes offered a variety of suggestions themed around making CPP activities more accessible for stakeholder to participate in effectively. A majority of stakeholders in large (46%) and small (43%) counties offered suggestions to improve meeting participation structure; however, only 8% of stakeholders offered that suggestion. In large counties, 31% of stakeholders suggested increasing CPP training for stakeholders while smaller percentages of stakeholders made this suggestion in medium (15%) and small (5%) counties. Similar percentages of stakeholders from large (31%), medium (31%), and small (29%) counties suggested improvements to meeting accessibility. More stakeholders in large counties (46%) suggested improving communication and transparency of the county compared to small (24%) and medium (8%) counties.

Counties generally agreed with stakeholders in terms of suggestions related to increasing stakeholder outreach and improving meeting accessibility. Otherwise, suggestions for future improvement of CPP processes differed among counties versus stakeholders, especially in terms of consumer involvement, improving meeting participation structure, increasing training and education, increasing stakeholder diversity, and improving county communication and transparency. Additionally, small portions of large (15%), medium (7%), and small (8%) counties offered suggestions related to increasing evaluation and input collection activities at CPP meetings. One large and one small county also made suggestions related to increasing resources for more staff at CPP meetings.

Statewide

Rationale: In order to understand what stakeholders liked the least about their counties' CPP processes as well as how the CPP process can be improved in the future, the evaluation team analyzed data from Stakeholder Focus Groups, Stakeholder Survey results, and Key Informant Interviews. Overall, results from both counties and stakeholders aligned in terms of suggestions for improvements to future CPP processes.

A large number of stakeholders (*n* = 311) were surveyed to understand what they disliked about their counties' CPP processes. Across the state, stakeholders most commonly disliked components of the CPP meeting itself. More specifically, stakeholders mentioned disliking the location and time of CPP meetings, the length of meetings, and the way information was shared at meetings. Similar to results regarding transportation barriers to participation, stakeholders also described disliking the travel related to attending CPP activities and made suggestions related to improving travel. Stakeholders also expressed dislike for how their input was used because many felt their counties already had a plan regardless of their input. Stakeholder survey responses were analyzed according to the following general domains and are presented accordingly.

Inputs

Many stakeholders were critical of the resources counties provided to conduct the CPP process. They disliked CPP meetings that felt underfunded and understaffed. They also disliked when counties failed to provide competent CPP facilitators.

Components of the CPP Meeting Structure

Across the state, stakeholders most commonly disliked components of the CPP meeting itself. More specifically, stakeholders mentioned disliking the location and time of meetings, the length of meetings, and the way information was shared at meetings. Additionally, similar to results regarding transportation barriers to participation, stakeholders also described that they disliked travel related to attending CPP activities and made suggestions related to improving travel.

Outreach

A portion of stakeholders also disliked stakeholder representation at CPP meetings and felt that counties could do a better job outreaching to diverse stakeholders.

Participant Input

Some stakeholders expressed disliking how their input was used because many felt the county already had a plan regardless of what was suggested at CPP meetings. Some stakeholders were critical of the CPP process because it was not clear how their input was documented and used in MHSA program planning. A small portion of stakeholders felt their input was completely disregarded.

Training

A small portion of stakeholders disliked how counties prepared stakeholders for participation and provided training. Stakeholders noted that unprepared participants often wasted time at meeting making

inappropriate requests or questions. It was noted that some stakeholders needed background information on the Mental Health Services Act, MHSA programming, and CPP processes.

Evaluation

A very small portion of stakeholders disliked how the counties evaluated the CPP process. They felt the county did not consider or use their feedback when asked how they could improve the CPP processes.

Stakeholder Perceptions and Satisfaction

A portion of stakeholders disliked their counties' CPP processes related to stakeholder perceptions and satisfaction; however, most of the examples provided by stakeholders were inconsistent and related to other topic areas such as participant input, training, and impacts.

Participant Impacts

A small portion of stakeholders disliked their counties' CPP processes for reasons related to participant impacts. Stakeholders described how participation in their counties' CPP processes negatively affected their sense of trust and collaboration with their county mental health department.

Mental Health System Impacts

A small portion of stakeholders disliked their counties' CPP process because of the impact, or lack thereof, that the CPP process had on their counties' mental health policy, program planning and implementation, monitoring, and access to services. Several stakeholders noted that their counties' CPP processes had been slow to produce visible outcomes.

Perceptions of Broader Community Impact

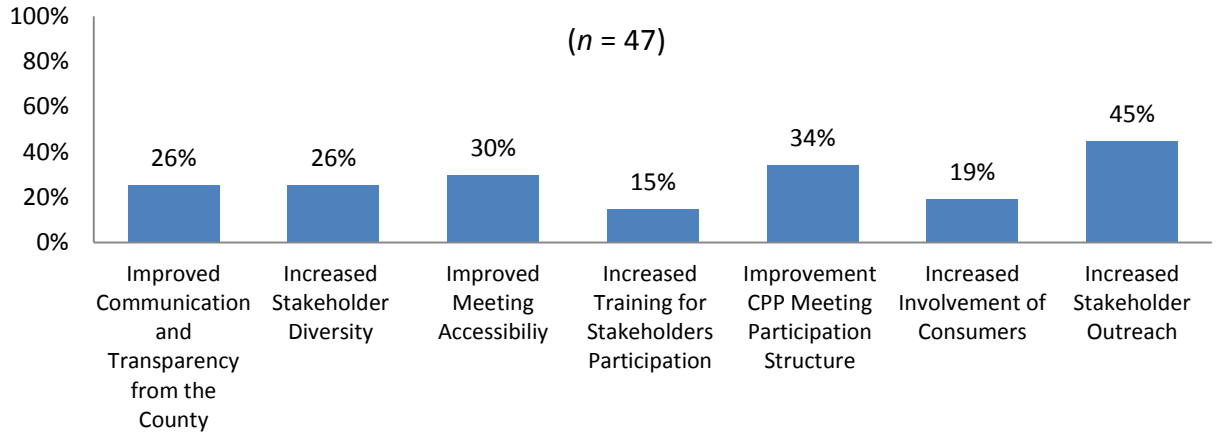
A small portion of stakeholders disliked their counties' CPP processes for their impacts on the perceptions of the broader community. A few noted that their counties' CPP processes had helped certain programs, but were not focused on the real problem of the seriously mentally ill in the counties. A small portion of stakeholders also felt critical of their counties' CPP processes because they felt they did not adequately address mental health stigma in the community at large.

Stakeholders from counties across the state offered a variety of suggestions for improving the CPP process process in their county.

Figure 111 depicts the types of suggestions for future improvements offered by stakeholders from counties across the state. Across the state, 45% of stakeholders suggested that counties improve their counties' CPP outreach efforts. In the same regard, stakeholders from 26% of counties suggested that counties take measures to increase the diversity of those participating in CPP processes, as well as consumer and family member participation, while 19% of stakeholders suggested increased involvement of consumers. Thirty-four percent of stakeholders from counties suggested improvements related to meeting structure, and 30% suggested improvements related to meeting accessibility. A smaller percent of stakeholders from across the state wanted to see more training for stakeholders (15%) to improve their

capacity to participate, while 26% suggested that counties improve their communication and transparency.

Figure 111: Stakeholder Suggestions for Future Improvement to the CPP Process, Statewide [Δ]

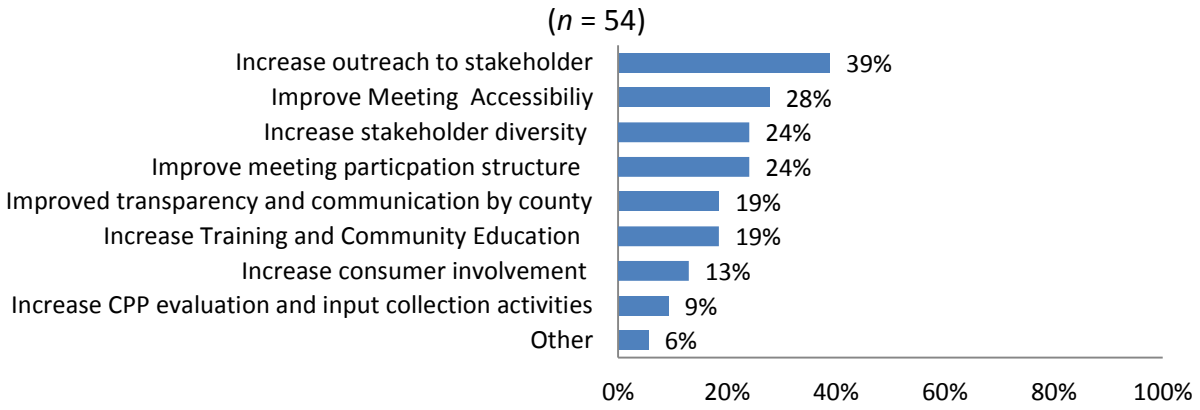


[Δ]*SOURCE:* Stakeholder Focus Group

Statewide, stakeholders, and counties provided similar suggestions for future improvements of their counties' CPP processes.

Figure 112 provides the types of suggestions for improving future the CPP processes provided by counties (*n* = 54). Similar to stakeholders, the most common suggestion offered by counties was to increase stakeholder outreach (39%). Over a quarter of counties suggested improvements to meeting accessibility (28%), increasing stakeholder diversity (24%), and improving meeting participation structure (24%). Nearly 20% of counties suggested improvements in how counties communicate and the levels of transparency (19%) and increased trainings and community education (19%). Of the 10 counties that suggested having more CPP training and community education, three counties suggested learning about what other counties are doing for their CPP process. Thirteen percent of counties suggested increasing consumer involvement, while 9% of counties suggested that more evaluation and input collection activities are used during CPP processes, and 6% of counties made other suggestions. Two counties suggested having more resources, specifically staffing, for CPP meetings and another county felt that its CPP process went great and encouraged counties and stakeholders to "keep up the good work."

Figure 112: County Suggestions for Future Improvements to the CPP Process, Statewide [β]



[β] *SOURCE*: County Key Informant Interviews

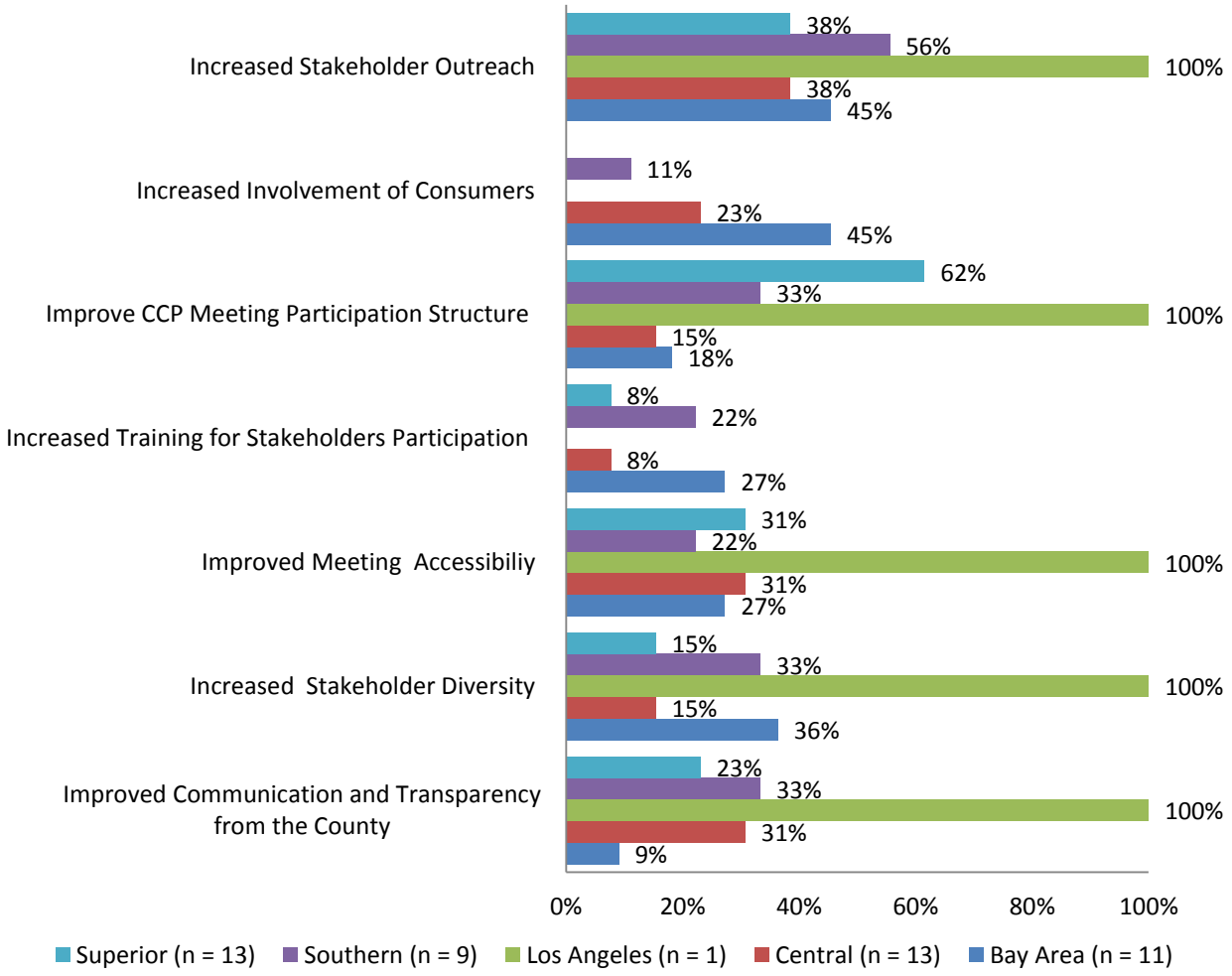
CMHDA Region

Rationale: Stakeholders from counties in different CMHDA Regions disliked different aspects of their counties' CPP processes. Stakeholders from counties in all CMHDA Regions said that they did not like CPP meetings because they felt their voices were not heard. Stakeholders also expressed disliking meetings that focused on statistical data and repetitive information. Stakeholders from counties in each CMHDA Region also disliked certain CPP activities; however, the type of activities stakeholders disliked differed for each CMHDA Region.

Stakeholders in each CMHDA Region offered various suggestions for future improvements of CPP processes and these varied in each of the CMHDA Regions.

Figure 113 depicts stakeholder suggestions for future improvement of the CPP process by CMHDA Region. As shown, there was some variation in what kinds of suggestions stakeholders offered for future improvements of their counties' CPP processes.

Figure 113: Stakeholder Suggestions for Future Improvement of CPP Processes, by CMHDA Region[Δ]



[Δ]*SOURCE:* Stakeholder Focus Group

A large portion of stakeholders in the Southern region (56%), Bay Area (45%), Central (38%), and Superior (38%) regions suggested increasing stakeholder outreach. Among stakeholders from counties in the Bay Area region, 45% suggested increasing consumer involvement, while only 23% of stakeholders from Central region counties, and 11% of stakeholders from counties in the Southern region, made that same suggestion. In addition, about a third of stakeholders from counties in the Bay Area (36%) and Southern (33%) regions suggested increasing stakeholder diversity, while only 15% of stakeholders in the Central and Superior regions made suggestions related to increasing stakeholder diversity.

Suggestions regarding CPP participation and accessibility varied among stakeholders in different CMHDA Regions. Similar percentages of stakeholders in the Bay Area (27%), Central (31%), Southern (22%), and Superior (31%) regions made suggestions related to improved meeting accessibility as a way to improve future CPP meetings. Suggestions relating to improvements in the participation structure of CPP meetings were made by 100% of stakeholders from the Los Angeles region and 62% of stakeholders from the Superior region; however, a smaller percentage of stakeholders from counties in the Southern (33%), Bay

Area (18%), and Central (15%) regions suggested improvements in the participation structure. More stakeholders from counties in the Bay Area (27%) and Southern (22%) regions suggested increased training for stakeholder participation than stakeholders from the Central (8%) and Superior (8%) regions.

Suggestions to improve communication and transparency from the county were made by 33% of stakeholders from counties in the Southern region, 31% of stakeholders from counties in the Central region, 23% of stakeholders from counties in the Superior region, and 9% of stakeholders from counties in the Bay Area region.

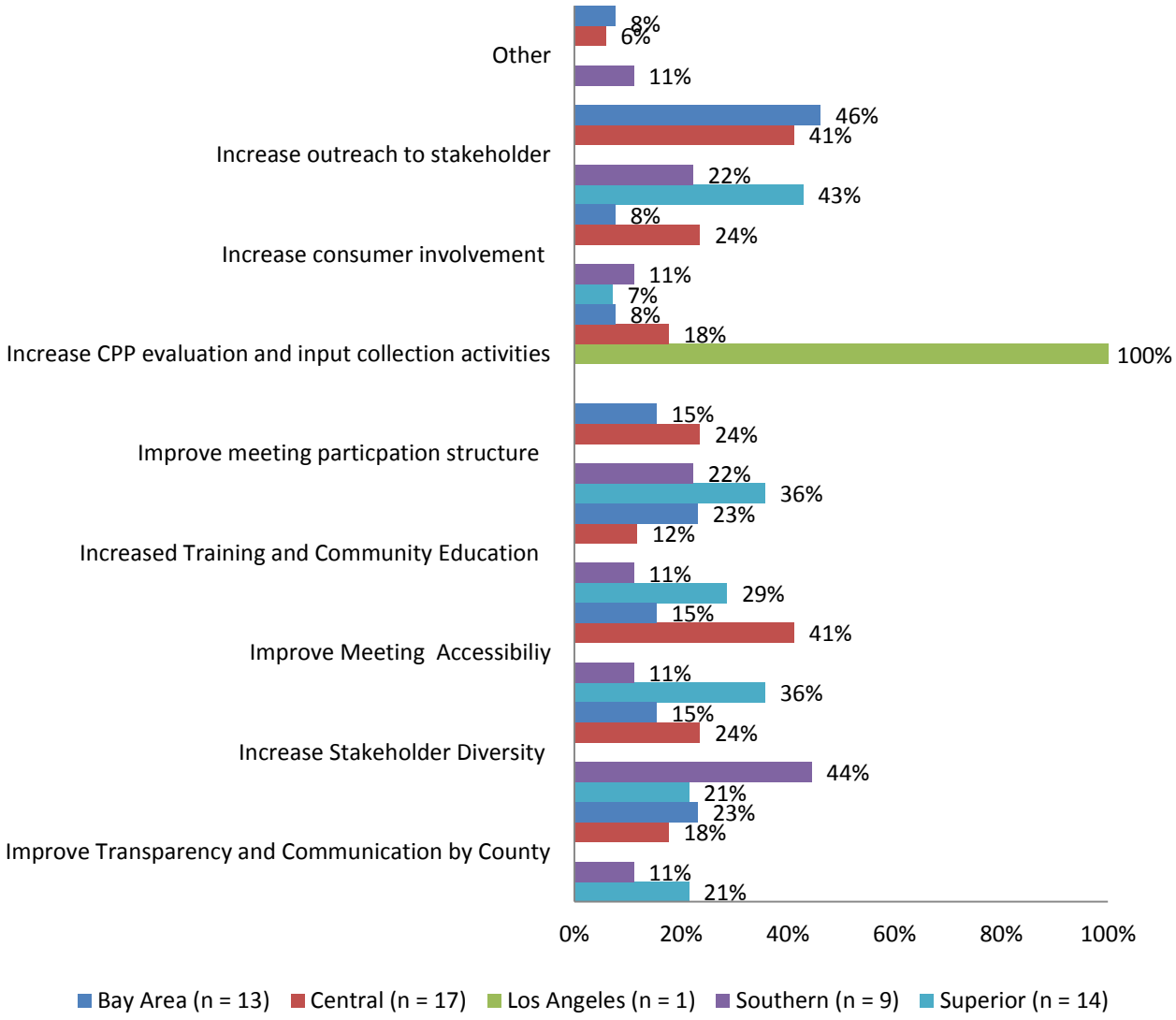
Also, as noted in

Figure 113, all stakeholders from the Los Angeles region (*n* = 1) offered suggestions related to increasing stakeholder outreach, improving meeting participation structure, improving accessibility, increasing stakeholder diversity, and improving communication and diversity.

Counties' suggestions on how to improve future CPP processes were largely similar to those offered by stakeholders from the same CMHDA Regions.

Figure 114 depicts suggestions offered by counties in each of the CMHDA Regions for future improvements of CPP processes. Suggestions made by counties differed from stakeholders in several instances. The only suggestion provided by the Los Angeles region was increased CPP evaluation and input collection activities. Unlike stakeholders counties also made suggestions relating to evaluation and other activities. Eighteen percent (18%) of counties in the Central region suggested increasing evaluation and input collection activities at CPP meetings as well as 11% of counties in the Southern region, 7% in the Superior region, and 8% in the Bay Area region. One county from the Bay Area region and one county from the Central region each suggested providing more resources at CPP meetings in the form of increased staff members.

Figure 114: County Suggestions for Future Improvements to the CPP Process, by CMHDA Region [β]



[β]*SOURCE*: County Key Informant Interviews

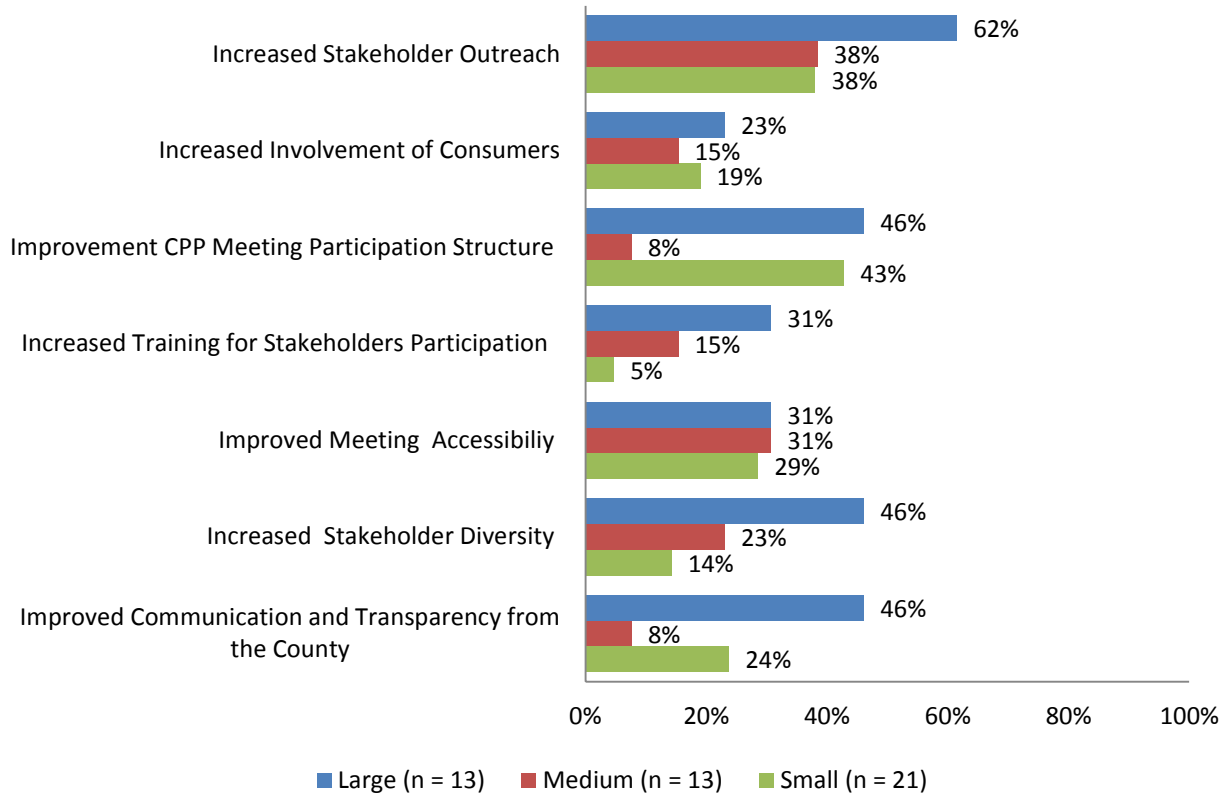
County Size

Rationale: There was some variation of what stakeholders liked about the CPP process based on the size of the county. Overall, stakeholders disliked activities that did not allow them to fully participate or understand the information. Stakeholders from large and small counties disliked traveling to meetings. Stakeholders from differently sized counties also described disliking specific CPP activities; however, the type of activities stakeholders disliked varied from county to county.

Stakeholder suggestions for future improvement of CPP processes varied based on the size of the county. Figure 115 depicts the types of suggestions offered by stakeholders based on the size of the county. Many stakeholders from large counties (62%) suggested increasing stakeholder outreach, while only 38% of stakeholders in medium and small counties made that suggestion. Similarly, more stakeholders from large

counties (46%) suggested increasing stakeholder diversity than in medium (23%) and small (14%) counties. Smaller portions of stakeholders in large (23%), medium (19%), and small (15%) counties suggested increasing the involvement of consumers. A near majority of stakeholders in large (46%) and small (43%) counties offered suggestions to improve meeting participation structure; however, only 8% of medium county stakeholders offered that suggestion. In large counties, 31% of stakeholders suggested increasing training for stakeholders while smaller percentages of stakeholders made this suggestion in medium (15%) and small (5%) counties. Similar percentages of stakeholders from large (31%), medium (31%), and small (29%) counties suggested improvements to meeting accessibility. More stakeholders in large counties (46%) suggested improving communication and transparency of the county compared to small (24%) and medium (8%) counties.

Figure 115: Stakeholder Suggestions for Future Improvement of CPP Processes, by County Size[Δ]



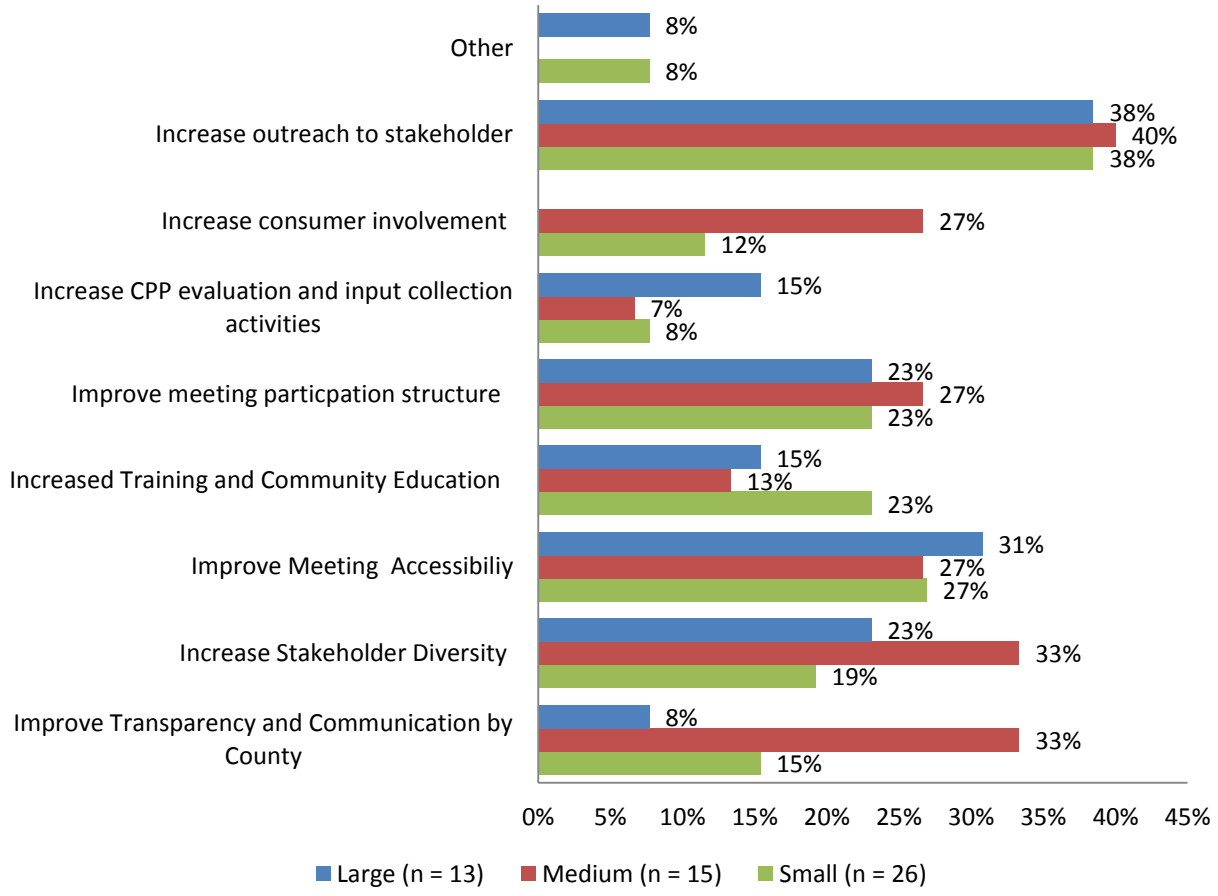
[Δ]*SOURCE:* Stakeholder Focus Group

County suggestions for improvements to future CPP processes varied based on the size of the county.

Figure 116 depicts the types of suggestions offered by counties based on the size of the county. About 40% of large (38%), medium (40%), and small (38%) counties offered suggestions related to increasing stakeholder outreach. More than a quarter of medium sized counties suggested increasing consumer involvement (27%), while only 12% of small counties and no large counties made that suggestion. Small portions of large (15%) medium (7%), and small (8%) counties offered suggestions related to increasing evaluation and input collection activities at CPP meetings. Around a quarter of large (23%), medium (27%),

and small (23%) counties suggested improvements to the CPP meeting participation structure. Increased training and community education was suggested by 23% of small counties, while smaller percentages of large (15%) and medium (13%) offered that suggestion. Thirty-one percent (31%) of large counties and 27% of medium and small counties suggested improving meeting accessibility. A third of medium counties (33%) suggested increasing stakeholder diversity, followed by 23% of large counties and 19% of small counties. More medium counties (33%) suggested improving communication and transparency than small (15%) and large (8%) counties. Only 8% of small and medium counties offered other suggestions.

Figure 116: County Suggestions for Future Improvements to the CPP Process, by County Size [β]



[β]*SOURCE*: County Key Informant Interviews

Impacts – Participants

This section reports on results pertaining to research questions around stakeholders' participation in the CPP process, including how it impacted their senses of well-being and recovery as well as increased their sense of trust in the mental health system.

IM-01: How, and to what extent, does a county's administration of the CPP process affect participants' sense of empowerment, hope, self-determination, social connection, wellness and recovery?

Statewide: Approximately 50% of Stakeholder Survey respondents (*n* = 581) reported that they agreed or strongly agreed that participating in the MHSA CPP process had improved their sense of well-being and recovery. Stakeholder Focus Group data supports this result. On a scale of 1 to 5, participants on averaged a score of 4, indicating participation in the CPP process had an overall positive impact on stakeholders' well-being and recovery.

CMHDA Region: Regional data largely reflected statewide data. On average, stakeholders reported that participation in MHSA CPP activities had positive impacts on their well-being and recovery.

County Size: County size data reflected statewide and regional data. In other words, across county size categories, Stakeholder Focus Group participants reported that their participation in CPP activities had a positive impact on their well-being and recovery. Similarly, approximately half of Stakeholder Survey respondents agreed or strongly agreed that participation in CPP activities had positive impacts on their well-being and recovery.

Statewide

Rationale: To address this research question, statewide data was analyzed from the Stakeholder Survey and Stakeholder Focus Groups. The qualitative data from the Stakeholder Focus Group was coded using a scale of 1 to 5. Responses ranged from a score of 1 (denoting a negative impact on well-being and recovery), 2 (denoting a slightly negative impact), 3 (denoting no impact), 4 (denoting a slightly positive impact), and 5 (denoting a positive impact). A higher average score indicates that respondents believed there was a more positive impact, whereas a lower average score indicates a more negative impact.

Overall, stakeholders reported participation in the CPP process had a positive effect on their well-being and recovery (average of 3.7);[Δ] Stakeholder Survey data supported this result. Approximately half of stakeholders (*n* = 580) agreed or strongly agreed that participation in CPP activities improved their well-being and recovery. Overall, stakeholders reported participating in CPP activities gave them a sense of hope and a stronger sense of purpose due to knowing that change is happening and people are committed to change. Others talked about feeling more empowered that their voice can make a difference. As one stakeholder said, "I felt like I was being invited to participate in my own recovery, and …the pleasure of seeing some of my ideas becoming reality [was rewarding]." Some stakeholders also discussed how participation helped them build a sense of community and helped them to not feel so alone. Related to community-building, it appeared that stakeholder participation helped increase awareness and

accessibility of mental health services, which in turn, also helped stakeholders to inform others in their community. One participant explained, "As a Latino, I get information, and then make myself available for my community. Helping my community helps me to get better."

Nonetheless, while overall stakeholder feedback was positive, some stakeholders also noted CPP participation did not have an impact on their wellness and recovery. Stakeholders from one particular county described feeling more empowered during the initial phases of CPP when they felt their voice had an impact. Participants who have been involved in CPP for a shorter time agreed, reporting no impact on their wellness and recovery.

CMHDA Region

Rationale: Stakeholders' perceptions of how participating in CPP affected participant well-being and recovery is shown in Table 35 by CMHDA Region. Across all CMHDA Regions, stakeholders reported an overall positive effect between their participation in their counties' CPP processes and their well-being and recovery. Bay Area region stakeholders were unsure of the impact, while Los Angeles and Southern region stakeholders indicated experiencing positive impacts.

Table 35: Impact of CPP Participation on Well-being and Recovery, by CMHDA Region [Δ]

	Min of Scales	Max of Scales	Average of Scales
Bay Area	2.0	5.0	3.5
Central	2.0	5.0	3.8
Los Angeles	4.0	4.0	4.0
Southern	3.0	5.0	4.0
Superior	2.0	4.0	3.6
Grand Total	2.0	5.0	3.7

[Δ] *SOURCE:* Stakeholder Focus Groups

Stakeholder Survey results support the Stakeholder Focus Group data. The Central, Los Angeles, Southern, and Superior regions agreed that participating in their counties' CPP process improved their well-being and recovery. On the other hand, a lower proportion of Bay Area region stakeholders felt that their participation in their counties' CPP processes had an impact on their well-being and recovery (see Table 36).

Table 36: Level of Agreement of CPP Participation on Stakeholder Well-being, by CMHDA Region [δ]

Participating in the MHSA CPP process improved my sense of wellbeing	
Bay Area (*n* = 111)	38%
Central (*n* = 128)	51%
Los Angeles (*n* = 32)	66%
Southern (*n* = 182)	52%
Superior (*n* = 127)	50%

[δ] *SOURCE:* Stakeholder Survey

County Size

Rationale: Stakeholders' perceptions of the impact of participating in their counties' CPP processes on well-being and recovery are shown in Table 37 by county size. Overall, stakeholders perceived that participation in CPP had a positive impact on their well-being and recovery. Stakeholders from large counties were more neutral regarding the impacts that they experienced, while stakeholders from medium and small counties had slightly more positive perceptions of their participation in their counties' CPP processes and its impact on their well-being and recovery.

Table 37: Impact of CPP Participation on Well-being and Recovery, by County Size [Δ]

	Min of Scales	Max of Scales	Average of Scales
Large	2.0	4.0	3.5
Medium	2.0	5.0	3.8
Small	2.0	4.0	3.8
Grand Total	2.0	5.0	3.7

[Δ] *SOURCE:* Stakeholder Focus Groups

Stakeholder Survey data indicates that across county size categories, approximately half of stakeholders agreed that their CPP participation had positive impacts on their well-being and recovery (see Table 38). However, a lower percentage of stakeholders from medium counties agreed that their participation in CPP activities improved their sense of well-being and recovery.

Table 38: Level of Agreement of CPP Participation on Stakeholder Well-being, by County size [δ]

Participating in the MHSA CPP process improved my sense of wellbeing	
Large (n = 250)	54%
Medium (n = 151)	40%
Small (n = 179)	50%

[δ] *SOURCE:* Stakeholder Survey

IM-02: How, and to what extent, does a county' administration of the CPP process affect participants' trust in, and collaboration with, the mental health system?

Results

Statewide: Overall, stakeholders strongly agreed that their participation increased their trust in the public mental health system.

CMHDA Region: This result was constant when analyzed across CMHDA Region.

County Size: This result was constant when analyzed across county size categories.

Statewide

Rationale: To address this research question, statewide data was analyzed from the Stakeholder Survey. Across the state, 62% of respondents (*n* = 581) agreed or strongly agreed that participating in the CPP process increased their trust in the PMHS. For a better understanding of how county informants and

stakeholders felt their counties' administration of CPP processes affected trust and collaboration in the mental health system, see IM-04 on page 178.

CMHDA Region

Rationale: CMHDA Regional data reflected statewide data (see Table 39). The majority of stakeholders agreed or strongly agreed that participating in their counties' CPP processes increased their trust in the mental health system as a whole. However, Bay Area stakeholders were less sure (50%, *n* = 111), while a high proportion of Los Angeles region stakeholders strongly agreed with this sentiment (71%, *n* = 31).

Table 39: Impact of CPP on Trust in the Mental Health System, by CMHDA Region [δ]

Participating in the MHSA CPP increased my trust in the mental health system	
Bay Area (*n* = 111)	50%
Central (*n* = 127)	62%
Los Angeles (*n* = 31)	71%
Southern (*n* = 182)	68%
Superior (*n* = 130)	64%

[δ] *SOURCE:* Stakeholder Survey

County Size

Rationale: County size data reflected data at the statewide and CMHDA Regional levels. Across county size categories, the majority of Stakeholder Survey respondents (62-63%) agreed or strongly agreed that participating in their counties' CPP processes increased their trust in the mental health system as a whole (see Table 40).

Table 40: Impact of CPP on Trust in the Mental Health System, by County Size [δ]

Participating in the MHSA CPP increased my trust in the mental health system	
Large (*n* = 249)	62%
Medium (*n* = 151)	63%
Small (*n* = 181)	62%

[δ] *SOURCE:* Stakeholder Survey

Impacts – Mental Health System

The following section looks at the impact of counties' CPP processes at the broader system-wide level. Information is provided regarding county informants' and stakeholders' perceptions of counties' CPP processes and the effects of those processes on the following: 1) mental health policy, program planning and implementation, as well as evaluation; and 2) trust and collaboration among mental health providers, between mental health providers and other human service providers, between mental health departments and government agencies or community based organizations, and between consumers and family members.

IM-03: How, and to what extent, does a county's administration of the CPP process affect mental health policy, program planning and implementation, monitoring, quality improvement, evaluation, and budget allocations?

Results

Statewide: MHSA/CPP Coordinators and stakeholders looked favorably upon counties' CPP processes and their impacts on mental health policy and program planning. While MHSA/CPP Coordinators were more positive about CPP's impacts on policy and planning, stakeholders were slightly less certain.

CMHDA Region: Overall, MHSA/CPP Coordinator and stakeholder feedback demonstrated that counties' CPP processes had resulted in more stakeholder input throughout their processes, from planning to evaluation. Data supported this result across CMHDA Regions and county size categories. Stakeholders reported that they felt they had a stronger voice, and as a result, communication and transparency between county staff and stakeholders had strengthened. Nonetheless, Southern region stakeholders were more critical of their counties' CPP processes and reported more positive impacts during their initial phases of CPP.

County Size: MHSA/CPP Coordinators and stakeholders noted that their counties' CPP process resulted in better understandings of program needs and gaps in service delivery, which in turn led to the creation of programs for underserved and ethnic communities. This especially seemed to be the case among large counties. According to medium and small counties, the CPP process seemed to foster a paradigm shift away from the medical model of focusing on treating the currently presenting health issues towards a model that highlights wellness and recovery. Public mental health services were adopting strength-based approaches towards service delivery, focusing on building relationships and partnerships in communities. Small counties, in particular, stressed how their CPP processes had increased the public's general knowledge of mental health, resulting in the de-stigmatization of mental health in their communities and more people feeling comfortable seeking mental health services.

Statewide

Rationale: To address this research question, statewide data was analyzed from County Key Informant Interviews and Stakeholder Focus Groups. This qualitative data was coded using a scale of 1 to 5. Responses ranged from a score of 1 (denoting a negative impact on well-being and recovery), 2 (denoting

a slightly negative impact), 3 (denoting no impact), 4 (denoting a slightly positive impact), and 5 (denoting a positive impact). A higher average score indicates that respondents believed there was a more positive impact, whereas a lower average score indicates a more negative impact.

Overall, MHSA/CPP Coordinators perceived counties' CPP processes to have had positive effects on mental health policy, program planning, and evaluation.[β] Stakeholders, on the other hand, were slightly less positive, indicating that they were more ambivalent about whether counties' CPP processes had impacts on mental health policy and planning.[Δ]

County informants and stakeholder feedback demonstrated that counties' CPP processes had incorporated more stakeholder input throughout the process, from planning to evaluation. Stakeholders reported that they felt they had a stronger voice, and as a result, communication between counties and stakeholders had strengthened. Overall, MHSA/CPP Coordinators reported counties' CPP processes had enhanced collaboration and partnership between counties and their communities. Specifically, counties' CPP processes had encouraged more stakeholder-driven planning. In other words, MHSA/CPP Coordinators reported that stakeholders were provided input throughout their CPP processes, from planning to evaluation. The CPP participation had also resulted in increased understanding of the mental health needs of underserved populations (e.g., veterans and LGBT) and ethnic communities (e.g., Latino and African American), which will hopefully lead to the identification of gaps in service delivery.

CMHDA Region

Rationale: Across CMHDA Regions, MHSA/CPP Coordinators reported that counties' CPP processes had positively changed the PMHS (see Table 41). Central region stakeholders reported the highest positive impact (average of 4.2), while Southern region stakeholders reported the lowest positive impact (average of 3.7).

Table 41: Impact of CPP Participation on PMHS, by CMHDA Region[β]

	Min of Scales	Max of Scales	Average of Scales
Bay Area	3.0	4.0	3.8
Central	4.0	5.0	4.2
Los Angeles	4.0	4.0	4.0
Southern	2.0	4.0	3.7
Superior	4.0	4.0	4.0
Grand Total	**2.0**	**5.0**	**4.0**

[β] *SOURCE*: County Key Informant Interviews

Stakeholders also reported that counties' CPP processes had an overall positive affect on the public mental health system and mental health services, however the data indicated a slightly lower impact. That is, stakeholders were less certain that their participation in their counties' CPP processes had positive impacts on mental health policy and planning (see

Table 42).

Table 42: Impact of CPP Participation on MH Policy and Planning, by CMHDA Region [Δ]

	Min of Scales	Max of Scales	Average of Scales
Bay Area	2.0	4.0	3.6
Central	3.0	5.0	3.9
Los Angeles	4.0	4.0	4.0
Southern	3.0	5.0	4.0
Superior	2.0	4.0	3.5
Grand Total	**2.0**	**5.0**	**3.7**

[Δ] *SOURCE* = Stakeholder Focus Groups

Stakeholder data largely reflects MHSA/CPP Coordinators' responses. That is, stakeholders reported that their counties' CPP processes had increased their voices and senses of engagement, fostering more dialogue and partnerships. For instance, stakeholders in the Los Angeles region had very favorable comments towards their CPP process's impact on mental health policy and planning. One stakeholder commented, "We have seen a lot of transformation: a huge impact that has improved the whole system in terms of communication, collaboration and better and more services. The 'no wrong door' approach had helped build deeper relationships and partnerships." Other stakeholders discussed how there are still competing voices and that the process is "hit or miss"; however, they noted that the different constituencies have learned to work together.

In addition to counties' CPP processes helping to create more programs and services for underserved and ethnic communities, stakeholders reported that their counties' CPP processes had also helped to generate consumer employment, wellness centers, WRAP services, and full service partnerships. Stakeholders reported a general shift towards a community-driven approach that was more in alignment with MHSA values. Nonetheless, the Southern and Superior regions were more ambivalent about their counties' CPP processes; stakeholders in both regions were concerned that stakeholder input would not have substantial "teeth" in mental health planning and implementation. Stakeholders cited feeling like the initial stages of their CPP processes were more sincere, whereas with time passing, these activities felt more ceremonial. Additionally, stakeholders in one Southern county also reported a lack of inclusivity at meetings. Data seemed to indicate a general lack of empowerment and trust between stakeholders and the county.

County Size

Rationale: County size data reflects statewide and CMHDA Region data. That is, overall, MHSA/CPP Coordinators reported that their counties' CPP processes had positive impacts on mental health policy and planning (see
Table 43). Stakeholders also felt that their counties' CPP process had an overall positive impact; however, they were slightly more ambivalent than MHSA/CPP Coordinators (see Table 44).

Table 43: Impact of CPP Participation on MH Policy and Planning, by County Size [β]

	Min of Scales	Max of Scales	Average of Scales
Large	2.0	5.0	3.8

Medium	3.0	4.0	3.9
Small	4.0	5.0	4.1
Grand Total	**2.0**	**5.0**	**4.0**

[β] *SOURCE*: County Key Informant Interviews

Table 44: Impact of CPP Participation on MH Policy and Planning, by County Size [Δ]

	Min of Scales	Max of Scales	Average of Scales
Large	3.0	5.0	3.9
Medium	3.0	5.0	3.7
Small	2.0	5.0	3.7
Grand Total	**2.0**	**5.0**	**3.7**

[Δ] *SOURCE*: Stakeholder Focus Groups

Across county size categories, MHSA/CPP Coordinators reported that their counties' CPP processes reinforced stakeholder-driven planning and the creation of programs and services for underserved communities. One MHSA/CPP Coordinator from a large county stated, "We have moved beyond a 'rubber-stamp' phase. Programs created with stakeholder input are far enough along to generate outcomes." MHSA/CPP Coordinators from large counties highlighted that their counties' CPP processes had increased resources and services for ethnic communities due to targeted outreach to these communities and better understanding of these communities' mental health needs. MHSA/CPP Coordinators in medium and small counties stressed the shift in focus from a medical model to wellness and recovery that is more community-driven. MHSA/CPP Coordinators noted how CPP activities had fostered more opportunities to build community partnerships and create programs and services based on community needs. For example, one MHSA/CPP Coordinator from a small county cited that his/her CPP process had resulted in a "Roving Clinician" program (which involves a clinician going to different schools to do assessments), education and intervention, collaborative courts, and a Parent-Child Interactive Program (which teaches parents skills-building and prevention approaches towards mental health issues).

Stakeholder feedback supports MHSA/CPP Coordinators data. That is, stakeholders reported that their counties' CPP processes had helped create stronger stakeholder voices in mental health policy and planning. As a result, stakeholders reported stronger communication and transparency between the county and its communities. While large and medium counties discussed the creation of more programs and services for underserved and ethnic communities, stakeholders from medium counties also emphasized the creation of peer-driven programs, wellness centers, and more consumer employment. Stakeholders in small counties emphasized that their counties' CPP processes had resulted in increased awareness of mental health services as well as greater awareness of mental health issues within the general public. For small counties, their CPP processes' impacts seemed to be most felt in the de-stigmatization of mental health within communities, encouraging more people to seek mental health services.

In addition, MHSA/CPP Coordinators and stakeholders reported that their counties' CPP processes had resulted in better understandings of the needs and gaps in service delivery for underserved and ethnic communities, which had led to the creation of various programs and services for particular populations.

This was particularly true among large counties. Stakeholders discussed how CPP activities had helped produce a paradigm shift towards a more community-driven approach that highlighted wellness and recovery. Small counties, in particular, stressed how the CPP process has resulted in greater awareness of mental health services for consumers as well as the general public's understanding of mental health.

IM-04: How, and to what extent, does a county's administration of the CPP process affect trust and collaboration among mental health service providers; and between mental health providers and other health and human service providers?

Results

Statewide: MHSA/CPP Coordinators and stakeholders were neutral regarding the impacts of their counties' CPP processes on building trust and collaboration between mental health providers, between mental health providers and other health and human service providers, and between consumers and family members. MHSA/CPP Coordinator and stakeholder feedback demonstrated that CPP had fostered greater communication among different agencies, specifically more collaboration between mental health and law enforcement and mental health with K-12 education programs. MHSA/CPP Coordinators, in particular, cited CPP's impacts on strengthening the relationship between consumers and family members. However, similar to the previous research question that discussed CPP's impact on mental health policy and planning, MHSA/CPP Coordinators recognized that there was still much work to be done, and that building trust and collaboration is a gradual process that takes time.

CMHDA Region: MHSA/CPP Coordinators and stakeholders in the Los Angeles region reported the highest favorable perception of stakeholders strongly believing CPP had had a positive impact on building trust and collaboration between mental health providers and between mental health providers andCBOs.

County Size: MHSA/CPP Coordinators and stakeholders in small counties were the least certain that their counties' CPP activities had affected trust and collaboration between providers and community partners.

Statewide

Rationale: To answer this research question, data was analyzed from County Key Informant Interviews and Stakeholder Focus Groups. This qualitative data was coded using a scale of 1 to 5. Responses ranged from a score of 1 (denoting a negative impact on well-being and recovery), 2 (denoting a slightly negative impact), 3 (denoting no impact), 4 (denoting a slightly positive impact), and 5 (denoting a positive impact). A higher average score indicates that respondents believed there was a more positive impact, whereas a lower average score indicates a more negative impact.

County informants and stakeholders were neutral regarding the impact of their counties' CPP processes on building trust and collaboration between mental health providers, between mental health providers and other health and human service providers, and between consumers and family members. MHSA/CPP Coordinators and stakeholders reported that their counties' CPP processes had fostered greater communication by initiating breakdowns in silos as well as fostering opportunities for mutual brainstorming of innovative projects across agencies. In particular, MHSA/CPP Coordinators and stakeholders noticed that there were increases in communication and collaboration between mental

health providers and law enforcement/criminal justice agencies as well as between mental health providers and school-based programs. However, despite the overall positive feedback, county informants recognized that building trust and collaboration among mental health service providers and among the various community partners and stakeholders was a gradual process that would take time.

CMHDA Region

Rationale: Overall, MHSA/CPP Coordinators were uncertain that their counties' CPP processes had an impact on building trust and collaboration between providers, between providers and other health and human service providers, as well as between consumers and family members. The uncertainty appeared to be related to time; MHSA/CPP Coordinators recognized that building trust and collaboration was a gradual process that took time. However, MHSA/CPP Coordinators in the Los Angeles (average of 4.0) and Southern (average of 3.9) regions had a more positive perception of CPP's impact on building trust and collaboration (see Table 45).

Table 45: Impact of CPP Participation on Trust and Collaboration, by CMHDA Region [β]

	Min of Scales	Max of Scales	Average of Scales
Bay Area	3.0	4.0	3.4
Central	2.0	5.0	3.6
Los Angeles	4.0	4.0	4.0
Southern	3.0	5.0	3.9
Superior	2.0	4.0	3.4
Grand Total	**2.0**	**5.0**	**3.6**

[β] *SOURCE*: County Key Informant Interviews

MHSA/CPP Coordinators reported that their counties' CPP processes had increased trust and communication among mental health service providers, between mental health providers and other stakeholders, and between consumers and family members. Central and Southern region MHSA/CPP Coordinators, in particular, described the positive impact of counties' CPP processes on bringing together consumers and family members. For instance, one MHSA/CPP Coordinator from the Central region described the impact of the CPP process on strengthening relationships between consumers and family members: "In 2009, [CPP] was a philosophy. Now it is being applied. By 2011, the two groups came together in a consumer and family member movement." The increased communication and dialogue created the space for stakeholders to come out of their various silos. Across CMHDA Regions, MHSA/CPP Coordinators noted more collaboration between mental health agencies and law enforcement/criminal justice as well as with K-12 education.

Stakeholders' comments largely reflected MHSA/CPP Coordinators' responses. Stakeholders also reported some ambivalence as to whether their counties' CPP processes had affected relationships between mental health departments and government agencies or CBOs. The exception to this was in the Los Angeles region, where stakeholders strongly believed that its CPP process had an impact on fostering trust and collaboration between the county and mental health agencies and CBOs (see Table 46).

Table 46: Impact of CPP Participation on Trust and Collaboration, by CMHDA Region [Δ]

	Min of Scales	Max of Scales	Average of Scales
Bay Area	1.0	4.0	3.6
Central	3.0	5.0	3.8
Los Angeles	5.0	5.0	5.0
Southern	2.0	4.0	3.7
Superior	2.0	4.0	3.5
Grand Total	**1.0**	**5.0**	**3.7**

[Δ] = Stakeholder Focus Groups

Similar to MHSA/CPP Coordinators, stakeholders discussed that their CPP processes had increased collaboration and communication. As one Los Angeles stakeholder responded, "It's been invaluable. There is no longer any 'wrong door.'" Participants discussed more opportunities to network as a result of the CPP process, thereby increasing their awareness of programs and services. Stakeholders in one Southern region county described how greater collaboration and communication had provided a space for mutual brainstorming and experimentation. This was supported by a stakeholder in another Southern region county who said the CPP process had resulted in new collaboration between mental health and a new human trafficking initiative.

County Size

Rationale: County size data reflected CMHDA Region data. County informants reported being uncertain whether CPP affected trust and collaboration between providers and mental health departments with other public agencies and community-based organizations (see Table 47). From the county perspective, large counties had a more favorable perception of their CPP processes and their impacts on building trust among providers, between different community partners, as well as between consumers and family members (average of 4.0). However, MHSA/CPP Coordinators in small counties were the most unsure of CPP's impact on building trust and collaboration (average of 3.4).

Table 47: Impact of CPP Participation on Trust and Collaboration, by County Size [β]

	Min of Scales	Max of Scales	Average of Scales
Large	3.0	5.0	4.0
Medium	2.0	5.0	3.5
Small	2.0	4.0	3.4
Grand Total	**2.0**	**5.0**	**3.6**

[β] *SOURCE*: County Key Informant Interviews

MHSA/CPP Coordinators feedback indicated that CPP activities had opened space for ongoing dialogue and communication, thereby increasing transparency between mental health providers as well as between mental health providers and other human service providers. Another impact of the CPP process was an increase in integrated services. An MHSA/CPP Coordinator from a medium county explained, "They [the county] have become more integrated. They now have a mental health adult court with probation and a juvenile court. They have collaborated with the veterans, which is helping to meet the community

needs. Consumers are at the table, as well. They have work groups to evaluate how they are doing. They just completed a set of 8 work groups to incorporate feedback into planning and quality improvement. This helps them address changing needs in the community."

Stakeholders were also neutral on counties' CPP processes' impacts on building trust and collaboration among providers and community agencies (see Table 48). Stakeholders from medium and large counties reported much more favorable perceptions of the impact of counties' CPP processes (4.1 and 3.9, respectively), while stakeholders from small counties had less favorable outlooks (average of 3.4).

Table 48: Impact of CPP Participation on Trust and Collaboration, by County Size [β]

	Min of Scales	Max of Scales	Average of Scales
Large	2.0	5.0	3.9
Medium	4.0	5.0	4.1
Small	1.0	4.0	3.4
Grand Total	**1.0**	**5.0**	**3.7**

[β] *SOURCE*: Stakeholder Focus Groups

Across county size categories, stakeholders reported more collaboration and interaction between the county mental health departments and law enforcement, with education, and with CBOs. Stakeholders described how the increased communication between county staff and agencies/CBOs had allowed stakeholders to share best practices across sectors.

IM-05: How, and to what extent, does a county's administration of the CPP process promote mental health advocacy efforts at regional, national, and state levels?

Specific data regarding how counties' CPP processes promoted mental health advocacy efforts at the regional, national, and state levels was not available. However, other relevant data was available and is presented in other sections of this report. This includes:

- IM-03 (on Page 174): How, and to what extent, does a county's administration of the CPP process affect mental health policy, program planning and implementation, monitoring, quality improvement, evaluation, and budget allocations?
- IM-06 (on Page 183): How, and to what extent, does a county's administration of the CPP process affect the community's perception of mental health diagnoses and/or seeking public mental health services (stigma)?
- IM-07 (on Page 192): What other impacts do stakeholders perceive the CPP process to have on the community at large, particularly-related to MHSA-defined outcomes?

While the available data was not specific to mental health advocacy efforts at regional, national, and state levels, it did relate to the impacts the CPP process had on the mental health system at large and its impact on stigma.

Impacts – Perceptions of the Broader Community Impacts

This section examines counties' CPP processes and their impacts on the broader community's perceptions of mental health issues. Information is provided on 1) how counties and stakeholders perceived the ability of counties' CPP processes to transform communities' perceptions of those with mental health diagnoses and/or seek public mental health services, 2) other impacts counties and stakeholders identified in relation to the CPP process, and 3) changing community perceptions of mental health.

IM-06: How and to what extent does a county's administration of the CPP process affect the community's perception of mental health diagnoses and/or seeking public mental health services (stigma)?

Results

Statewide: Across the state, the majority of MHSA/CPP Coordinators (77%, *n* = 40) and half of stakeholders (50%, *n* = 23) felt that their counties' CPP processes had positive effects on community perceptions of mental health diagnoses and seeking mental health services. Overall, stakeholders were less positive than MHSA/CPP Coordinators regarding their CPP impacts on reducing public stigma around mental health and seeking mental health services. MHSA/CPP Coordinators and stakeholders agreed that the most common way that the CPP process affected community perceptions of mental health was through increased outreach and community engagement around mental health issues and services. MHSA/CPP Coordinators also felt that CPP impacted public perceptions through community-based activities that promoted wellness (35%, *n* = 18), while stakeholders believed opportunities to share stories of lived experiences (23%, *n* = 7) was another way by which CPP positively impacted public perceptions of mental health diagnosis and seeking mental health services.

CMHDA Region: County and stakeholder data differs regarding the impacts of CPP processes on the community's perceptions of mental health diagnosis and seeking mental health services. Overall, the majority of counties across CMHDA Regions indicated that CPP processes had positive impacts on reducing public stigma around mental illness. However, the Bay Area region had the lowest proportions of counties that found their CPP processes to have had positive impacts. CMHDA Regions varied regarding how their CPP processes positively impacted public perceptions of mental health and seeking mental health services. A smaller proportion of stakeholders felt that CPP processes had positive impacts on public perceptions of mental health and seeking mental health services, with the Bay Area region reporting the lowest percentage of stakeholders who perceived a positive impact (30%, *n* = 10) and the highest percentage of stakeholders (70%, *n* = 10) reporting that CPP processes had no effect on public perceptions of mental health diagnosis and seeking mental health services. Overall, there was no significant regional difference between the kinds of activities through which counties' CPP processes positively affected public perceptions of mental health and mental health services. One notable exception was that a significantly higher proportion of counties in the Southern (44%, *n* = 9) and Superior (60%, *n* = 5) regions reported that their CPP processes positively impacted community perceptions of mental health diagnosis and seeking services through increased public outreach activities.

County Size: County and stakeholder responses differed regarding their respective understandings of the impact of CPP processes on public perceptions of mental health and seeking mental health services. The majority of counties, across county size categories, found CPP to have had positive impacts on community perceptions of mental health and seeking mental health services. A smaller percentage of stakeholders agreed that CPP had a positive effect. Sixty-four percent of stakeholders in small counties felt their counties' CPP processes had no effect on reducing public stigma associated with mental health and seeking mental health services. Counties primarily found CPP processes to have reduced stigma associated with mental illness by encouraging community-based activities that promote mental health wellness and creating opportunities to share lived experiences of mental illness. A higher percentage of medium counties (26%, *n* = 23), relative to large (13%, *n* = 15) and small counties (11%, *n*= 38), also found that the CPP processes helped with the integration of mental health with other disciplines. Stakeholders across county size primarily found the CPP processes beneficial by increasing outreach and raising awareness about mental health issues and services and creating opportunities to share lived experiences of mental illness.

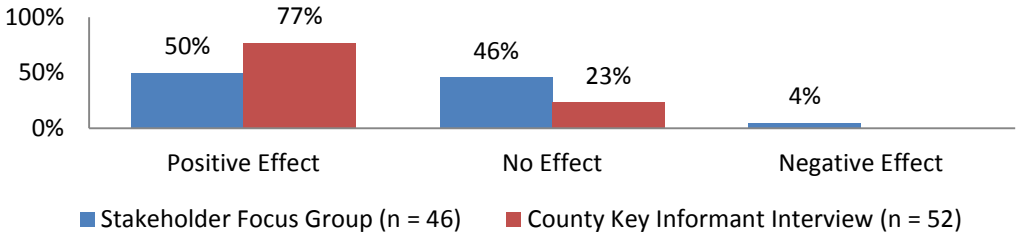
Statewide

Rationale: To answer this question at the statewide level, data was analyzed from County Key Informant Interviews and Stakeholder Focus Groups.

Across the state, the majority of MHSA/CPP Coordinators (77%, *n* = 52) and half of stakeholders (50%, *n* = 46) felt that their counties' CPP processes had a positive effect on community perceptions of mental health diagnosis and seeking mental health services. Almost half of stakeholders (46%, *n* = 46) felt CPP had no impact, whereas approximately a quarter of MHSA/CPP Coordinators (23%, *n* = 52) perceived CPP to have had no effect on countering public perceptions of mental health diagnosis and seeking mental health services. A small percentage of stakeholders in two county focus groups (4%, *n* = 46) cited CPP's negative impacts on public perceptions of mental health diagnosis and mental health services (see

Figure 117). In one county's Stakeholder Focus Group, stakeholders discussed how CPP processes were targets for negative media attention from a local newspaper that was already hostile towards public mental health services. In another case, stakeholders felt CPP processes were only offering token participation opportunities and thus, perpetuating stigma.

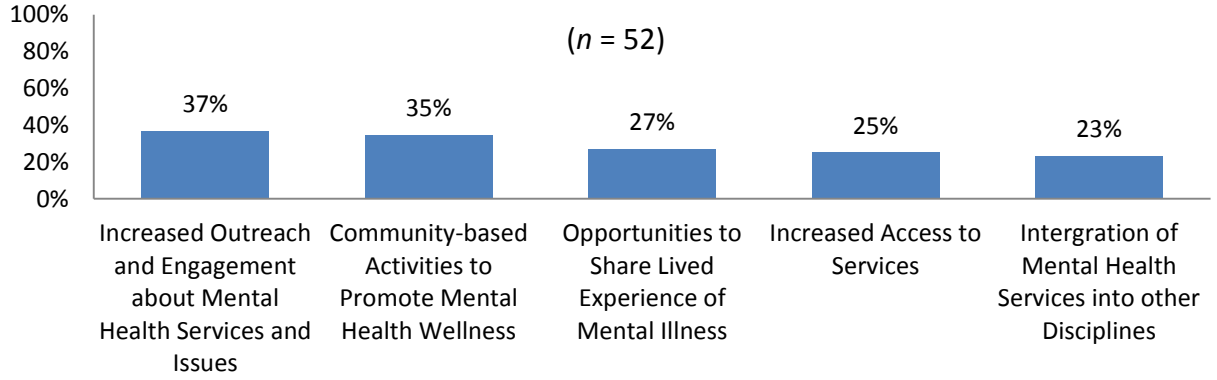
Figure 117: Stakeholder and County perception of the Impact of CPP Processes on Community Perceptions of Mental Health Diagnosis and/or Seeking Public Mental Health Services, Statewide [β Δ]



[β] *SOURCE*: County Key Informant Interviews
[Δ] *SOURCE:* Stakeholder Focus Groups

Both counties (37%, *n* = 30) and stakeholders (37%, *n* = 52) agreed that the most common way CPP processes impacted community perceptions of mental health was through increased outreach and community engagement around mental health issues and services (see Figure 118 and Figure 119). Among counties, over one-third (35%, *n* = 52) felt that their CPP processes had impacted public perceptions of mental health through community-based activities to promote wellness, while approximately one-fourth of counties (27%, *n* = 52) agreed that opportunities to share lived experiences of mental illness, increase access to services (25%, *n* = 52), and integrate mental health into other disciplines (23%, *n* = 52) had also affected public perceptions of mental health diagnosis and seeking mental health services (see Figure 118).

Figure 118: Impact of CPP Process on Community Perceptions of Mental Health Diagnosis and Seeking Mental Health Services, Statewide [β]

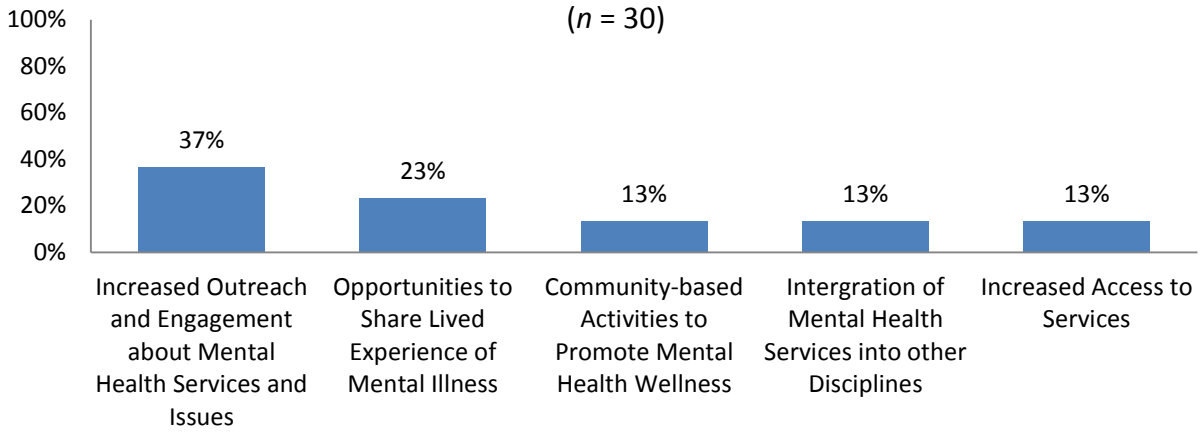


[β] *SOURCE* = County Key Informant Interviews

Stakeholders reported another common way that CPP activities had impacted public perceptions of mental health diagnosis and seeking mental health services was through sharing stories of lived experiences of mental illness (23%, *n* = 30). Only 13% of stakeholders (*n* = 30) cited community-based

activities to promote wellness, integration of mental health into other disciplines, or increased access to services as ways that CPP processes impacted public perceptions of mental health services and mental illness (see Figure 119).

Figure 119: CPP Impact on Community Perceptions of Mental Health Diagnosis and Seeking Mental Health Services, Statewide [Δ]

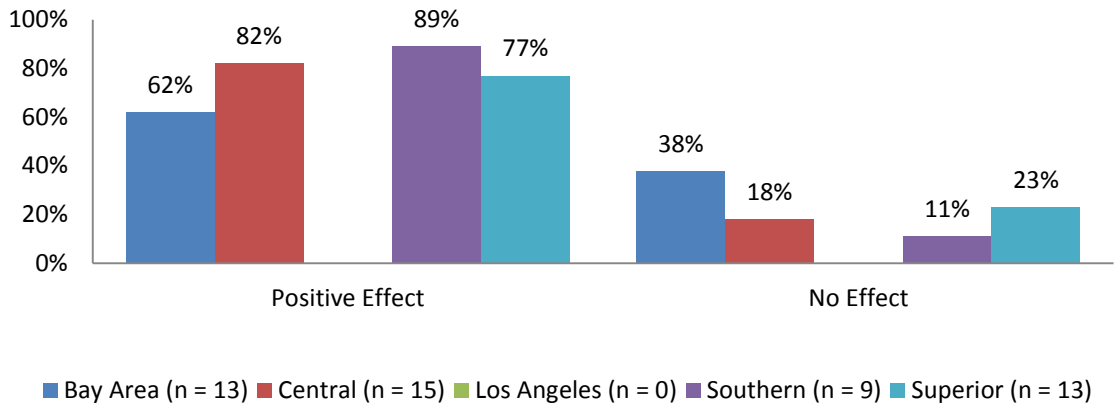


[Δ] *SOURCE* = Stakeholder Focus Groups

CMHDA Region

Rationale: County and stakeholder data differed regarding the counties' CPP processes' impacts on community perceptions of mental health diagnosis and seeking mental health services. Overall, the majority of counties across CMHDA Regions indicated that their CPP processes had strong impacts on reducing public stigma around mental illness (see Figure 120). However, a lower proportion of the Bay Area region felt that their CPP processes had a positive impact on community perceptions of mental illness and seeking mental health services (62%, *n* = 8). At the same time, the Bay Area region reported the highest proportion of counties that felt CPP had no effect on public perceptions of mental health diagnosis and seeking mental health services (38%, *n* = 5). The Southern region reported the lowest percentage of counties that felt CPP had no impact (11%, *n* = 1).

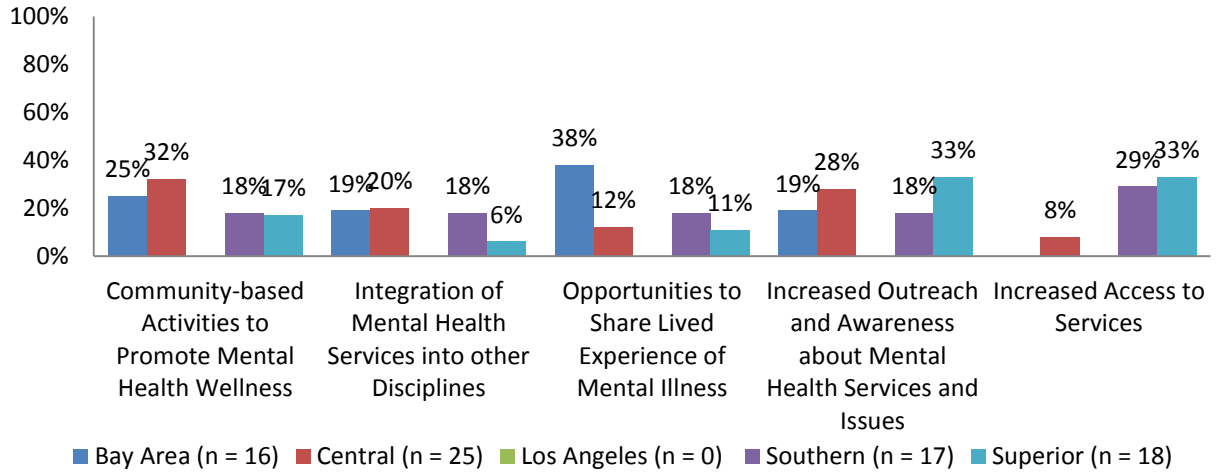
Figure 120: Perception of CPP Impact on Community Perceptions of Mental Health Diagnosis and/or Seeking Public Mental Health Services, by CMHDA Region β



β *SOURCE:* County Key Informant Interview

When asked how CPP processes had positively affected public perceptions of mental illness and seeking mental health services, MHSA/CPP Coordinators varied in their responses across CMHDA Region (see Figure 121). The majority of Bay Area region counties cited opportunities to share stories of lived experiences of mental illness (38%, *n* = 6). A higher percentage of Central region counties felt CPP's had the greatest impact on community-based activities that promoted wellness (32%, *n* = 8). One-third of Superior region counties cited CPP processes as having increased outreach and therefore raised public awareness of mental health issues and services (33%, *n* = 6). Finally, one-third of Southern region counties reported CPP processes had increased access to services, which had resulted in reducing community stigma around mental health issues and seeking services (33%, *n* = 6).

Figure 121: How CPP Activities Impacted Community Perceptions of Mental Health Services and Mental Illness, by CMHDA Region β

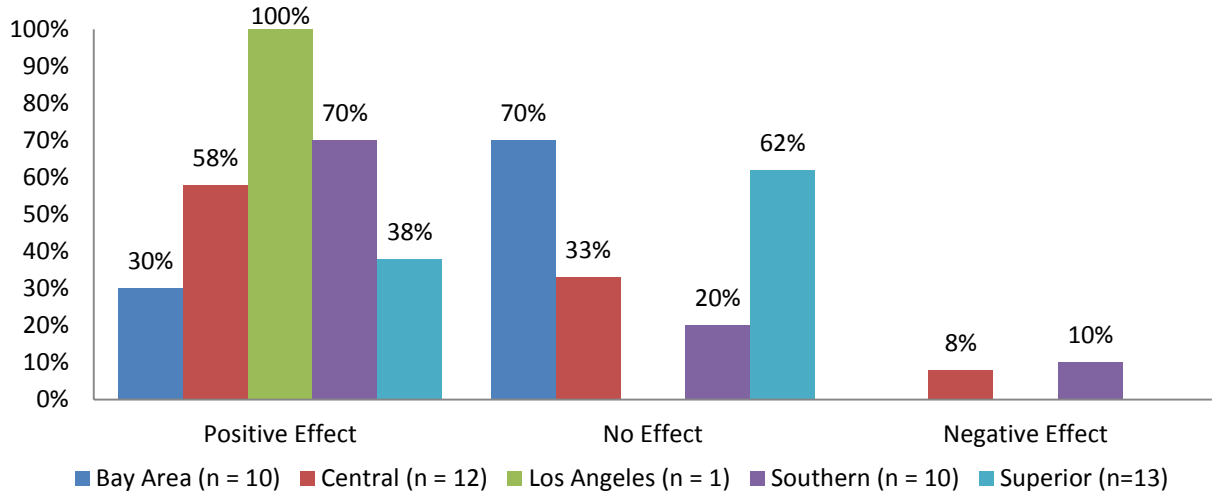


β *SOURCE:* County Key Informant Interviews

Stakeholders' perceptions of their counties' CPP processes' impacts on mental illness and seeking mental health services also varied across CMHDA Regions (see

Figure 122). All or the majority of stakeholders in the Los Angeles (100%, *n* = 1) and Central (70%, *n* = 7) regions felt that their CPP processes had positive impacts on community perceptions of mental health diagnosis and seeking mental health services. A significantly lower proportion of the Bay Area (30%, *n* = 3) and Superior (38%, *n* = 5) regions' stakeholders cited CPP's positive impact. Instead, the majority of Bay Area and Central region stakeholders found CPP to have had no impact (70%, *n* = 10 and 62%, *n* = 13, respectively) on public perceptions of mental health. Southern region stakeholders appeared to fall in the middle, with a little over half (70%, *n* = 10) thinking CPP processes had a positive impact on reducing public stigma around mental illness and seeking mental health services.

Figure 122: Perception of CPP Impact on Community Perceptions of Mental Health Diagnosis and Seeking Public Mental Health Services, by CMHDA Region [Δ]

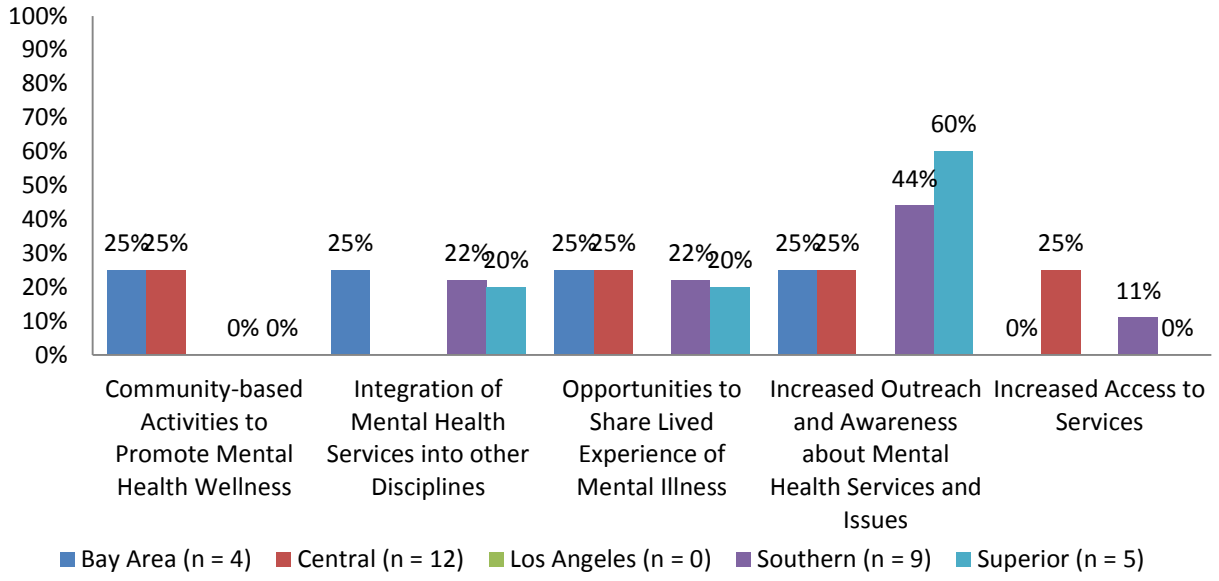


[Δ] *SOURCE:* Stakeholder Focus Groups

In general, an equal proportion of counties across the Bay Area and Central regions (25% for both regions, *n* = 4 and *n* = 12, respectively) found CPP processes to have had an impact through the following activities: 1) community-based activities to promote mental health wellness, 2) integration of mental health wellness with other disciplines, 3) stories of lived experience of mental illness, 4) increased outreach and awareness of mental health services and issues, and 5) increased access to services. A significantly higher proportion of counties in the Southern (44%, *n* = 9) and Superior (60%, *n* = 5) regions reported that CPP processes positively impacted community perceptions of mental health diagnosis and seeking services through increased public outreach activities, as shown in

Figure 123.

Figure 123: How CPP Processes Impact Community Perceptions of Mental Health Diagnosis and/or Seeking Public Mental Health Services, by CMHDA Region [Δ]



[Δ] *SOURCE:* Stakeholder Focus Groups

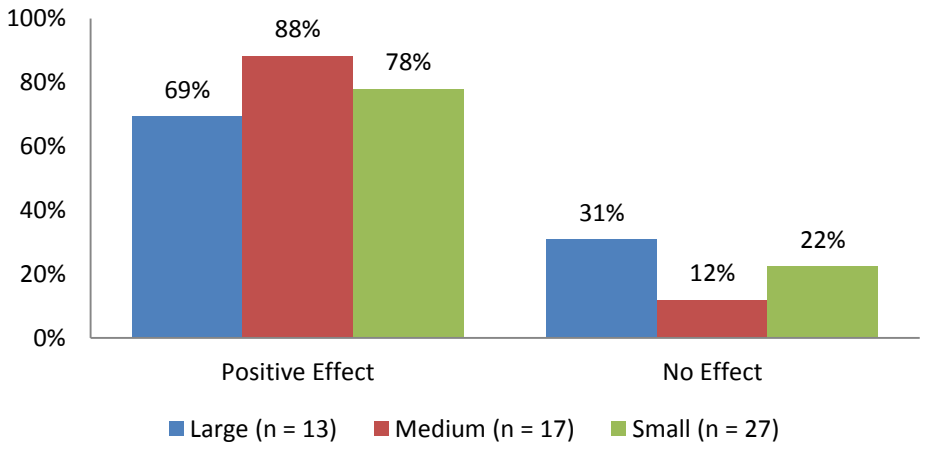
County Size

Result: A majority of stakeholders in large (69%), medium (88%), and small (78%) counties agreed that CPP processes had a positive effect on community perceptions of mental health diagnosis and seeking mental health services.

Rationale: County and stakeholder data varied in their respective understandings of CPP's impacts on public perceptions of mental health and seeking mental health services. Across county size categories, the majority of counties perceived CPP to have had positive impacts on public perceptions of mental health and seeking mental health services. The highest proportion of counties that reported CPP processes having positive effects were medium counties (88%, *n* = 17). Seventy-eight percent of small counties (*n* = 27) and 69% of large counties (*n* = 13) felt that their CPP processes had positive impacts on reducing public stigma around mental health (see

Figure 124). Approximately one-third of large counties (31%, *n* = 13) did not feel that their CPP processes had any effect on reducing public stigma around mental health and seeking mental health services.

Figure 124: Perception of CPP Impact on Community Perceptions of Mental Health Diagnosis and/or Seeking Public Mental Health Services, by County Size [β]

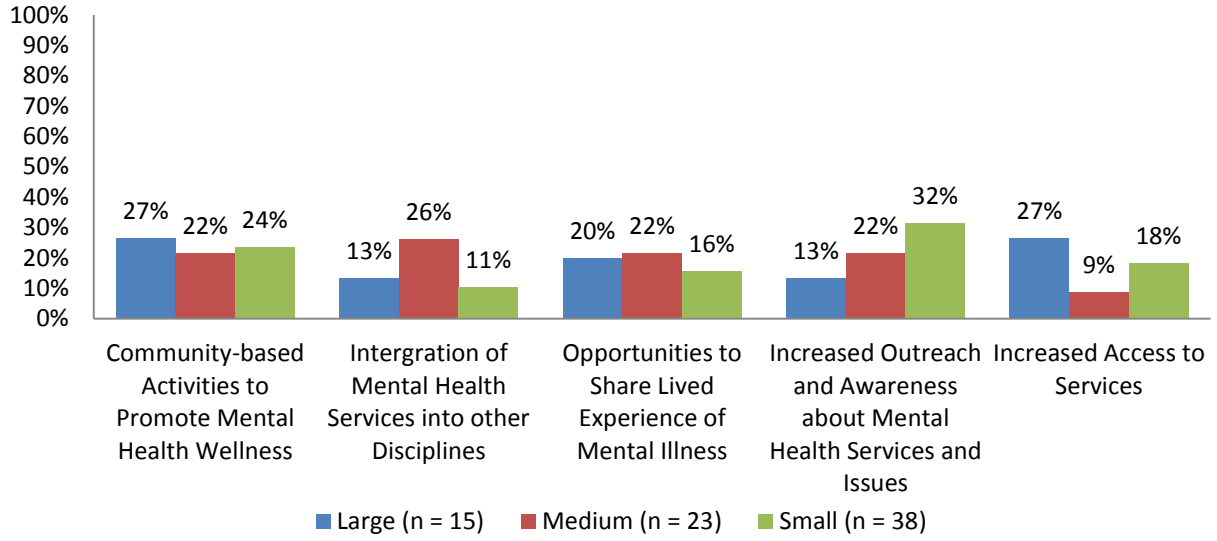


[β] *SOURCE:* County Key Informant Interviews

A higher percentage of large counties (27%, *n* = 15) relative to medium (9%, *n* = 23) and small (18%, *n* = 38) counties found their CPP processes to have positively changed public perceptions of mental health by increasing access to mental health services. A higher percentage of medium counties (26%, n= 23), relative to large (13%, *n* = 15) and small (11%, *n* = 38) counties reported that CPP's positive impact on community perceptions of mental health and mental health services was primarily through the integration of mental health services into other disciplines. Finally, a higher proportion of small counties (32%, *n* = 38) relative to large (13%, *n* = 15) and medium (22%, *n* = 23) counties felt that CPP positively affected public perceptions around mental health and seeking mental health services by increasing community outreach activities (see

Figure 125).

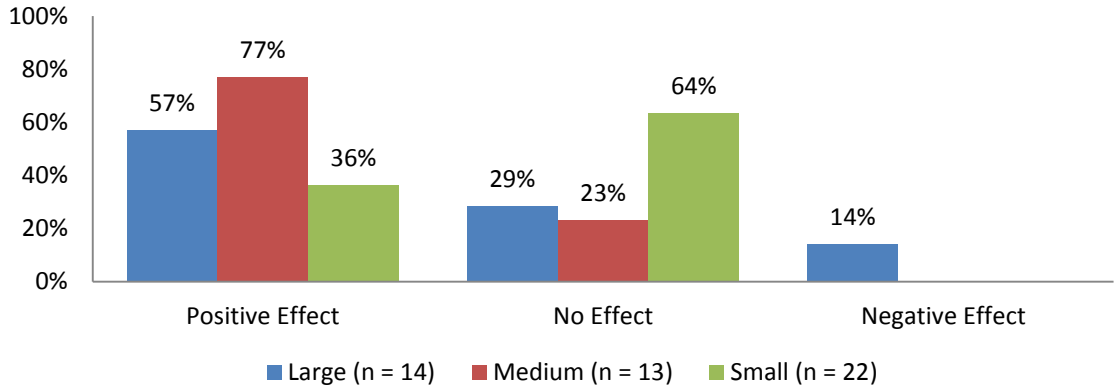
Figure 125: How CPP Activities Impacted Community Perceptions of Mental Health Diagnosis and Seeking Mental Health Services, by County Size [β]



[β] *SOURCE:* County Key Informant Interviews

Stakeholder data varied across county size categories. A significant majority of medium counties (77%, *n* = 13) and the majority of large counties (57%, *n*= 14) perceived the CPP process to have had positive impacts on public perceptions of mental health and mental health services. A significantly lower percentage of small counties (36%, *n* = 22) found CPP activities to have had positive effects on reducing stigma associated with mental health. Instead, a large majority of small counties (64%, *n* = 22) felt that CPP had no impact, whereas approximately one quarter of large (29%, *n* = 14) and medium (23%, *n* = 13) sized counties felt the same. Fourteen percent of large counties (*n* = 14) thought CPP processes had negative impacts on reducing public stigma around mental health issues and seeking mental health services. These results are presented in Figure 126.

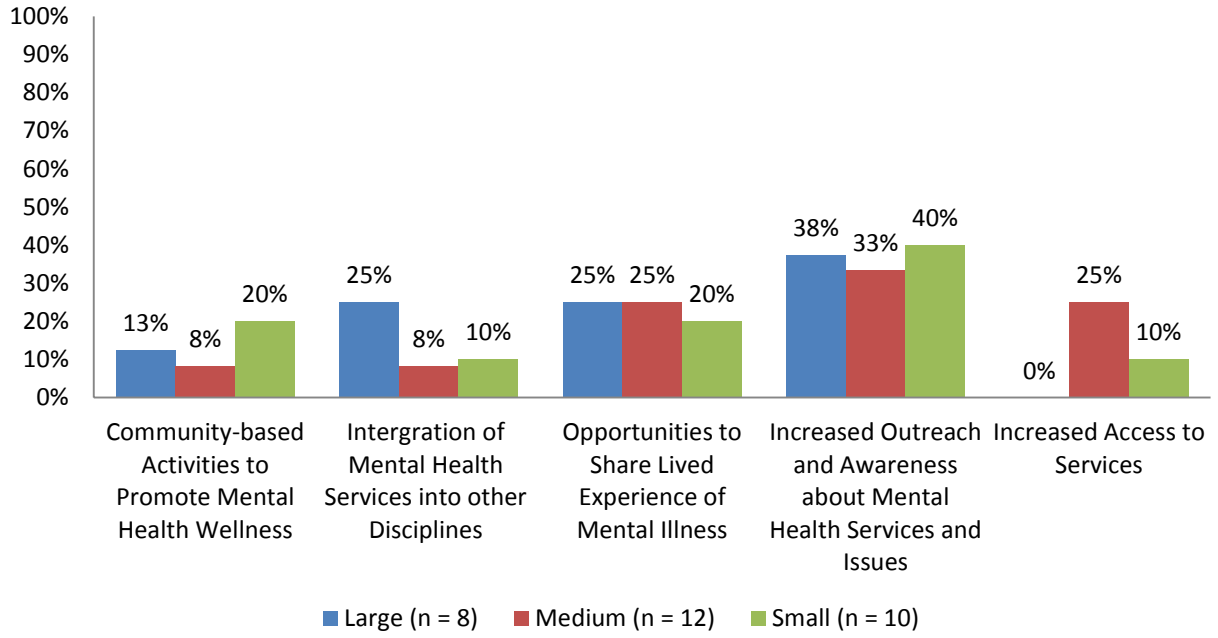
Figure 126: Perception of CPP Impact on Community Perceptions of Mental Health Diagnosis and/or Seeking Public Mental Health Services, by County Size [Δ]



[Δ] *SOURCE:* Stakeholder Focus Groups

When asked how the CPP process has impacted community perceptions of mental health and seeking mental health services, stakeholders across county size categories primarily found their counties' CPP processes to be beneficial by increasing outreach and raising awareness about mental health issues and services and creating opportunities to share lived experiences of mental illness (see Figure 127). A higher percentage of stakeholders in large counties (25%, n = 8) also found that their counties' CPP processes positively impacted community perceptions of mental health through an integration of mental health services into other disciplines. A smaller percentage of medium (8%, *n* = 12) and small (10%, *n* = 10) counties found this activity to have a smaller impact. A higher percentage of stakeholders in medium counties (25%, *n* = 12) found that CPP increased access to services, which in turn reduced stigma associated with mental illness and seeking mental health services.

Figure 127: How CPP Activities Impacted Community Perceptions of Mental Health Diagnosis and Seeking Mental Health Services, by County Size [Δ]



[Δ] *SOURCE:* Stakeholder Focus Group

IM-07: What other impacts do stakeholders perceive the CPP process to have on the community at large, particularly related to MHSA-defined outcomes?

Results

Statewide: Overall, 77% of stakeholders (*n* = 577) found CPP planning to be valuable.[δ] Counties and stakeholders reported that their counties' CPP processes had strengthened trust and communication between counties and stakeholders, empowered stakeholders to bring their voice to the table, increased participation from un/underserved communities, produced more programs and services in alignment with MHSA values, and addressed needs specific to each community. At a broader level, counties and stakeholders felt their counties' CPP processes had increased communities' knowledge of mental health in general in addition to mental health programs and services.

CMHDA Region: No significant differences were noted when analyzed by CMHDA Regions.

County Size: No significant differences were noted when analyzed by county size categories.

Statewide

Rationale: Overall, 77% of stakeholders (*n* = 577) found CPP planning to be valuable.[δ] When asked how CPP had positively impacted the broader communities, both counties and stakeholders felt that CPP had improved communication and information-sharing between stakeholders, county departments, and the community at large. In addition, counties and stakeholders identified the following outcomes as results of CPP:

- Increased trust between county staff and stakeholders.
- Encouraged collaboration among diverse groups of stakeholders who might not have had the opportunity to work together.
- Created more programs and services in alignment with MHSA values, resulting in increased community awareness around mental health.
- Stakeholders felt that CPP encouraged participation from members of underserved communities who may not have felt heard in the past.
- Counties felt that stakeholders involved in CPP activities had developed an increased understanding of outcome-driven planning and evaluation of mental health services. Stakeholders, on the other hand, framed this impact in terms of an increased capacity to understand a community's mental health needs and develop accountability standards as a result of the CPP process**.**

To better understand how the CPP process impacted CPP participants as well as the broader mental health system, refer to the other research questions in this section (IM-01 through IM-05).

CMHDA Region

Rationale: No significant differences were noted when analyzed by CMHDA Regions.

County Size

Rationale: No significant differences were noted when analyzed by county size categories.

Stakeholders Who Did Not Participate in CPP Process

The following section identifies those activities and incentives that would have promoted participation among those individuals who did not participate in past CPP processes. This section also highlights those barriers that would prevent participation in CPP processes.

NP-A: Activities and incentives that would promote these persons to participate in future CPP processes

Results

Statewide: Statewide, stakeholders who did not participate in a past CPP process (*n* = 724) reported that email (70%), flyers, posters, and brochures (49%), and referrals from the Mental Health Department (30%) were the most effective methods to inform stakeholders of CPP processes. Stakeholders across the state named referrals from friends or family members or a service provider (16% and 12% respectively) or "other" activities (5%) as the least effective means to informing stakeholders of CPP processes. In terms of incentives, stakeholders who did not participate in a past CPP process (*n* = 714) indicated that the most effective incentives to participate in future CPP events were meals at meetings (47%), multiple meeting times (43%), stipends or other financial incentives (33%), and transportation to meetings (32%). Statewide, stakeholders named "other" (8%), "none" (8%), and translation and interpretation services as the least effective incentives to encourage participation in their counties' CPP processes.

CMHDA Region: Similarly, most stakeholders, regardless of CMHDA Regional affiliation, who did not participate in past planning processes, indicated that emails, flyers, posters, and brochures, and referrals from the Mental Health Department were the most effective outreach methods to inform stakeholders about CPP processes. For stakeholders from the Central (*n* = 220) and Los Angeles (*n* = 66) regions, flyers, posters, and brochures (56% for both regions) and phone calls (34% and 33% respectively) were more popular outreach methods compared to any other CMHDA Region. When looking at just referrals from the Mental Health Department, 45% of Los Angeles stakeholders approved of that outreach method; this was more than in any other CMHDA Region. Generally, referrals from a friend or family member, or a service provider, and "other" methods of outreach were considered to be least effective by stakeholders from all CMHDA Regions.

In terms of incentives, across all CMHDA Regions, meals at meetings, multiple meeting times, stipends or other financial incentives, and transportation to meetings were supported as the most effective incentives to encourage stakeholders who had not participated in these processes in the past to participate in CPP processes. Fifty-two percent of stakeholders from the Los Angeles (*n* = 66) and Southern (*n* = 229) regions reported that meals at meetings were the most effective incentive, more than any other CMHDA Region. However, 56% of those surveyed from the Bay Area region (*n* = 130) indicated that multiple meeting times were the most effective incentive to participating in CPP processes. More stakeholders from the Los Angeles region (38%) indicated that stipends or financial incentives were more effective than in any other CMHDA Region, whereas stakeholders from the Central region (38%) were more supportive of transportation to meetings than in any other CMHDA Region. Translation/interpretation services were regarded as the least effective incentive across all CMHDA Regions, except for Los Angeles (17%).

County Size: More stakeholders from large counties who had never participated in past CPP processes (*n* = 394) reported that emails (73%) were the most effective outreach strategy for counties to inform stakeholders about CPP processes compared to other sized counties. Stakeholders from large counties were less likely to support phone calls (24%) or newspaper announcements (18%) as effective outreach methods compared to other county size categories. Stakeholders from medium counties (*n* = 195) also indicated that emails were the most effective method to inform stakeholders about CPP processes. Almost half of surveyed stakeholders from medium counties were also supportive of using flyers, posters, and brochures (46%) as an effective outreach method. Stakeholders from medium counties were less likely to indicate than stakeholders from other county size categories that used referrals from the Mental Health Department (27%) or from a service provider (7%) as effective outreach strategies to inform stakeholders about CPP processes. Surveyed stakeholders from small counties (*n* = 135) were also most supportive of using emails (67%) as an effective method to inform stakeholders about CPP processes. In addition, stakeholders from small counties were supportive of all other outreach strategies compared to any other county size category to inform stakeholders about counties' CPP processes.

Surveyed stakeholders from large counties (*n* = 387) who did not participate in past CPP processes were more supportive of meals at meetings (49%), multiple meeting times (46%), the use of continuing education credits or certificates (34%), and transportation vouchers as effective incentives to encourage stakeholder participation in CPP processes compared to stakeholders in any other county size category. Surveyed stakeholders from medium counties (*n* = 191) supported the use of emails and multiple meeting times (45% each) as the most effective incentives to encourage stakeholder participation in CPP processes. Thirty-six percent of stakeholders surveyed from medium counties indicated that stipends or other financial incentives were effective in encouraging stakeholder participation, more than stakeholders in any other county size category. More surveyed stakeholders from small counties (*n* = 134) suggested that transportation to meetings (38%) was the most effective incentive, compared to any other incentive or to stakeholders from all other county size category, for encouraging stakeholder participation in CPP processes.

Statewide

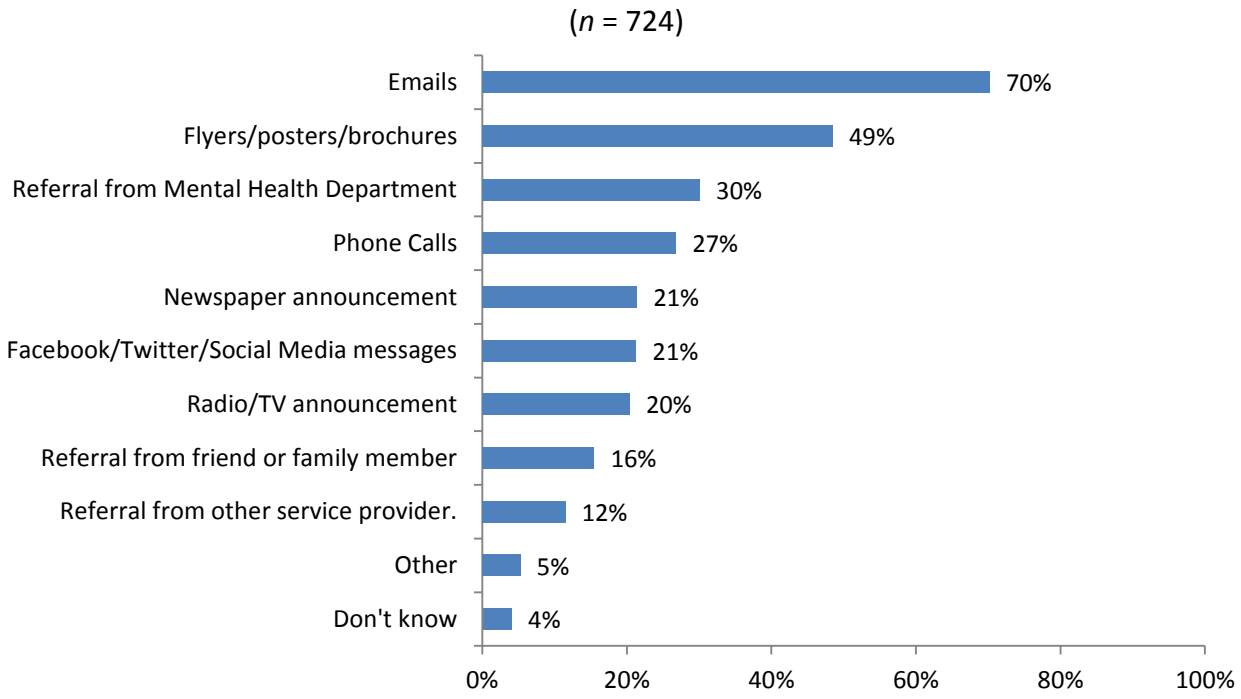
Rationale: In order to understand which activities and incentives counties could use to encourage participation among those who have not participated in CPP processes in the past, data was analyzed from the Stakeholder Survey. The information is presented thematically by activities and incentives.

Activities

Across all counties, the best way for counties to outreach to stakeholders who did not participate in CPP processes (*n* = 724) was by email (70%), as shown in
Figure 128. Nearly half of stakeholders (49%) also felt that flyers, posters, and brochures were an effective way of inform people of CPP processes. A portion of stakeholders also felt that referrals from the mental health departments (30%), phone calls (27%), newspaper announcements (21%), social media messages (21%), and radio and TV announcements (20%) would also be effective. A smaller portion of stakeholders viewed referrals from family members (16%), referrals from service providers (12%), and other (5%) as

effective. Only 4% of stakeholders did not know the best way to inform community members for CPP processes.

Figure 128: Effective CPP Outreach Methods, Statewide [δ]



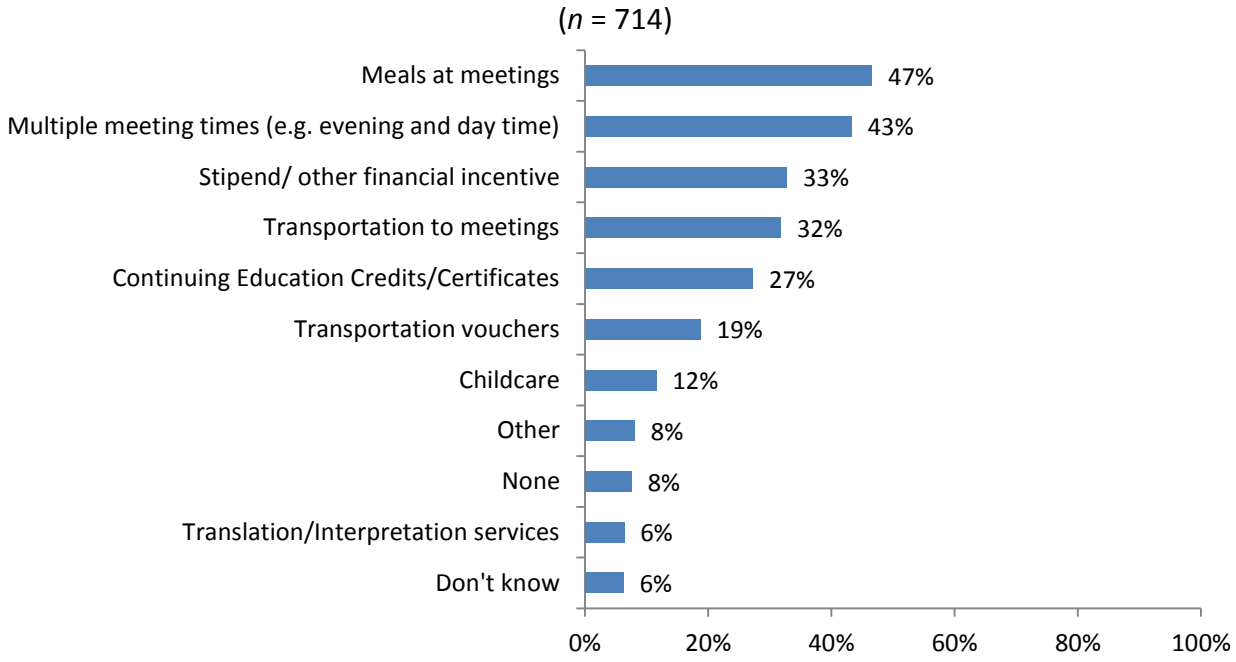
[δ] *SOURCE:* Stakeholder Survey

Incentives

Across all counties, providing meals at CPP meetings (47%) and holding CPP meetings at multiple times (43%) were the most common incentives to encourage stakeholder participation at CPP meetings among stakeholders who have never participated in CPP processes (*n* = 714) (see

Figure 129). Almost a third of stakeholders felt that a stipend or other financial incentives (33%) and transportation to meetings (32%) would be effective incentives to participate. Continuing education credits and certificates were identified as effective incentives by 28% of stakeholders. Smaller percentages of stakeholders identified transportation vouchers (18%), childcare (12%), other (8%), and translation services (6%) as incentives. Only 8% of stakeholders selected "none," and 6% of stakeholders did not know.

Figure 129: Effective Incentives for CPP Participation, Statewide [δ]



[δ] *SOURCE:* Stakeholder Survey

CMHDA Region

Rationale:

Figure 130 shows which CPP outreach methods were considered to be the most effective in encouraging participation among those who have not participated in the past, by CMHDA Regions. Similarly,

Figure 131 shows which incentives were considered to be the most effective in encouraging participation among those who have not participated in the past, by CMHDA Regions.

Activities

In the Bay Area region (*n* = 134), stakeholders who did not participate in past CPP processes reported that emails (81%), flyers, posters, and brochures (42%), and referrals from the Mental Health Department (33%) were the top three most effective outreach methods to inform stakeholders about CPP processes. Less than a quarter of stakeholders from the Bay Area region indicated that newspaper announcements (22%), social media messages (21%), phone calls and radio/TV announcements (17% each) were effective activities for counties to inform stakeholders about their CPP processes. Stakeholders in the Bay Area region felt that referrals from a service provider (17%), friend or family member (16%), and "other" (4%) were the least effective information-sharing strategies. Only 3% of stakeholders from the Bay Area region indicated that they "don't know" effective ways for counties to inform stakeholders about CPP processes.

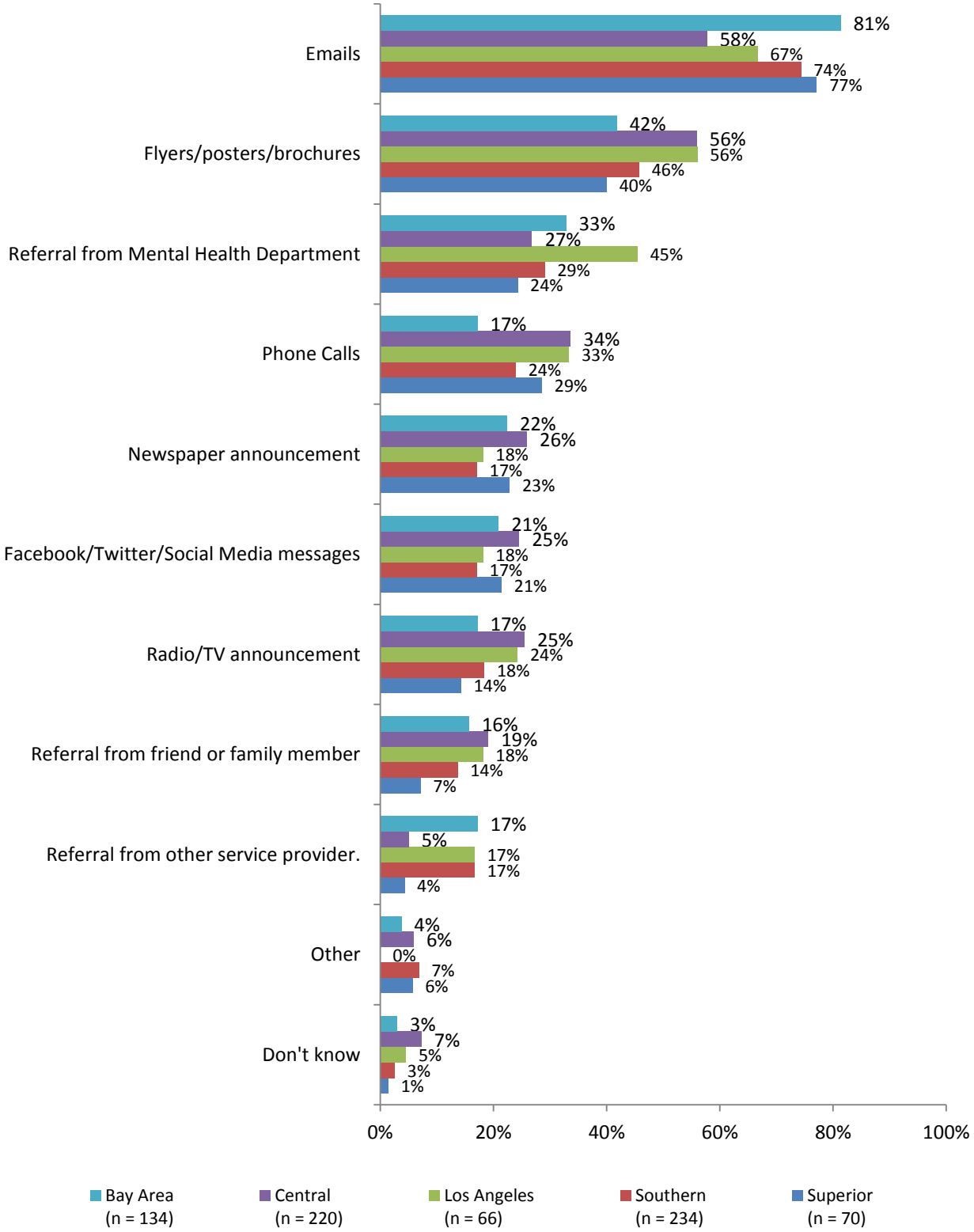
In the Central region (*n* = 220), stakeholders who did not participate in past CPP processes reported that emails (58%), flyers, posters, and brochures (56%), and phone calls (34%) were the most effective activities counties can use to inform stakeholders about CPP processes. More than a quarter of Central region stakeholders supported county outreach methods, including referrals from the Mental Health Department (27%), newspaper announcements (26%), social media and radio/TV announcements (25% each). Referrals from friends or family members (19%), service providers (5%), and "Other" (6%) activities by counties to inform stakeholders of CPP processes were least popular among Central region stakeholders. Among those surveyed in the Central region, 7% indicated that they "Don't know" effective outreach strategies.

In the Los Angeles region (*n* = 66), emails (67%), flyers, posters, and brochures (56%), referrals from the Mental Health Department (45%), and phone calls (33%) were indicated as the most effective activities for counties to conduct to inform stakeholders of CPP processes. Less than one quarter of stakeholders surveyed from the Los Angeles region supported the use of radio/TV announcements (24%), newspaper announcements and social media (18% each) in outreach. Referrals from a friend or family member (18%), service provider (17%), and "Other" (0%) methods to inform stakeholders about CPP processes were indicated as the least effective in the Los Angeles region. Only 5% of stakeholders surveyed indicated that they "Don't know" the best way for counties to inform stakeholders about CPP processes.

In the Southern CMHDA Region (*n* = 234), emails (67%), flyers, posters, and brochures (46%), and referrals from the Mental Health Department (29%) were indicated as the most effective outreach strategies to inform stakeholders about CPP processes. Less than one quarter of stakeholders supported the use of phone calls (24%), radio/TV announcements (18%), newspaper announcements, the use of social media, and referrals from a service provider (17% each) to conduct outreach. Southern region stakeholders reported that referrals from friends or family members (14%) and "Other" (7%) outreach strategies were the least effective ways of disseminating information about CPP processes to stakeholders. Only 3% of Southern region stakeholders who were surveyed indicated that they "Don't know" the best way for counties to inform stakeholder of CPP processes.

In the Superior region (*n* = 70), emails (77%), flyers, posters, and brochures (40%), and phone calls (29%) were the most supported methods counties can use to inform stakeholders about CPP processes. Less than one quarter of those surveyed from the Superior region supported the use of referrals from the Mental Health Department (24%), newspaper announcements (23%), social media (21%), and radio/TV announcements (14%). Superior region stakeholders reported that referrals from a friend or family member (7%), service provider (4%), and "Other" (6%) were the least effective outreach strategies. Only 1% of those surveyed from the Superior region indicated that they "Don't know" what the best way is for the county to inform stakeholders about CPP processes.

Figure 130: Effective CPP Outreach Methods, by CMHDA Region [δ]



[δ] *SOURCE:* Stakeholder Survey

Incentives

In the Bay Area region (*n* = 130), multiple meeting times (58%), meals at meetings (42%), stipends or other financial incentives (34%), and continuing education credits (29%) were indicated by stakeholders who never participated in past CPP processes as the four most effective incentives to participate in future CPP activities. Less than one quarter of Bay Area region stakeholders reported transportation (20%) or transportation vouchers (21%) as effective incentives to participate in CPP processes. Of the stakeholders surveyed from the Bay Area region, only some felt that childcare (8%) and translation or interpretation services (4%) would be effective incentives. Few stakeholders who were surveyed indicated that "Other" (5%) incentives were effective and the same proportion felt that "None" (5%) incentives were effective in encouraging stakeholders to participate in CPP processes. Eight percent of stakeholders in the Bay Area region reported that they "Don't know" any effective incentives to encourage participation in future CPP processes.

In the Central region (*n* = 217), meals at meetings at meetings (44%), transportation to meetings (38%), multiple meeting times (36%), and stipends or other financial incentives (34%) as the four most effective incentives to encourage stakeholders to participate in CPP processes. Less than 20% of Central region stakeholders reported transportation vouchers (19%), continuing education credits and certificates (16%), and childcare (15%) as effective incentives. Central region stakeholders were least supportive of translation or interpretation services and "Other" (6% each) incentives as effective in encouraging participate in CPP processes; similarly, only 6% indicated that "None" incentives were effective to encourage participation. Only 8% of Central region stakeholders reported that they "Don't know" effective incentives to encourage stakeholder participation in future CPP processes.

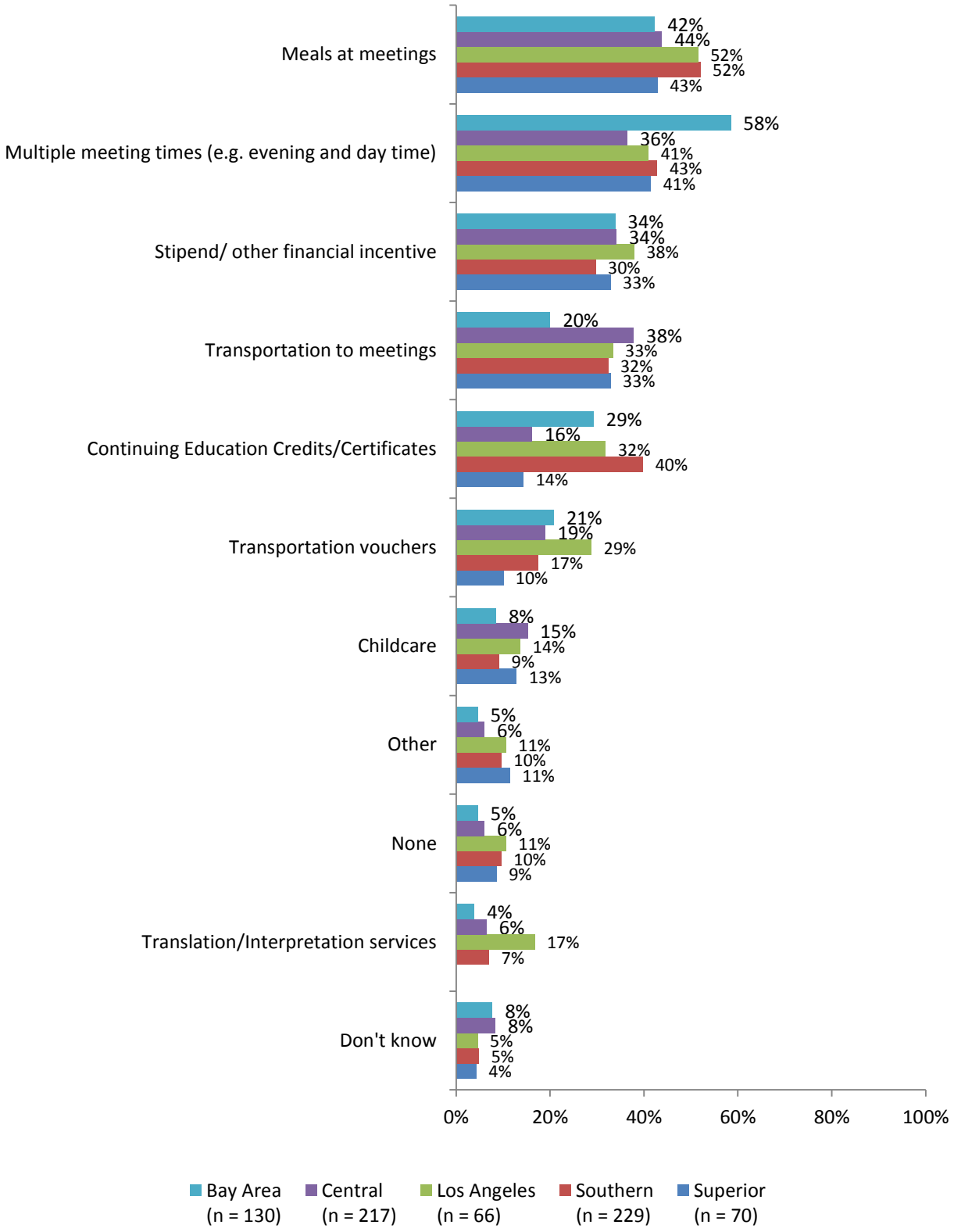
In the Los Angeles region (*n* = 66), meals at meetings (52%), multiple meeting times (41%), and stipends or other financial incentives (38%) were identified as the top three most effective incentives to encourage stakeholder participation in CPP processes. About one-third of Los Angeles region surveyed stakeholders indicated that transportation to meetings (33%), continuing education credits or certificates (32%), and transportation vouchers (29%) were also effective incentives to help encourage participation for CPP processes. Translation services (17%), childcare (14%), and "Other" (11%) incentives were reported as the least effective incentives for stakeholders to participate in the CPP process. Eleven percent of stakeholders from the Los Angeles region indicated that "None" incentives were effective in encouraging stakeholder participation in CPP processes. Only 5% of those surveyed from the Los Angeles region reported that they "Don't know" effective incentives to encourage stakeholder participation in CPP processes.

In the Southern region (n=229), meals at meetings (52%), multiple meeting times (43%), and continuing education credits or certificates (40%) were indicated by stakeholders who did not participate in past CPP processes as the three most effective incentives to encourage stakeholders to participate in future CPP processes. About one-third of Southern region stakeholders felt that transportation to meetings (32%) and stipends or other financial incentives (30%) were also effective incentives to encourage stakeholder to participate in CPP processes. However, stakeholders were less supportive of the use of transportation vouchers (17%), childcare (9%), and translation or interpretation services (7%) as effective incentives to encourage participation. Ten percent of stakeholders surveyed from the Southern region indicated that

"Other" incentives were effective and the same proportion of stakeholders said that "None" (10%) incentives were effective in encourage stakeholder participation in CPP processes. Only 5% of stakeholders reported that they "Don't know" of effective incentives to encourage stakeholder participation in CPP processes.

In the Superior region (*n* = 70), meals at meetings (43%), multiple meeting times (41%), stipends or other financial incentives and transportation to meetings (33% each) were indicated by stakeholders who did not participate in past CPP processes as the most effective incentives to encourage their participation in the future. Superior region stakeholders were less supportive of using continuing education credits or certificates (14%), childcare (13%), and transportation vouchers (10%) as effective incentives to encourage participation. Eleven percent of Superior region stakeholders reported "Other" incentives would also be effective, whereas 9% said that "None" incentives would be effective methods to encourage more stakeholder participation in future CPP processes. In addition, 0% of stakeholders from the Superior region said that translation or interpretation services would be an effective incentive. Only 4% of stakeholders surveyed from the Superior region reported that they "Don't know" of effective incentives to encourage stakeholder participation in CPP processes.

Figure 131: Effective Incentives for CPP Participation, by CMHDA Region [δ]



[δ] *SOURCE:* Stakeholder Survey

County Size

Rationale: Figure 132 shows which CPP outreach methods were considered to be the most effective in encouraging participation among those who have not participated in the past, by CMHDA Regions. Similarly,

Figure 133 shows which incentives were considered to be the most effective in encouraging participation among those who have not participated in the past, by CMHDA Regions.

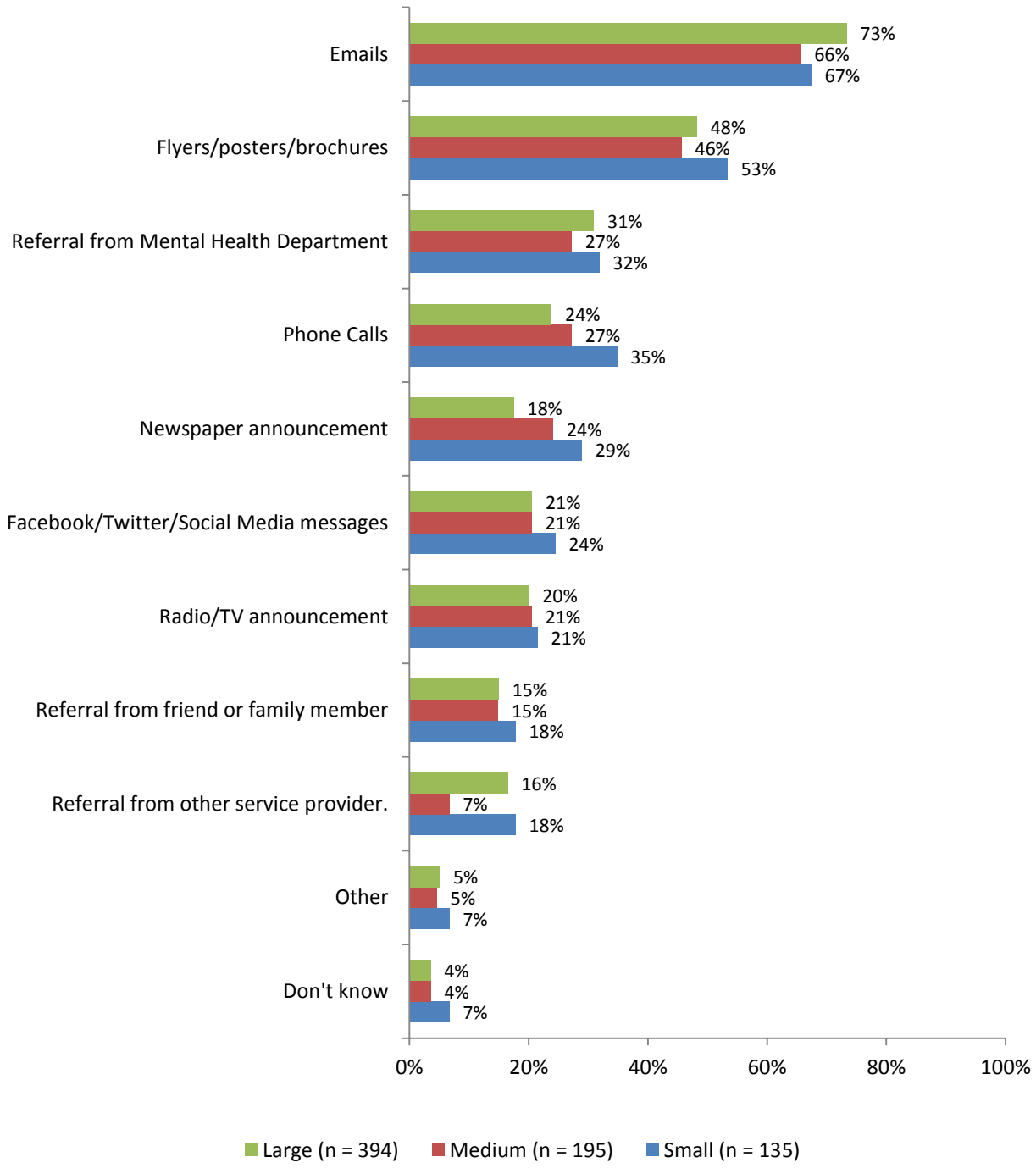
Activities

For large counties (*n* = 394), emails (73%), flyers, poster, and brochures (38%), and referrals from the Mental Health Department (31%) were the top three most effective methods counties can use to inform stakeholders about CPP processes. Less than one-quarter of stakeholders surveyed from large counties reported that phone calls (24%), social media messaging (21%), radio/TV announcements (20%), and newspaper announcements (18%) are also effective strategies to inform stakeholders about CPP processes. Referrals from a service provider (16%), friend/family member (15%), or "Other" (5%) methods to conduct outreach were indicated by large county stakeholders as the least effective. Only 4% of surveyed stakeholders from large counties said they "Don't know" effective outreach methods to inform stakeholders about CPP processes.

For medium counties (*n* = 195), emails (66%), flyers, posters, and brochures (46%), referrals from the Mental Health Department and phone calls (27% each) are the most effective methods for counties to inform stakeholders about CPP processes. Less than one-quarter of surveyed stakeholders from medium-sized counties felt that newspaper announcements (24%), social media messaging, and radio/TV announcements (21% each) were also effective outreach methods to inform stakeholders about CPP activities. Referrals from a friend or family member (15%) and from a service provider (7%) were reported by stakeholders from medium counties as the least effective outreach methods. Only 5% of stakeholders indicated that "Other" methods would also be effective and 4% of stakeholders from medium counties said they "Don't know" of effective outreach methods to inform stakeholders about CPP processes.

For small counties (*n* = 135), emails (67%) and flyers, posters, and brochures (53%) were reported as the most effective ways counties can inform stakeholders about CPP processes. About one-third of stakeholders from small counties reported phone calls (35%), referrals from the Mental Health Department (32%), and newspaper announcements (29%) were also effective outreach methods. Less than one-quarter of surveyed stakeholders from small counties felt that social media messaging (24%), radio/TV announcements (21%), and referrals from a friend, family member, or service provider (18%) were effective outreach methods to inform stakeholders about CPP processes. Seven percent of surveyed stakeholders from small counties indicated that "Other" methods would be effective and/or they "Don't know" of effective outreach methods for counties to use to inform stakeholders about CPP processes.

Figure 132: Effective CPP Outreach Methods, by County Size [δ]



[δ] *SOURCE:* Stakeholder Survey

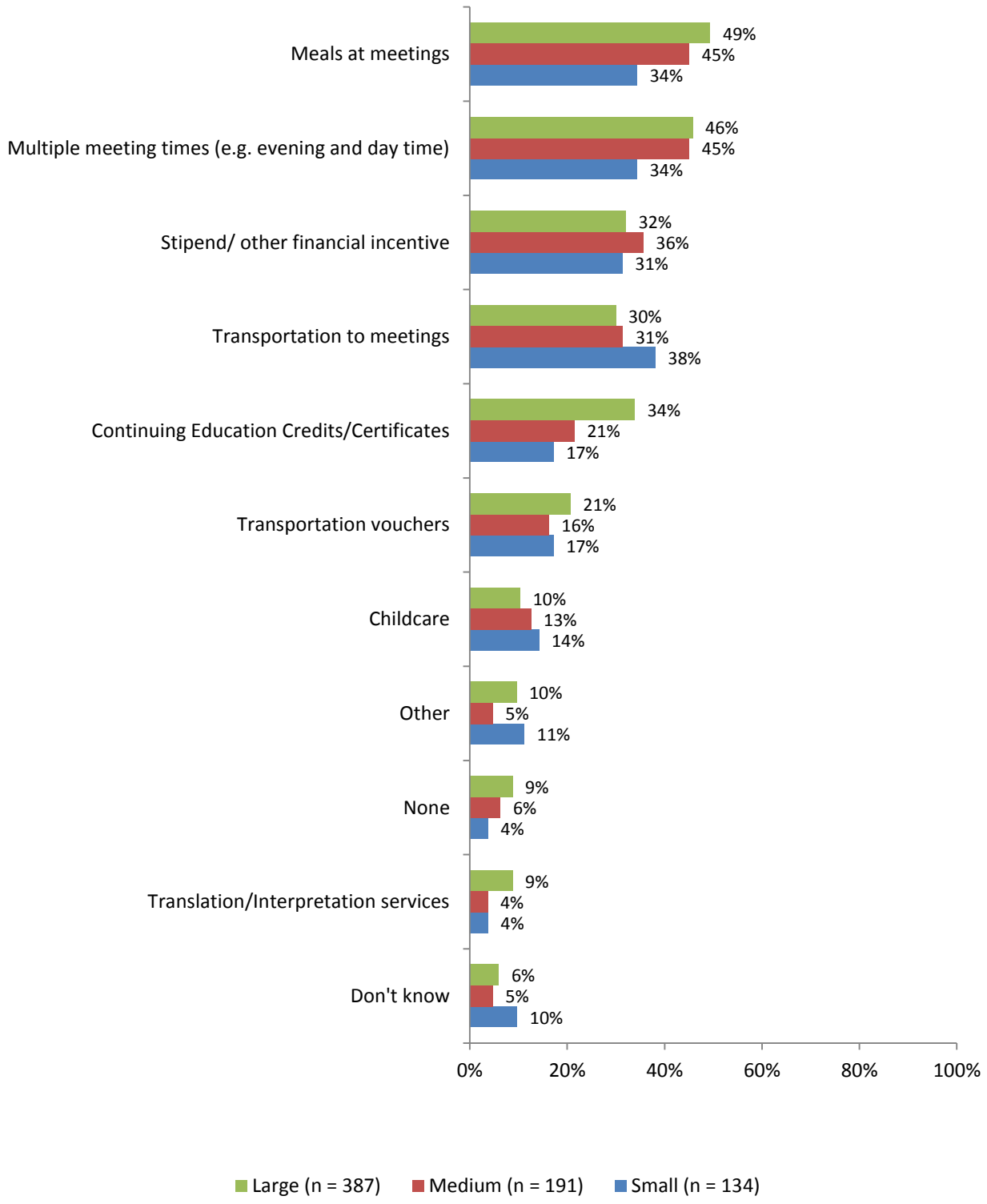
Incentives

For large counties (*n* = 387), meals at meetings (49%) and multiple meeting times (46%) were the most effective incentives to encourage stakeholder participation in CPP processes. About one-third of stakeholders from large counties reported that continuing education credits (34%), stipends or other financial incentives (32%), and transportation to meetings (30%) were also effective incentives. Transportation vouchers (21%), childcare (10%), and translation or interpretation services (9%) were reported as the least effective incentives to encourage stakeholder participation in CPP processes. Ten-percent of surveyed stakeholders suggested that "Other" incentives were also effective, whereas 9% of stakeholders said that "None" of the incentives were effective in encouraging stakeholder participation in CPP processes. Only 6% of surveyed stakeholders from large counties said that they "Don't know" of effective incentives to encourage stakeholder participation in CPP processes.

For medium counties (*n* = 191), 45% of surveyed stakeholders felt that meals at meeting and multiple meeting times were the most effective incentives to encourage stakeholder participation in CPP processes. About one-third of stakeholders also felt that stipends or financial incentives (36%) and transportation to meetings (31%) were also effective incentives to encourage stakeholder participation in CPP processes. Twenty-one percent of stakeholders were supportive of continuing education credits or certificates as effective incentives. Transportation vouchers (16%), childcare (13%), and translation or interpretation services (4%) were reported as the least effective incentives to encourage stakeholder participation of CPP processes in medium counties. Only 5% of surveyed stakeholders suggested that "Other" incentives would also be effective, and 6% of stakeholders said "None" incentives would be effective for encouraging stakeholder participation in CPP processes. Five percent of stakeholders surveyed from medium counties said that they "Don't know" of effective incentives to encourage stakeholder participation in CPP processes.

For small counties (*n* = 134), transportation to meetings (38%) was reported by stakeholders as the most effective incentive to encourage stakeholders to participate in CPP processes. Thirty-four percent of stakeholders felt that meals at meetings and multiple meeting times were effective incentives to encourage participation in CPP processes. About one-third of surveyed stakeholders from small-sized counties also suggested that stipends or other financial incentives (31%) were also effective in encouraging stakeholder to participate in CPP processes. Less stakeholders from small counties reported that continuing education credits and transportation vouchers (17% each), childcare (14%), or translation or interpretation services (4%) were effective incentives to encourage stakeholder participation in CPP processes. Eleven percent of stakeholders in small counties said that "Other" incentives would be effective, and 4% said that "None" of the incentives were effective in encouraging stakeholder participation in CPP processes. About 10% of surveyed stakeholders from small-sized counties said that they "Don't know" of effective incentives to encourage stakeholder participation in CPP processes.

Figure 133: Effective Incentives for CPP Participation, by County Size [δ]



[δ] *SOURCE:* Stakeholder Survey

NP-B: Barriers that would prevent these persons from participating in future CPP processes

Results

Statewide: A majority of responding stakeholders who did not participate in FY 2012-13 CPP activities (*n* = 704) reported the primary barriers that prevented them from participating in future CPP processes were inconvenient meeting times and inaccessible locations. They also reported that language barriers were least likely to prevent them from participating.

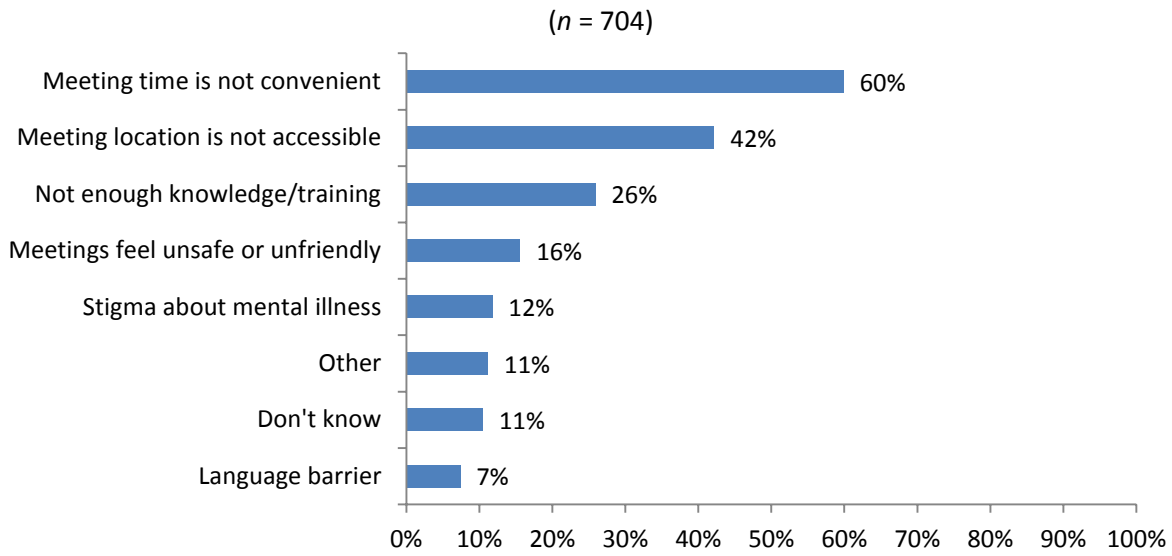
CMHDA Region: There were some differences between CMHDA Regions in how their non-participating stakeholders identified participation barriers. All regions besides Los Angeles identified inconvenient meeting times as the primary barrier to participation while respondents from Los Angeles (*n* = 63) identified the inaccessibility of meeting locations as the top barrier to participation. Further, Los Angeles respondents more frequently identified other barriers than respondents from most other regions. For example, while only 3-8% of respondents from other regions identified language as a barrier to participation, 14% of Los Angeles respondents identified language as a barrier.

County Size: There were few differences between counties of different sizes and the frequency at which their non-participating stakeholders identified each barrier to participation. The only noticeable differences were that respondents from large counties (*n* = 379) identified inconvenient meeting times at a 8-9% greater rate than respondents in medium and small counties, while respondents from medium counties (*n* = 191) identified the lack of knowledge or training at a 6% greater rate than non-participating stakeholders from large and small counties, and respondents from small counties (*n* = 134) stated that they did not know what the barriers were at a 6-7% greater rate than their counterparts in large and medium counties.

Statewide

Rationale: The majority (60%) of Stakeholder Survey respondents who reported that they did not participate in FY 2012-13 CPP activities (*n* = 704) identified inconvenient meeting times as the primary barrier to their CPP participation, shown in Figure 134. Nearly half (42%) identified inaccessibility of meeting locations as a barrier while a little over a quarter (26%) identified their lack of knowledge or training as a barrier to participation; the least of their concerns was a language barrier as only 7% of the respondents identified this.

Figure 134: Barriers Preventing CPP Participation, Statewide [δ]

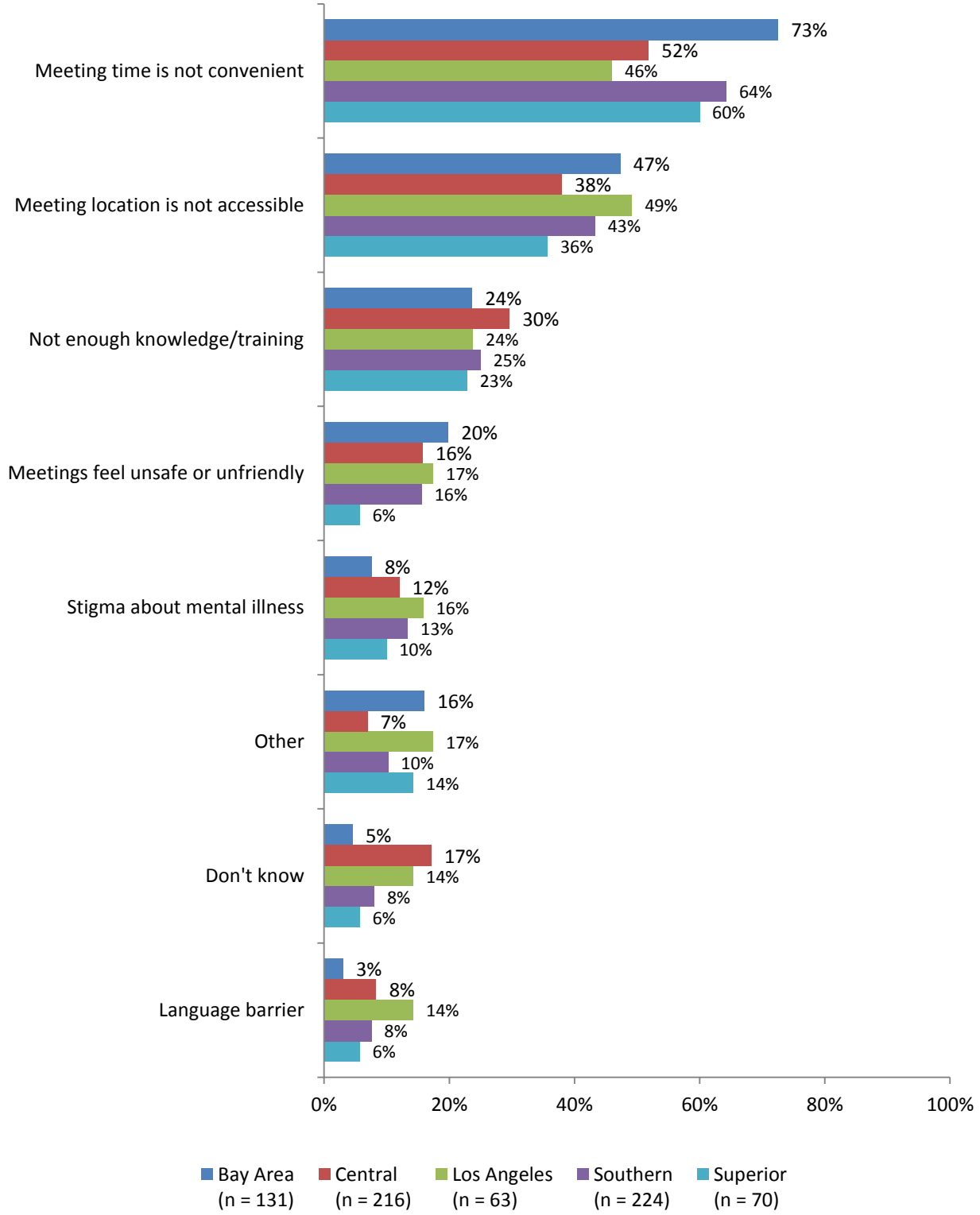


[δ] *SOURCE*: Stakeholder Survey

CMHDA Region

Rationale: A closer look at the Stakeholder Survey data showed some differences between respondents from different CMHDA Regions and the frequency with which they identified barriers to CPP participation. While respondents from all CMHDA Regions identified inconvenient meeting times and inaccessibility of meeting locations as the top barriers to participation, the frequency in which stakeholders identified these barriers differed from region to region (Figure 135). For example, while inconvenient meeting times were a barrier for 60-73% of stakeholders from the Bay Area, Southern, and Superior regions, it was only a barrier for 52% of non-participating stakeholders from the Central region (*n* = 216) and for 46% of non-participating stakeholders from Los Angeles (*n* = 63). Further, while inaccessible meeting locations were a barrier for 49% of non-participating stakeholders from Los Angeles and for 47% of non-participating stakeholders from the Bay Area region (*n* = 131), it was only a barrier for 43% of non-participating stakeholder from the Southern region (*n* = 224), 38% of non-participating stakeholders from the Central region, and 36% of non-participating stakeholders from the Superior region (*n* = 70).

Figure 135: Barriers Preventing CPP Participation, by CMHDA Region [δ]

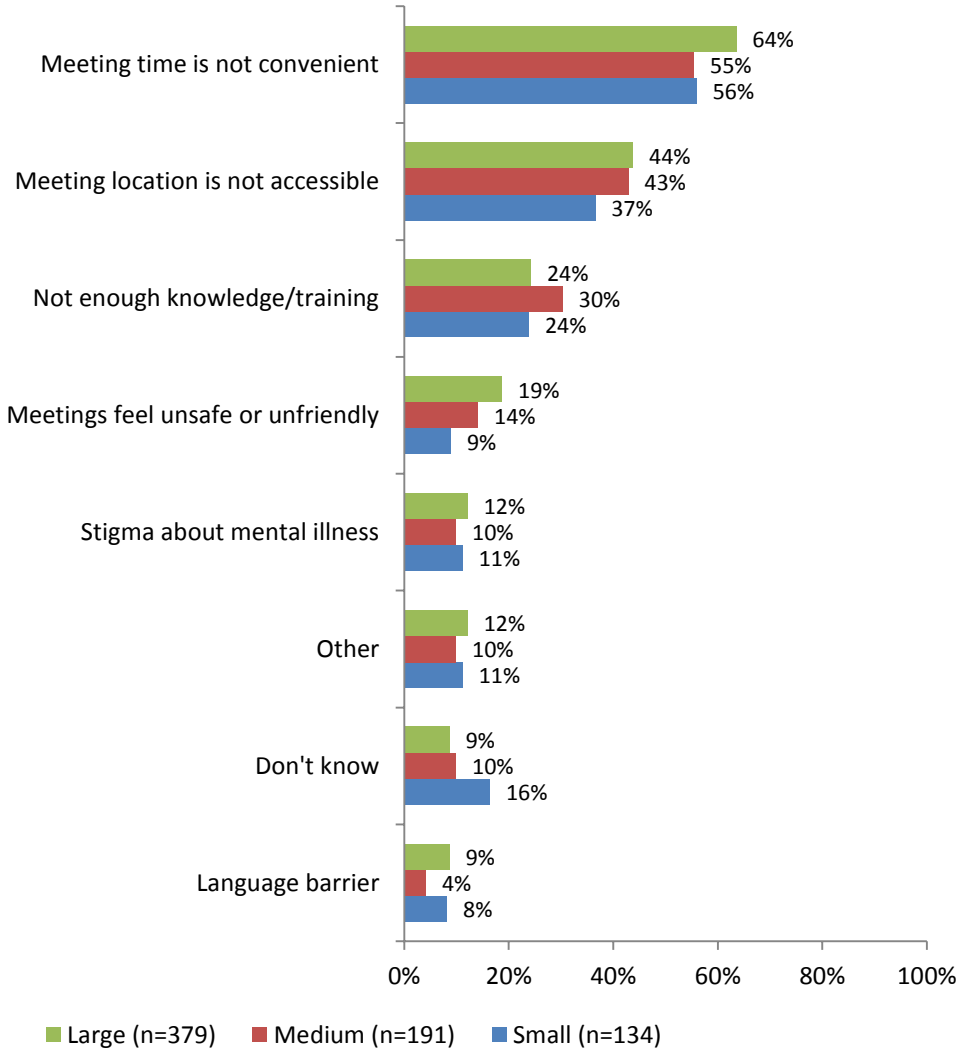


[δ] *SOURCE*: Stakeholder Survey

County Size

Rationale: Figure 136 shows the Stakeholder Survey results of non-participating stakeholders' identification of participation barriers by county size. There were few variations between counties of different sizes in the frequency at which these stakeholders identified participation barriers. Non-participating respondents from large counties (*n* = 379) tended to identify barriers more often than respondents from medium and small counties, except in identifying the lack of knowledge or training, which 30% of respondents from medium counties (*n* = 191) identified, at a 6% greater rate than respondents from large and small counties. Respondents from small counties (*n* = 134) typically identified barriers at less frequent rates, with a notable exception of 16% of respondents stating that they did not know what barriers prevented them from CPP participation, a 6-7% greater rate than respondents from large and medium counties.

Figure 136: Barriers Preventing CPP Participation, by County Size [δ]



[δ] *SOURCE*: Stakeholder Survey

Appendices

[REFER READERS TO APPENDICES IN MAIN REPORT. SAME #S USED HERE.]

Appendix 2: Data Collection Instruments

See attached Appendix 2 document for all five data collection instruments as they were viewed in SurveyGizmo. In the attached Appendix 2, the data collection instruments are presented in the following order:

1. County Web-Based Data Request
2. Annual Update Document Review
3. Key Informant Interviews (notes entry)
4. Focus Groups (notes entry)
5. Stakeholder Survey (English version)

Appendix 4: Qualitative Data Themes

The table below lists the various themes in which the evaluation team's qualitative data were organized by, as well as the specific data collection instruments (Key Informant Interview and/or Stakeholder Focus Group) from which qualitative data could be found for each theme.

Table 49: Qualitative Data Themes

Themes / Categories	Key Informant Interview Data Source	Focus Group Data Source
CPP outreach activities - Most effective	KII	
CPP outreach activities - Least effective	KII	
CPP outreach activities - Received by stakeholders		FG
General outreach thoughts		FG
Barriers to CPP participation		FG
Stakeholder groups - Frequent participation	KII	FG
Stakeholder groups - Underrepresented	KII	FG
Barriers to CPP participation	KII	
CPP activities - Liked most	KII	FG
CPP activities - Liked least		FG
MHD training activities		FG
MHD communication is informative		FG
Decisions with stakeholder input are transparent		FG
Consistent with MHSA principles - CPP process	KII	
Steps to create safe environments	KII	FG
Impact on participant empowerment, hope, etc.		FG
Impact on participant trust/collaboration with MHD		FG
Impact on trust/collaboration between providers	KII	FG
Impact on community perception of MH stigma	KII	FG
Impact on MH policy, planning, etc.	KII	FG
Other impacts of CPP	KII	FG
Overall satisfaction of county's CPP processes	KII	FG
Opportunities for improvement	KII	FG

Appendix 5: Qualitative Data Codes

The tables below list the qualitative data codes that the evaluation team used throughout its qualitative data analyses.

Table 50: Qualitative Data Codes for CPP Outreach and Informational Activities

Code	Category
O-A	Post flyers/ posters/ brochures
O-B	Phone calls/ invitations by mental health dept. staff
O-C	Emails to list-serve
O-D	Radio/ TV announcements
O-E	Print announcements (e.g., newspaper)
O-F	Social media (e.g., Twitter, Facebook)
O-G	Announcement at meetings
O-H	Word-of-mouth/Personal contact/Referral
O-N	None
O-O	Other (specify)
O-S	Comments about services provision

Table 51: Qualitative Data Codes for Incentives for CPP Participation

Code	Category
Inc-A	Transportation to meetings
Inc-B	Transportation vouchers
Inc-C	Meals at meetings
Inc-D	Multiple meeting times (e.g., evening and daytime)
Inc-E	Stipends/Other financial incentives
Inc-F	Childcare
Inc-G	Continuing Education Credits/Certificates
Inc-H	Translation/Interpretation services
Inc-I	Meetings in languages other than English
Inc-N	None
Inc-O	Other (specify)
Inc-S	Comments about services provision

Table 52: Qualitative Data Codes for CPP Stakeholder Input Activities

Code	Category
I-A	Survey/questionnaires
I-B	Focus Groups
I-C	Town hall/community meetings to gather input
I-D	Public hearings
I-E	Key informant interviews
I-F	Suggestion boxes
I-N	None
I-O	Other (specify)
I-S	Comments about services provision

Table 53: Qualitative Data Codes for CPP Stakeholder Participation Activities

Code	Category
P-A	Stakeholder Steering Committee/Stakeholder Planning Committees
P-B	Strategy roundtables/strategizing sessions
P-C	Voting or prioritization activities
P-D	Community meetings and town hall meetings to plan, prioritize or make decisions
P-E	Public campaign
P-F	Advocacy group
P-G	Mental health board/advisory board
P-H	Informal social activity/community event
P-N	None
P-O	Other (specify)
P-S	Comments about services provision

Table 54: Qualitative Data Codes for Training and Education for CPP Participants

Code	Category
T-A	Produce and distribute CPP educational materials
T-B	Offer professional development or continuing education credits
T-C	County-specific trainings on participation in the local stakeholder planning process
T-D	Support for participants to attend trainings not sponsored by the county
T-M	Need more training activities.
T-N	None
T-O	Other (specify)
T-S	Comments about services provision

Table 55: Qualitative Data Codes for Creating Safe Environments for CPP Participation

Code	Category
S-A	Inclusive/neutral locations/environments
S-B	Safe locations/environments
S-C	Setting-up agreements/rules beforehand
S-D	Open participation to variety of stakeholders
S-E	Setting-up agreements/rules beforehand
S-F	Creating alternative forms of communication
S-G	Create vision statement
S-H	Organizing activities that allow for socializing & camaraderie
S-I	Anonymity
S-J	Well-trained, friendly MHD staff
S-I	Anonymity
S-O	Other (specify)
S-S	Comments about services provision

Table 56: Qualitative Data Codes for Barriers to CPP Participation

Code	Category
B-A	Transportation (including geography, size, rural)
B-B	Money
B-C	Outreach (including promotion and education of CPP)
B-D	Language & Cultural Competence
B-E	Accessibility (Meeting times, location, inviting)
B-F	Community Stigma (including protecting anonymity)
B-G	Childcare / work
B-H	Impact (not results; input not seen as used)
B-O	Other (specify)
B-N	None
B-S	Service provision

Table 57: Qualitative Data Codes for Outreach to Underrepresented/Underserved Communities

Code	Category
U-A	Cultural brokers/community navigators
U-B	Agencies/community orgs working with ethnic communities
U-C	Tribal groups
U-D	Faith-based groups/Places of worship
U-E	MHSA Ethnic Service Manager
U-O	Other (specify)
U-N	None
U-S	Service provision

Table 58: Qualitative Data Codes for Stakeholder Groups/Affiliations

Code	Category
G-A	Children and Family Services
G-B	Community-based/non-profit mental health service provider
G-C	Community based organization (non-MH)
G-D	Consumer/client
G-E	County mental health department staff
G-F	Family member
G-G	Hospital/health care provider
G-H	K-12 education provider
G-I	Law enforcement/Justice system
G-J	Senior Services
G-K	Substance abuse service provider
G-L	Veteran Services
G-M	Mental health advisory/board members
G-N	Racial/Ethnic group
G-P	Veterans
G-O	Other (specify)
G-Q	None
G-S	Service provision