

Mental Health Services Act Implementation Study:

Community Services and Supports State Planning Process



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Front cover artwork: *Window to the World* by Sylvia Borgman. "I didn't discover art until my first art class when I was 32, (after a previous career). The world of art is a wonderful place for me to express feelings and thoughts through the use of color, composition, and design. I thoroughly find the process of creating my work to be very meditative and peaceful. I enjoy the solitude and listening to classical music as I work.

"*Window to the World* began as a charcoal sketch and developed into a oil painting of the universal forms used to suggest a three-dimensional world, cylinders, circles, rectangles, etc. I then painted in a window to suggest another dimension of a spiritual world of light."

The painting received a first place in the Open Abstract category at the Monterey County Fair.

Back cover artwork: *Abstract Hands* by Gabriel Gonzales. "My art came to me in a dream. I call my art '...in the details,' because that's where God is found, and that's where I find serenity."

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TABLE OF CONTENTS

EXECUTIVE SUMMARY.....	2
BACKGROUND	4
PART 1: VISION, VALUES, AND GOALS	5
PART 2: PLANNING PROCESS	5
Strengths	5
Challenges.....	7
Technical aspects of the planning process	9
PART 3: COUNTY PLANS.....	11
Policy decisions.....	11
Plan requirements.....	12
CSS plan review process.....	13
PART 4: EXPECTED IMPACT AND CONCERNS	15
Expected impact	15
Concerns.....	16
PART 5: LESSONS LEARNED AND RECOMMENDATIONS.....	17
Planning process	17
Plan requirements.....	18
Plan reviews	19
Implementation issues	20
ENDNOTES	20
APPENDIX A.....	21
Survey about state-level Community Services and Supports (CSS) planning process	21
APPENDIX B.....	23
Stakeholder organizations and individuals.....	23

EXECUTIVE SUMMARY

The passage of Proposition 63 created a unique opportunity for California's mental health system while posing enormous challenges to the California Department of Mental Health (DMH).

After years of managing a system with shrinking resources, the state's mental health community was suddenly confronted with an estimated 15 percent increase in available state funding for community services and supports. Expectations for increases in services, particularly among those who had been active in supporting the Initiative, were high. While Proposition 63 provided general parameters for how the money should be spent and how it should be administered, the structure and details for distributing the funds were left to DMH, which faced this enormous task initially without any additional staff or resources.

Given the complexity and magnitude of the process, the approval of the first Community Services and Supports (CSS) plan approximately one year after passage of the Mental Health Services Act (MHSA) constitutes a major achievement.

Pressures to act quickly were balanced by DMH with the strong intent to have the funds make a major difference in the entire system. An early decision to allocate the funds to support transformation of the system as opposed to "business as usual" has had a major impact on how the entire MHSA has been conceived and implemented. While some informants in this study would have preferred quicker implementation, others felt that such an approach would have sacrificed the opportunity for widespread involvement in what is hoped to be a transformative process and transformed system.

The first transformational feature was the unprecedented planning process undertaken by DMH for the implementation of the CSS component of the MHSA.

DMH undertook an eight-month planning effort¹ which engaged a broader range of constituencies than any previous planning process. Special training programs were provided for consumers and family members to enhance their ability to participate meaningfully in the process. The level of

involvement, particularly of adult consumers, marked a turning point for the state's public mental health system. The commitment to a broad-based community planning effort was extended to the county level as the state required the counties to undertake the same kind of effort as part of the preparation for their CSS plans.

Additional transformation was sought in the requirements for the types and quality of services and the target populations that the CSS would fund.

Goals for a changed and improved mental health system were clearly articulated and focused the CSS planning process. These goals included a wellness/recovery/resilience focus, consumer- and family-driven services, enhanced community collaboration, integrated service experiences for clients and families, and culturally competent services.

Equally critical, DMH attached high importance to addressing the needs of the unserved and underserved. This had particular relevance for ethnic/cultural groups and the uninsured which have less access to services and lower rates of voluntary service use and/or may use high intensity and involuntary services as a result of this lack of access.

Another vital planning emphasis was the age focus. While children/youth and adults have traditionally been the heart of planning efforts and the structure of county mental health systems, the DMH planning process for MHSA also required attention to two more often under-represented groups: transition-age youth and older adults.

The planning process has drawn substantial attention to the issue of ethnic disparities and promoted a deeper level of understanding of the issues underlying these disparities.

Efforts to engage representatives of ethnic/cultural groups were not sufficiently successful. The logistics of the meetings (large meetings held during the day in hotels in major cities) were not conducive to involvement for many of these groups that do not have statewide organizations with staff to track activities like mental health planning meetings. The experience made clear the need to undertake more and different outreach efforts.

Informants were generally positive in their views about the direction and focus of the county plan requirements and the process of reviewing the plans.

¹ The first meeting was on 12/17/04, and the requirements were issued on 8/1/05

The CSS county plan requirements were generally effective in reinforcing the underlying principles of the MHSA and in focusing the counties on new types of services. The collaborative nature of the plan review process was widely appreciated as a learning process for the counties, the state, and the consumer/family members who participated in the reviews.

Constructive feedback about the planning process is being considered as DMH undertakes planning for subsequent MHSA components.

The CSS planning requirements were generally viewed as requiring too much detail resulting in excessively large plans that were burdensome to counties and hard to understand for consumers and families. DMH must continue to weigh the relative balance between focusing county efforts and providing adequate information to the state for accountability purposes with the need for limited administrative burden for counties, and county flexibility to accommodate local circumstances and to promote innovative efforts.

Policy decisions about the allowable use of CSS funds were made as the issues arose during the planning process, resulting in some changes of rules that were particularly problematic for counties that were ahead in their planning efforts. While impossible to anticipate every issue, it is important to address major policy issues about other MHSA components as early as possible. Finally, many people felt the initial CSS planning did not focus sufficiently on evaluation and accountability for the use of the funds.



Some issues will continue to be problematic for some constituencies because of their varying perspectives and the inclusion of multiple goals within MHSA.

One inherent tension in the CSS planning process was between promoting an open planning process while at the same time placing restrictions on how the funds can be used. It is likely that this tension will continue to exist with subsequent MHSA components.

While the CSS effort attempts to transform the system for some consumers and families (e.g., through the Full Service Partnerships and System Development Funds), other parts of the mental health system may

not be directly or immediately improved. The possibility of dual systems of care is of concern to many.

Decisions on the allowable use of funds for involuntary care, or the creation of special offsets of funds for ethnic/cultural groups, or a requirement to include particular type of providers in local plans will all continue to be problematic

for varying constituencies, depending on how DMH handles these issues.

While most informants expect significant positive impact from CSS, they also expressed concern about excessive expectations.

An increase in consumer involvement in planning and services and an expected improvement in the system as a result is viewed as the most likely transformation resulting from CSS. The biggest worry is that overall funding levels will not be sufficient to overcome institutional barriers to making the kinds of changes needed to really transform the current mental health system.

BACKGROUND

This is the first part of a study to examine the early phases of the Community Services and Supports (CSS) component of the Mental Health Services Act (MHSA).

The California Department of Mental Health (DMH) has contracted with a study team of eight individuals to explore the planning and early implementation of the CSS component of the MHSA. The study team brings together people with consumer and family member experience and individuals involved in public mental health leadership, management, research and evaluation, and cultural competence. The overall purpose of the study is to gain useful knowledge about what has transpired thus far in the ongoing implementation process of CSS as well as the ongoing development of other MHSA components. The study is not a formal evaluation. It is rather an attempt to identify aspects of the process that have worked well, along with those that have been challenging.

This initial report covers preliminary findings about the state's planning process, its CSS plan guidelines, and CSS plan review process. A second report, which will cover the planning and early implementation in selected counties, is scheduled for completion in early fall 2007.

The findings are based largely on a Web-based survey of participants in the state-level process and on interviews with key statewide organizations and informants.

A survey was placed on the DMH MHSA Web site, and an e-mail message was sent to all persons who were on the DMH list to receive e-mail updates on CSS activity with a link to the survey. The purpose of the survey was to obtain feedback from individuals who were knowledgeable and invested in the CSS planning process. It does not represent in any way the general public or segments of the population who may not have access through this technology and/or who might be considered unserved or underserved

by the mental health system. A total of 1,205 names were on the list, and a total of 233 responses were obtained.¹ The survey (copy in Appendix A) contains structured and open-ended questions. The survey results should be understood as representative of a select group of participants in the CSS planning process, i.e., people who are English speakers and who owned computers and were comfortable enough with computer technology to answer an on-line survey.

The study team conducted 27 interviews (primarily face-to-face and a few by telephone) with major statewide stakeholders in the state planning process (listed in Appendix B). Representatives of statewide associations and organizations in which such entities existed were interviewed; in other cases, the team identified a representative of the stakeholder group who had participated in the statewide planning process.

Face-to-face and/or telephone interviews were also conducted with seven key DMH staff members, and phone interviews were conducted with eight consumers, family members, and cultural competence experts who participated in the state's county plan reviews.

The final source of information includes interviews with persons in the seven case study counties. While the findings from these interviews will largely be in the next report, their views on the state's planning process, its plan guidelines, and plan review process are included in this report.

This report includes a large number of direct statements to reflect the voices and passion of many of the participants.

The CSS effort thus far has generated a great deal of excitement and enthusiasm on the part of those who have participated. This has not been "business as usual"—the mental health community has responded with an amazing level of energy. This report conveys some of that passion with quotes by individuals who were interviewed or who responded to the survey.

PART 1: VISION, VALUES, AND GOALS

Two overarching goals were mentioned by interviewees with great consistency and agreement.

When asked what the goals were for CSS, the two items mentioned most frequently were:

- To serve the unserved/underserved; and,
- To transform the system.

The former goal focused specific attention on reducing ethnic disparities in access to and use of appropriate mental health services. Of concern are not only lower rates of service usage by certain ethnic groups but also patterns of usage that suggest overuse of more intensive and restrictive services. Included most frequently in the latter goal was mention of the full inclusion of consumers and family members in all aspects of the system, and a shift in focus to a recovery/resilience orientation and service design.

Interviewees reported that there was widespread agreement about the vision of a transformed mental health system and the values that should underlie it.

The decision to utilize the MHSA to transform the entire mental health system as opposed to simply doing more of “business as usual” has been widely accepted. DMH articulated a statement of vision and values for a transformed mental health system in its documents and workshops which facilitated consensus across the mental health community. The vision and guiding principles are reflected in the key concepts articulated in the CSS Plan Requirements, which are:

- Community collaboration
- Cultural competence
- Client- and family-driven services and system
- Wellness focus, which includes concepts of recovery and resilience
- Integrated service experiences for clients and families

“Serving underserved and transforming the system are the goals, and they are the right ones.”

PART 2: PLANNING PROCESS

Strengths

It is noteworthy that most stakeholders and participants in the state’s planning process found it to be effective.

Interviewees were impressed that DMH was able to complete the planning process given the magnitude of the task. As one state staff member noted, “Just getting it done” was the best thing about the process. On the Web-based survey, roughly three-quarters of the respondents said the process was at least moderately effective.

The involvement of consumers and families, the broad representation, and the transparency of the process were the most frequently mentioned best things about the planning process.

The Web-based survey asked, “What was the best part of the state-level planning process?” The open-ended answers were grouped into categories; those categories with more than five responses are shown at right.

Web-based Survey (N=233)

“How effective do you think the state-level planning process was? “

Extremely effective	3%
Very effective	20%
Moderately effective	50%
Minimally effective	20%
Not effective	6%

“I think the state-level planning process for MHSA is comprehensive and very extensive. At present, I cannot think of anything that would make the state-level planning process more effective.”

The state planning process was the most open and inclusive effort ever undertaken by DMH and the mental health community.

While not successful in all its efforts to be inclusive (as will be noted in sections that follow) most interviewees agreed that this was by far the best effort ever made at the state level to obtain and listen to a wide range of input about the future of the mental health system. The broad representation of stakeholders and the openness of the process were among the most frequently mentioned “best things” about the process on the Web-based survey and were consistently cited by interviewees.

A sample of comments reflects the wide appreciation for the openness and inclusiveness of the planning process.

Stakeholders felt their input was heard.

A substantial number of comments indicated that a good representation of stakeholders was invited, and everyone’s voice was heard. While not everyone’s views were implemented, participants felt that their opinions had been heard and considered. The substantial changes in the local plan requirements from the first to the second draft were cited as confirmation of stakeholders’ input.

Web-based Survey (N=224)

“How would you rate the amount of involvement in the state-level planning process of the following constituencies?”

Stakeholder	Too much	The Right Amount	Too Little
Consumers	8%	59%	33%
Family members	7%	57%	37%
Transition-age Youth (TAY)	4%	34%	62%
Older adult (OA)	3%	33%	64%
Ethnic groups	5%	44%	52%

Web-based Survey (N=146)

“What was the best part of the state-level planning process?”

Categories with > 5 responses	N
Involvement of consumers and/or families	24
Broad representation	21
Open, transparent process; listened to input	19
Helpfulness of DMH – responsiveness, flexibility, county liaisons	12
Plan review process being open, collaborative, helpful	10
Plan requirements – guidelines and directions and making counties follow them	10
Stakeholder meetings with interactions and opportunities for learning	8
Training and technical assistance	6
Web site, updates, e-mails	5

The active involvement of adult consumers was cited as the most notable accomplishment in terms of inclusiveness.

Adult consumers were viewed as playing a vocal and influential role in the planning process. One state representative suggested that of all constituencies, adult consumers were the most prepared and consistently present. While some comments suggested that participation would have been even better if more attention had been paid to providing stipends and improving accessibility, a general consensus indicated this process represented a breakthrough in consumer participation.

Interviewees cited a number of instances in which consumer input was particularly effective. These included the exclusion of involuntary services from CSS funding and the change in the concept and name from required “enrollment” to full-service partnership. The consumers were strong advocates for including consumer-run services as a recommended system development strategy and for urging an increase in the hiring of consumers.

Some interviewees suggested that the adult consumer participants were not representative of

- ❑ ***“The level of excitement of all stakeholders. They were finally asked for their opinions.”***
- ❑ ***“They were open to everyone.”***
- ❑ ***“Involvement of a broad representation of interests.”***
- ❑ ***“The goal of inclusiveness.”***
- ❑ ***“The transparency of the process and the inclusion of a wide number of stakeholders in the process.”***

the full range of consumers, e.g., individuals who are homeless, not-engaged in services or clients who are institutionalized. This view was expressed largely by those who were advocates of the inclusion of non-voluntary services in CSS.

Family members were also viewed as active participants.

While not as involved as adult consumers, family members were consistent participants. One of the representatives of families of children and youth believed this group had a larger voice in this planning process than any initiative the state has developed in the past. Family members of adults said they had an opportunity to state their positions, but also indicated more weight was given to positions that were repeatedly addressed, despite the fact that DMH said that repetition was not necessary.

This process brought more attention to the issues of ethnic disparities than any other prior state DMH effort.

The specific designation of the reduction in ethnic disparities as a goal and the provision of data on ethnic group penetration highlighted the need for ethnic participation. Additionally, having diverse ethnicity of participants helped to educate all participants about the importance of considering these issues. The reduction of ethnic disparities in access and treatment became one of the major guiding principles and goals of the planning effort.

“These folks (who participated) are already recovered and so are not the folks who currently have a serious mental illness and who need the services of the MHSA.”

Challenges

DMH needed a better process for identifying and reaching out to representatives of major ethnic groups and communities.

A general consensus from interviewees and results of the Web-based survey indicated that more attention was placed on ethnic disparities. However, obtaining active participation from groups that are not engaged with the mental health system requires more than an invitation to participate. Outreach activities essential to obtaining involvement by major ethnic groups were not sufficient. Some examples of these activities include providing translated versions of important documents, identifying and soliciting participation from ethnic organizations that are not traditional mental health providers, more extensive outreach to assure the unserved communities are made aware

- ❑ ***“For the Department to open the process and seek input into the planning process as a clear and obvious goal with no pretense about it is remarkable. It was not lip service.”***
- ❑ ***“Anyone could be involved.”***
- ❑ ***“Having everyone in the room at the same time was wonderful.”***
- ❑ ***“An attempt was made to consider all those who would be affected. DMH had contact with the client population, family groups and community that had not happened in the past”***
- ❑ ***“The openness of the process so anyone truly interested and having the time could understand the process.”***
- ❑ ***“Its inclusiveness of all voices.”***

of MHSA, seeking input in locations that were more convenient, culturally relevant, and comfortable for members of the ethnic communities, giving special attention to issues of lack of trust, and including community representatives in actual decision making in order to overcome cynicism about the process. DMH representatives acknowledged that they should have been more sensitive to cultural differences and made greater efforts to engage major ethnic groups.

- ❑ ***“We have opened a door that cannot be shut again. It may not have been opened as wide as consumers wanted but once opened, it will get wider.”***
- ❑ ***“There was much more involvement of consumers than previously. It was an impressive effort but did not reach the variety it should. Due to limited financial support, scheduling of meetings, transportation problems, etc, many consumers were not able to be involved.”***

Some groups advocated for set-aside money for ethnically specific services. This was seen by some as a missed opportunity.

Some respondents advocated for money to be set aside within CSS for services (at the state and/or local levels) specifically for ethnic groups. They felt that this would have been an important first step and sign of willingness to truly engage ethnic communities in a meaningful and relevant fashion. The fact that the state decided against this opportunity has left some groups disenchanted.

Advocates for other cultural groups would have liked more attention.

Specific comments in the interviews and on the Web-based survey indicated a lack of involvement and specific attention to other unserved or underserved groups, including the gay-lesbian-bisexual-transgender community, the deaf community, and women who have experienced significant trauma.

The focus on age-specific planning greatly enhanced attention to Transition-Age Youth (TAY) and Older-Adult (OA) issues.

While the process specifically required attention to these age groups, the nature of the planning process (see details below) made it difficult for TAY and OA persons to participate directly. As reflected in the Web-based survey, the level of participation by these groups was rated as too little by almost two-thirds of

“You have to do more than just say come on in—naivety about what it takes to overcome the distrust—to effectively engage the real non-traditional folks there has to be a payoff for them.”

the respondents. It was felt that those who served these age groups, particularly in the case of older adults, were able to represent their interests, but all acknowledged that actual participation would have been preferable.

The nature of the planning process also limited direct participation from rural counties; however, this is mitigated somewhat by a history of negotiations between DMH and the County Mental Health Directors Association (CMHDA) to accommodate policies and funding specifically to the needs of small rural counties.

DMH actively sought involvement from other state agencies, although results were mixed.

An enhanced level of coordination with other agencies is one of the desired system transformation aims. In alignment with this, DMH funded other state agencies (Department of Health Services, Department of Education, Department of Rehabilitation, Department of Alcohol and Drug

- ❑ ***“To get ethnics you need to go out to them and do focus groups—you can’t expect them to come to meetings in big cities.”***
- ❑ ***“There should be greater outreach to community-based organizations who serve specific ethnic and language groups, including those who are not traditional providers of mental health services.”***
- ❑ ***“We (DMH) have not done as well as we could have or should have in addressing ethnic inclusiveness and disparities.”***

Programs and Department of Social Services) to foster their participation in the MHSA planning process. DMH funded positions in each of these departments. Although invitations to participate were a good first step and were appreciated by the other state agencies, their actual level of participation varied. One department representative expressed strong appreciation for the collaborative effort, the outreach to other departments, and the funding for the positions. Some representatives interviewed expressed frustration at continuing lack of coordination, particularly with regard to persons with multiple disabilities. Other respondents felt that DMH lacked sufficient staff to inform and coordinate with their partners in this element of the planning process.

While different service providers were represented, some were disappointed when their positions were not adopted.

Certain parts of the provider community said they felt ignored in the process, in part because of the involuntary treatment issue. This included both the psychiatrists and hospitals whose contact with the public mental health system is more likely to entail involuntary treatment, which was excluded from CSS funding.

Primary care providers participated in the process but indicated they were disappointed that county plan requirements did not require more explicit direction to consider their possible role in CSS plans.

In addition, service providers were concerned that line staff from both county and contract mental health programs were not sufficiently involved, even though they have the most direct contact with consumers of mental health services. Their lack of participation is attributable largely to the timing and location of meetings. One suggestion was that meetings of specialized providers might be a means by which to obtain more involvement from this constituency.

County mental health programs did not have any special role in the state planning process.

CMHDA was not as actively involved in the CSS planning process as it is likely to be in the rest of the MHSA rollout. Because of CMHDA's unique role as implementers of both the plan and the subsequent services, many felt they should have had a special role in the development of the plan requirements. Some of the directors and other administrators attended state meetings, but because of other responsibilities were not able to attend regularly; therefore, their impact and sense of involvement was minimal.

The Web-based survey responses highlighted more participation by the underserved, a faster process, earlier and clearer directions from the state, and more involvement of professionals as areas for improvement.

An open-ended question on the Web-based survey asked, "What would have made the state-level planning process more effective?" Answers were grouped into the following categories:

Web-based Survey (N=166)

"What would make the state planning process more effective?"

Categories with > 5 responses	N
More efforts to include the unserved and underserved, including ethnic groups, dual diagnosis, those who couldn't attend meetings	18
Faster process	16
More clarity sooner from the state, fewer changes, better definitions	15
More involvement of professionals	15
More flexibility to the counties, less micromanaging	13
More accessible meetings, e.g. regional meetings, teleconferencing, night meetings	11
Greater role for the counties	10
Simpler, less redundant process	8
More and better consumer and family member involvement	7
Even wider input, e.g. the general public	5
Attention to bigger picture, e.g. all of mental health, all the MHSA components	5

Technical Aspects of the Planning Process

DMH decisions about the mechanics of the planning process were determined by the need to move quickly and efficiently.

Holding large meetings in hotels in the major north and south cities maximized the number of persons who could participate, but created barriers for some groups. In particular, the process was weighted to stakeholders located in these major urban centers and to mainstream entities that were comfortable with this way of doing business as opposed to some ethnic

groups for whom DMH's approach was not culturally appropriate. Holding the meetings during the day limited the participation of persons whose work precluded their attendance. In general, the cost of attendance was prohibitive for many stakeholders.

Some persons found the large meetings very useful, while others thought the format was not productive.

The ability to exchange views, learn from each other, and to air issues publicly were positive features of the large meetings. For some, the meetings were too tedious and repetitious, sometimes lacked a clear focus, and were too fragmented. Suggestions for the future included having smaller regional meetings or meetings focused on specific issues.

- "It is now two years and programs are now just hitting the street. We have an embarrassment of riches stored in the treasury."***
- "Very slow. Frustrating for consumers and community involved in the process."***

The other methods used by DMH were viewed as generally positive complements to the large meetings.

The phone calls prior to the meetings were generally viewed as useful for imparting information but not for giving feedback. The ability to provide written comments was appreciated. The Web site was seen as useful, although it was acknowledged that not everyone has access to this means of communication. Additionally, the lack of translated materials limited participation to English speakers. The following were cited as the "best things" about the planning process by individual Web-based survey respondents.

- "Access to information via Web."***
- "Good posting on Web site when we couldn't attend meetings."***
- "The DMH Web site information for MHSA and the resources that are available on the site."***
- "Telephone conference calls with accompanying slides distributed in advance."***

Despite satisfaction with the comprehensive planning process, the predominant view was that it has taken too long to get money out to the counties.

As the time since the enactment of the MHSA has lengthened, the concern about timeliness has increased.

It is difficult to place these concerns wholly on the state planning process because of delays encountered from the initial planning to the actual implementation. But half the respondents to the Web-based survey question said the process had been too slow.

Web-based Survey (N=233)

"How would you rate the overall timing and scheduling of the state-level CSS planning process?"

Much too fast	6%
Somewhat too fast	12%
About right	32%
Somewhat too slow	31%
Much too slow	19%

Some of those who felt the process was too slow acknowledged that it might have been necessary in order to gather all the needed information and input, and to give everyone a voice. A minority opinion argued for an even longer process, either to obtain better representation or because the process itself was so useful for the mental health community.

- "About right in terms of speed. Some were impatient, but it was very complicated so you couldn't go too fast."***
- "The planning process was so rich that would have been good if it could have gone on even longer but had to get it done to get the money out."***

PART 3: COUNTY PLANS

Policy Decisions

During the planning process, several key issues emerged and significant policy decisions were made.

One of the fundamental early decisions was that the planning process would be as inclusive and broad-based as possible. The county plans were required to include documentation of substantial outreach to unserved and underserved communities. This requirement had a profound impact on the way in which the local plans were developed.

Other decisions were made along the way as issues arose. As policy decisions were made, they were not always as explicit as they might have been. Four of these key decisions are described below.

- ***Inclusion of three types of funds:*** Full-Service Partnership (FSP) funds, System Development funds, and Outreach and Engagement funds. Because many of the key persons involved in drafting and campaigning for Proposition 63 were key stakeholders in AB 2034, an implicit expectation was made **by some people** that the CSS funds would be used for a service model similar to AB 2034. Feedback from consumers about not wanting to have to enroll in a program to receive services, concerns about the lack of comprehensive services to support persons with serious mental illness (SMI) and serious emotional disorders (SED), and input that without special outreach efforts, ethnic disparities were unlikely to be reduced led to a scaling back of funds required to be budgeted for FSPs and the inclusion of the other two elements in CSS services.
- ***Limitations on involuntary services.*** Another crucial issue that generated substantial discussion and to some individuals an ongoing concern is the limitation regarding involuntary services as an allowable CSS service. During the planning process, a key policy decision was made to allow individuals with involuntary status to receive MHSA services. A related policy decision was made to require that programs/services be voluntary in nature. Certain stakeholders continue to believe that this limitation violates the intent of the MHSA which they say was intended to provide all types of programs and services. This issue has been particularly contentious since some of the major supporters of

Proposition 63 find their constituencies excluded from potential benefit. While some advocates continue to argue for more access to involuntary services, consumer groups have made it clear that they will fight strenuously to exclude funding for involuntary services.

- ***Exclusion of non-mental health services and supports.*** One county raised the question of whether CSS funds could be used to support non-mental health (in this case law enforcement) personnel as part of a collaborative to provide comprehensive services. DMH decided that MHSA funds must be used for mental health services and supports and could not fund personnel in other agencies who were performing non-mental health services, even if these services were provided to mental health clients.
- ***Definition of wraparound programs for children/youth.*** Another issue with some ongoing confusion among stakeholders is the meaning of the requirement of wraparound services for children/youth. Counties were required to either provide a wraparound program as an FSP if they did not already have such a program, or to indicate why they had decided not to use such a model. Strong advocates for the initial SB 163 Wraparound

- ❑ ***“Still fighting the involuntary issue...initiative was silent on the voluntary-involuntary issue on purpose.”***
- ❑ ***“I believe DMH has ignored the will of the voters by disallowing the use of MHSA funds for involuntary programming.”***
- ❑ ***“It remains unclear from a legal point of view whether funds can be used for involuntary care. The great majority of Californians who voted for the proposition assumed that at least some of the funding would be utilized to treat those whose minds and insight into their illness have been impaired to the point they are incapable of making a voluntary choice for treatment.”***
- ❑ ***“DMH has said that if a person is in an FSP and has to go to a hospital, it’s okay to use MHSA funds to pay for inpatient if no other funds available. We [consumer advocates] see this as supplantation and using funds for involuntary treatment.”***

model have found the state's allowance of general "wrap-like" services to be an issue.

Although it was difficult to anticipate all of the issues, providing answers to these key policy decisions earlier in the process would have been helpful.

As noted above, many of these issues were addressed by DMH as they rose to attention either through advocacy for a particular position during the stakeholder process or through a question raised by either a county or a stakeholder. The lack of earlier clear direction on some of these issues was problematic for counties that had to alter their planning efforts in response to DMH decisions. DMH could not have anticipated all the issues that might have arisen, but making decisions as promptly as possible once issues are raised eases the local planning effort.

Plan Requirements

The underlying principles, values, and concepts of MHSA were well integrated into the plan requirements.

Respondents agreed that the plan requirements incorporated the key values and goals of the MHSA.

The requirement for age-based planning made a significant difference in the overall distribution of resources.

While counties had some services for TAY and OA prior to the CSS planning effort, these groups had not received the level of attention that had been invested in the adult and children/youth systems of care. While no specific plan requirements were placed on the total amount of investment in these two age groups (and the plan requirements were specific in indicating that a county did not need to develop FSPs for all age groups), the simple requirement to plan by age group led to virtually all counties targeting some resources to TAY and older adults.

- ❑ ***"Brought together data on ethnic groups and more focus to this issue."***
- ❑ ***"Glad to see emphasis on recovery and ethnic issues."***
- ❑ ***"Emphasis on wellness and consumer/family very congruent with direction already moving in."***

One downside of the age-based planning was its discordance with generational and family-oriented concepts in some ethnic cultures. In some cultures, it is not appropriate to separate services for individual persons by age groups; a more relevant concept would be to provide services to the full family in the context of their community.

The explicit requirements for how the local planning process should be conducted were viewed as beneficial, although some stakeholders would have preferred clearer mandates.

A perceived danger in the local planning efforts was that the process would include "all the same people" and that the county would continue to do what it always had done with the same providers it always used, i.e., that it would be "business as usual." The requirements on the counties to conduct outreach and to provide training for consumers and family members was viewed as critical in getting counties to do more than they had in the past to open up the planning process to new voices. Some stakeholders, generally those who are not the traditional participants and those who serve ethnic communities, would have liked to see more explicit requirements on who should have been involved in the local planning process.

- ❑ ***"Without mandates about stakeholders, the counties will just work with who they want to."***
- ❑ ***"Not much involvement of constituencies after initial input—always worries about counties doing end runs."***

The plan to plan requirements did not include specifics on how actual decisions were to be made at the county level once input was received from the broad range of stakeholders. As a consequence, the process varied across counties with some stakeholders expressing concerns about their being left out of the decision-making process. (More extensive discussion of this issue will appear in the County Case Study Report.) One suggestion was that the planning requirements could have been more explicit about what was to happen once the draft plan was presented to the county Board of Supervisors, i.e., the process from draft to final plan.

The majority of Web-based survey respondents felt the plan requirements were too rigid, but this may have been confused with level of detail.

About one-quarter of the Web-based survey respondents indicated the plan requirements were about right in terms of the balance between flexibility and rigidity, while about 60 percent suggested that they leaned towards being too rigid.

Web-based Survey (N=229)

“What is your view of the County Plan Requirements that resulted from the planning process?”

Much too rigid	28%
Somewhat too rigid	32%
About right	27%
Somewhat too flexible	10%
Much too flexible	2%

The tenor of the comments suggests that the concern was not so much with the direction of what was required but the level of detail. Many said that the resulting CSS plan requirements were too bureaucratic and that the state was trying to micromanage the counties’ efforts.

- “Too many requirements for the counties—too much data, too many attachments—overwhelming...documentation was overkill.”**
- “Too complicated—too prescriptive and not oriented enough to outcomes.”**
- “Some level of not trusting that counties will do the right thing.”**

The minority view generally reflects the views of those who have been left out of the usual process and would have liked even more stringent requirements, e.g., for contracting with non-traditional providers.

Some respondents commented on the inherent tension between an open planning process and the structuring of the result through the plan requirements.

The planning process contained an implicit set of contradictory directives. One was to create an open

process by which stakeholders would inform the county of their needs and desires. On the other hand, the actual requirements for the kinds of services (and target populations) that were eligible for funding were rather tightly constrained in the final plan

“Fine for those already in the process but not for those not at the table.”

requirements. As will be noted again in the County Case Study Report, this resulted in both confusion and some frustration at the local level, particularly for counties who began their planning process promptly after the passage of the proposition.

- “The state guidelines overrode the impulse for community planning—the message was to engage folks, and then the CSS guidelines came out with strict requirements.”**
- “Things outside the target population would have emerged without the constraints—like gang violence.”**
- “FSPs would not have emerged out of the local planning process.”**

CSS Plan Review Process

The review process for county CSS plans was viewed positively and seen as unique in DMH experience with respect to the collegiality of the process.

DMH created review teams which included consumers, family members, former mental health directors, cultural competence experts, an OAC representative, and state staff. The teams reviewed the plans using a plan review tool, held a “heads-up” conference call with the county to alert the county to issues of concern and then met in a lengthy face-to-face meeting with county representatives. After that meeting, a letter was sent from DMH to the county that outlined issues that needed to be addressed. Upon submission of requested additional information and/or revisions, state staff made a decision on whether or not to approve the plan or request additional information or changes.

Both the reviewers and the counties indicated that this was the most open and collegial review process in which they had participated. The “partnership” feel of the reviews resulted from the fact that it was

not a competitive selection process as are most such reviews but rather a process by which counties would be assisted to produce a plan that the state could approve.

The holding of the pre-visit “heads up” phone calls that alerted the counties to potential issues of concern reinforced the orientation of mutual work towards an acceptable plan.

While state staff members reported that the process was an overwhelming task to organize and complete, they found the process informative and useful to their understanding of county programs and processes.

Comments on the Web-based survey reflect the generally positive views about the county plan review process.

- “The review process was very collaborative.”***
- “The interviews with county teams by DMH review panels were very collaborative and helpful.”***
- “Meeting directly with the plan reviewers and working with our regional DMH contact person.”***

The extensive nature of the process and the sheer volume of work entailed meant additional time was required.

As noted, to find and train plan reviewers and to schedule and conduct thorough reviews was a huge task that strained the capacity of DMH. As a consequence, the reviews did not happen as quickly as some stakeholders would have liked.

Web-based Survey (N=227)

“What is your view of the process by which the state has reviewed the county plans?”

	Yes	No	Don't know
Timely	36%	48%	16%
Thorough	56%	19%	25%
Good representation of constituencies affected by the plans	34%	38%	29%
Transparent	39%	32%	28%

- “The state document went further than the Act, but the review process bowed to the need to get along with the counties.”***
- “Would have liked strict reviews like with AB 2034, but not sure this happened.”***
- “Would like DMH to focus more on the overall transformation rather than the details.”***

Some stakeholders would have preferred a more stringent plan review.

The very orientation (which many liked) of working collegially to produce a plan that could be approved was called into question by some who wanted the state to conduct a more traditional stringent review. Some questioned whether the counties were really being true to the transformative nature of the efforts. For example, some felt that the review tool and the reviews themselves were too concerned with details and may have missed the bigger issues of adoption of new values and approaches.

Consumers and family members participated fairly actively in the review teams.

All review teams included consumers and family members. Consumer and family member participants had differing experiences in terms of how welcoming they felt the review team was to their input, with some finding it “open and inviting.” Others found the manner in which their input was sought “too intimidating.” These differences are likely a function of both the experience and skills of the consumers and family members selected, and the skill of the review team leader in helping consumers and family members feel more at ease.

The cultural competence experts were a valuable addition to the review teams, but they expressed some frustration with the process.

Cultural competence experts on the review teams suggested that the lack of specificity in the guidelines made it difficult to evaluate the adequacy of the cultural competence plans. While the plans said they would ensure cultural competence, conduct outreach to unserved and underserved communities, and hire bicultural staff, they generally lacked specifics about how they would do these things. And there was little additional detail that emerged when questioned

during the face-to-face review sessions. For this reason, it felt often as if the counties knew what they were supposed to do but lacked the competence to accomplish what was in the plan.

Reviewers also noted the general lack of discussion of what some of the wellness and recovery concepts might mean for diverse ethnic cultures, and how these concepts need to be presented and/or altered to be meaningful and useful in communities in which the greatest expressed need may be greater access to helpful services.

- ❑ ***“I have grown so much in the process, if I did it now I would be more helpful.”***
- ❑ ***“First review was tough – did not do a good job. Needed to be more specific about what they were looking for.”***
- ❑ ***“Took a couple of reviews before the review tool was useful – yes/no not always useful since the plan could meet the letter but not the spirit.”***
- ❑ ***“I felt we were an equal part in the team. Counties had willingness to hear. It was delightful, they were respectful of consumers, took notes, treated us as equal partners.”***

Finally, respondents were concerned that because cultural competence experts were on the review team, other review team members were not as likely to address cultural competence issues. So while the expertise was useful and probably necessary, it reduced the obligation of other reviewers to be better informed and attentive to issues of cultural competence.

- ❑ ***“This was the typical approach – raise the issue, use the words, but not a lot of depth.....just talked about cultural competence – not how to look for that.”***
- ❑ ***“For example, should identify things to watch for, look carefully at proposals for connection between community work and what you see in proposals; are they realistic, feasible, innovative, creative.”***
- ❑ ***“In groups I was in, I was the only one looking at cultural competence.”***

Stakeholders who were not part of the review process had little information about this part of the process.

Once the plans were submitted to the state, the general public received little information about what was happening until the plan was approved. Because of the complexity and detail of the actual plan, the state did not require that counties submit a revised plan in response to the review teams’ concerns. Rather, they accepted additions and addendums and other responses to the concerns. As a consequence, no official public record exists of the plans as they were finally approved by the state. The public record consists of the original plan and all the correspondence that followed the review.

The Oversight and Accountability Commission (OAC) also reviewed CSS plans, but this process was not always well coordinated with the DMH reviews. Like DMH, the OAC was developing its role as the review process was proceeding, and this resulted in some lack of clarity about roles and responsibilities.

“For transparency, would have been good to have DMH and OAC review comments made public and changes from original to final plans—would allow the public to know DMH policy on issues.”

PART 4: EXPECTED IMPACT AND CONCERNS

Expected Impact

Most people interviewed believed that the CSS component would have a significant and positive impact over time on the public mental health system.

Most stakeholders are optimistic about the ability of the CSS values and funds to bring change to the public mental health system. The following is a sample of the comments people made.

“Unlike anything we have seen before.”

“Great impact will be seen over time.”

“The money will provide a tipping point for the system.”

“Impact won’t be seen from this first effort because amount is only enough to cover recent losses.”

Optimism about positive impact was tempered by an acknowledgement of real limitations and barriers to change.

The two most frequently mentioned cautions were that the additional funding is coming at the same time many counties are undergoing budget cuts of about comparable size and the fact that there is not enough money to create system transformation.

Interviewees expressed different views of how MHSA will create change in the whole system. Some believe that the values and approaches in the programs that are being funded by CSS will gradually move out of these programs to the overall system. Others felt that the FSP will become the basic mechanism by which services are delivered, and the rest of the system would dissolve. Still others believe that the real mechanism for change will come through greater consumer direction and influence within the whole system.

Web-based Survey (N=230)

“How much impact do you think the CSS component of the MHSA will have on the following parts of California’s mental health system?”

	A great deal	Some	Very little
More recovery-resilience oriented	28%	57%	15%
Reducing ethnic disparities	13%	57%	30%
More cultural competence	16%	53%	31%
Increasing consumer involvement	39%	46%	15%
Increasing parent/caregiver involvement	25%	57%	18%
Improving co-ordination with other organizations and agencies	25%	46%	29%

Consistent with findings cited earlier, the greatest impact is expected in the area of consumer involvement with the least expected in the areas of reducing ethnic disparities.

About 40 percent of the Web-based survey respondents expect “a great deal” of impact in terms of increasing consumer involvement. They were less optimistic in terms of reducing ethnic disparities (13 percent expect a great deal of impact) and making services more culturally competent (16 percent). Less optimism was also revealed regarding improving coordination with other organizations and agencies, with about 30 percent expecting very little impact.

- “We need all the components out. Lots of what we need is tied to workforce development and capital improvement monies.”***
- “Biggest concern is human resource lacks.”***

Concerns

There is frustration about how long it has taken to get money for transformation on the street.

From the start, a tension has existed between making this an open, inclusive, thorough planning and implementation process and wanting to provide funds for services that are sorely needed. Added to this tension are the inevitable delays that occur in the implementation of any complex statewide governmental initiative. Given these constraints, many respondents acknowledged that the process actually proceeded as smoothly and efficiently as anyone might have expected.

The infrastructure limitations in counties are perceived to be potential obstacles to effective implementation.

A number of interviewees expressed concern that counties would have difficulty implementing plans because of inadequate infrastructures—particularly with regard to human resources. Some noted that it would have been more logical to begin with the MHSA infrastructure components or at least to have implemented these on the same timeline as the CSS.

A major substantive concern is the potential for the creation of a dual system.

A number of interviewees expressed concern that the public mental health system may become separated into well-funded CSS programs and the old regular programs. This was expressed most often in relationship to the level of service available within the FSPs compared to what other consumers will receive. Divergence is all the more apparent for those stakeholders who reside in counties where budget cuts are reducing available funding for existing programs and clients. That makes the creation of particularly richly staffed efforts under CSS all the more noticeable.

- ❑ ***“Investing money to a small group while reducing services to a larger group.”***
- ❑ ***“You will see a bifurcated system; people on the road to recovery may not get support (if not in an FSP). Uninsured will not get help.”***
- ❑ ***“Not integrated enough with core mental health services, likely to result in a ‘super-silo’ called MHSA within counties. More planning should go into the interaction between MHSA and the core services, to better transform the rest of the system.”***

Stakeholders are concerned about how to insure accountability.

There were two sides to these concerns. The most frequent was the worry that counties were not to be trusted in terms of following through with what was in their plans and that the state needed to implement a strong means of tracking compliance to ensure that there is not supplantation of funds and that the programs are implemented as described in the plans. The alternative concern expressed primarily

- ❑ ***“Overall plan is good but no way to really be sure what counties are doing.”***
- ❑ ***“Need accountability to the public for the use of funds—various groups need to clarify their oversight responsibilities.”***
- ❑ ***“Lack of teeth ...could be a problem in selected counties.”***

by county representatives is that the accountability methods should not be too onerous or bureaucratic. Of particular concern is that they may be subject to audits on issues about which there are not yet clear rules.

Some worry that expectations may have been raised too high.

This fairly widespread concern is best expressed by one interviewee.

“We have a lot of funding for MHSA but the public thinks it will take care of everything. We could see the impact of failed expectations.”

PART 5: LESSONS LEARNED AND RECOMMENDATIONS

The CSS public planning process, the resulting CSS county plan requirements, and the plan review effort represented a new way of doing business for DMH. The report has noted the wide variety of views and feedback on all the aspects of this undertaking. While not perfect, many of those interviewed for this study felt the public planning and review process represented a way of doing business by DMH that is more open and more consumer and family member friendly and that DMH attempted to establish partnerships and reach out to those affected by serious mental illness in a way that has not been done in the past. The recommendations below are based on the study team’s assessment of those themes upon which there was sufficient respondent consensus to warrant being considered a “lesson learned.” The recommendations flow from these lessons and are meant to assist DMH as it plans for and implements subsequent MHSA components.

Planning Process

The high level of involvement of consumer and family members in the state CSS planning process was a transformative effort within DMH, and should be continued and strengthened in subsequent planning processes.

Consumers and families played an active and effective role in the CSS planning process. Not only did consumers and family members have seats at the table, they used their voices effectively on a number of key issues. Adult consumers, particularly, were influential

in helping focus funding on voluntary services, in advocacy for consumer-run services, and in altering the concept of “enrollment” into programs. Consumers and family members were also active and influential members of plan review teams.

DMH should continue to utilize mechanisms to assist consumer and family participation, e.g., with stipends, more accessible location of meetings, training, and adopt as much flexibility as possible to encourage meaningful involvement. An area needing significant improvement is the recruitment of consumers and family members from diverse ethnic communities. Additional efforts will be required to increase the participation of consumers from the TAY and older adult age groups.

It became clear during the planning process that DMH needs to seek new ways and more effective ways of engaging and working with ethnic groups that are currently underrepresented in the mental health system and in the usual planning processes.

While greater attention was paid to ethnic issues than in any prior statewide mental health planning effort, the actual amount of ethnic diversity among participants in the planning process was limited. For a variety of reasons, the process was not as welcoming as many would have preferred. Relying on invitations to large meetings as the primary mechanism for engagement will not work for many ethnic communities.

Some basic changes would improve the situation, e.g., providing translated materials, having smaller more focused more conveniently located meetings, and seeking out and working with ethnic organizations and providers. But beyond this, DMH will need to develop strategies, trust, and communication with representatives of ethnic communities and organizations who are in touch with ethnic communities to learn from them effective methods for outreach to improve stakeholder participation. No one should expect easy and/or fast results, but the mental health system must be transformed in a way that respects and accommodates the different ethnic cultures within California.

Future planning processes should consider using smaller specialized meetings as a way to engage and obtain input from some constituencies for whom a large formalized planning process is less effective.

The large formalized planning process did not work well for some specialized groups. Some could

not access the meetings, e.g., persons who are institutionalized or are homeless. Some found the process irrelevant and not engaging, e.g. transitional-aged youth. For others, the whole process may have been too intensive or incomprehensible, e.g., older adults. Others may have found most of the information and planning not relevant to their specialized concerns, e.g., the deaf community or the lesbian, gay, bisexual and transgender community. And some could simply not afford to take the time or make the investment to become involved in such an intensive effort, e.g., line staff from county and contract agencies, other providers, and researchers.

One suggestion is to hold smaller, specialized forums that can address the issues of concern to these specialized groups. This would both reduce the time and resources they must expend to participate and increase the chance that their involvement in the planning process will be relevant and rewarding.

While opinions varied on desired comprehensiveness of subsequent planning efforts, attempts should be made to create a more focused and time-limited process for subsequent MHSA components without sacrificing inclusiveness and effectiveness.

Fifty-four percent of the Web-based survey respondents answered “Yes” to the question of whether the planning processes for other MHSA components should be as extensive as this one, while 46 percent said “No.” The tension between obtaining wide input and the need for speed was reflected in many of the comments. The drain on resources was also often cited as a reason to simplify the process.

These comments reflect the inherent tension between obtaining wide input and having a shorter planning process. Efforts should be made to utilize planning processes that have already been developed and to build on the input and information already obtained.

Plan Requirements

Plan requirements for future components should be less detailed, duplicative, and “boiler-plate” and more focused on what counties are going to do and how they are going to do it.

Participants generally agreed that the final plan requirements were too bureaucratic and resulted in plans that were too voluminous and contained statements that “sounded good” but were not indicative of what the counties were actually going to do. One example was the intention of many

Web-based Survey (N=213)

“Do you think the future planning for the other components of the MHSA should be as extensive as for the CSS?”

YES – As Extensive

- “To be transparent and effective, the process needs to be extensive so that everyone that wants to be involved can participate.”*
- “The maintenance of involvement will be crucial in the long run, otherwise it will be ‘business as usual.’”*
- “If the goal of MHSA is transformation, the planning for the other components needs to be extensive. The expectations for counties need to be clear.”*

NO – Not as Extensive

- “Hopefully, we won’t have to reinvent the wheel every time.”*
- “The planning process was so extensive that it has delayed implementation of programs. I would hope that the other components could be implemented more efficiently.”*
- “We gathered a great deal of information related to all aspects of MHSA when we did the community planning for CSS and have reams of information. We do not have the infrastructure, time, or spirit to go through another extensive planning process.”*

counties to engage and increase access for particular underserved ethnic communities but without sufficient explanation about exactly how they intended to do this. Future plan requirements should focus on those content items that will highlight what the county actually intends to do.

Definitions, key policy decisions, and plan requirements should be clearly specified as early as possible.

While it is impossible to anticipate all the issues that will arise, efforts should be made to anticipate difficult areas as early as possible and to address them decisively to alleviate wasted effort on the part of counties trying to adapt to those decisions. At the same time, DMH must be open for reconsideration of key decisions and further refinement of definitions and requirements as experience is obtained from the field, for example, the increasing need to develop a clearer definition of FSPs.²

² As plans were submitted it became clear that not all counties held the same view of what constituted an FSP. Plan reviewers raised questions about program models which seemed either too richly or too leanly funded, but in general the reviews demonstrated flexibility in program structure for the FSPs. As implementation has proceeded increasing questions about FSP structure have arisen particularly with regard to service intensity, and the meaning of “whatever it takes”. The County Case Study report will discuss this issue in more detail

Plan Reviews

Future plan reviews should continue the basic orientation and structure of those conducted for the CSS component.

As noted in the report, not everyone was pleased with the plan review process—some wanted a more stringent review and some less attention to detail. But, on the whole, the process was perceived as collegial, educational, and useful for both county and state stakeholders. The process was time- and resource-intensive but generally left participants feeling good about the endeavor. Replicating a similar process for future MHSA components may be more challenging, since it will need to incorporate more formally other stakeholder input and expertise.³

Some changes to the review mechanisms would make the process even better.

The state conducted a training for plan reviewers which was generally viewed as useful but not sufficient. Some consumer and family members said

³ A representative from the OAC participated in the plan reviews, but the OAC also conducted their own separate review of the county CSS plans. The OAC has a more clearly articulated role in the review and approval of the Prevention and Early Intervention component and the Innovation funds.

that more experience with the plan review tool in the training would have been useful, as it took a couple of reviews before they were comfortable with the process and felt they could participate as active members of the team. Some people on the review teams indicated there was not enough training or emphasis during the reviews on the cultural competence part of the plans.

Future review tools should not only assess whether plans address the technical requirements, but also whether counties are understanding and meeting the “spirit” of the MHSA. In general, most participants agreed that the review tool did not allow a full assessment of whether county plans reflected an understanding of and commitment to the key concepts of transformation, recovery/resiliency, and cultural competence. In the future, plan review tools should include a place to comment on overall strengths and weaknesses, with examples to help counties identify areas in which they could strengthen their plans.

Implementation Issues

DMH and counties will need to work together to integrate new CSS programs and services in such a way as to transform existing mental health systems.

MHSA funds represent about a 15 percent increase over the base level of funding, which many fear is not enough to create the kinds of changes which have been articulated, particularly with base mental health budgets being cut in many counties. The challenge will be whether new CSS programs and services motivate and initiate positive change in the balance of the mental health system or become instead silos of richly resourced services amidst a generally impoverished system.

In addition, some stakeholders worry that some county mental health programs and systems are not sufficiently grounded in a substantive understanding of the recovery/resiliency vision articulated in the Act and the CSS planning documents. Without sufficient training and support, this cornerstone to transformation may meet with limited understanding at the operational level, making the actual process of overall system change even more difficult.

DMH, in cooperation with other stakeholders, needs to create an accountability system that will assess progress towards the goals of CSS and the whole MHSA.

One of the stated intents in the MHSA is “to ensure that funds are expended in the most cost-effective manner and services are provided in accordance with recommended best practices, subject to local and state oversight to ensure accountability to taxpayers and the public.” Many stakeholders spoke to the state’s need to create an accountability system that will assure stakeholders and the public that counties are spending MHSA funds and delivering services as they indicated in their CSS plans, that they are truly changing their systems, and that they are achieving positive outcomes for individuals and families.

ENDNOTES

¹The following are the basic characteristics of respondents to the Web-based survey. Although the use of a Web-based method for this survey may have reduced participation of some groups, the low percentages of younger adults and ethnic groups other than Caucasian are more likely reflective of the overall under-representation of these groups in the planning process.

Consumers	18%
Family members	32%
Age	
16-25	1%
26-40	10%
41-59	68%
Over 60	21%
Ethnicity	
African American	4%
Latino	9%
Caucasian	75%
Asian or Pacific islander	4%
Native American	3%
Other	6%
Do you work in or represent a (could answer more than one so total >100%)	
Mental health program	62%
County MH management or administration	33%
State or county association	33%
State department or agency	11%
Non-mental health program or organization	20%

APPENDIX A

Survey About State-Level Community Services and Supports (CSS) Planning Process

1. How effective overall do you think the STATE-LEVEL planning process was for the Community Services and Supports (CSS) portion of the MHSA?

- Extremely effective
- Very effective
- Moderately effective
- Minimally effective
- Not effective

2. How would you rate the overall timing and scheduling of the STATE-LEVEL CSS planning process?

- Much too fast
- Somewhat too fast
- About right
- Somewhat too slow
- Much too slow

3. How would you rate the AMOUNT of involvement in the STATE-LEVEL planning process of the following constituencies:

	1=Too much	2=The right amount	3=Too little
Consumers	1	2	3
Family members	1	2	3
Transitional-age youth	1	2	3
Older adults	1	2	3
Ethnic groups	1	2	3

4. How would you rate the overall EFFECTIVENESS of the involvement in the planning process of the following constituencies:

	1=Very effective	2=Moderately effective	3=Not very effective
Consumers	1	2	3
Family members	1	2	3
Transitional-age youth	1	2	3
Older adults	1	2	3
Ethnic groups	1	2	3

5. What is your view of the county plan requirements that resulted from the planning process? Were they:

- Much too rigid
- Somewhat too rigid
- About right
- Somewhat too flexible
- Much too flexible

6. What is your view of the process by which the state has reviewed the county plans?

	1=Yes	2=No	3=Don't know
Have the reviews been timely?	1	2	3
Have the reviews been thorough?	1	2	3
Have the reviews included good representation of all constituencies affected by the plan?	1	2	3

7. What was the best part about the STATE-LEVEL planning process?

8. What would make the STATE-LEVEL planning process more effective?

9. How much impact do you think the CSS component of the MHSA will have on the following parts of California's mental health system?

	1=A great deal	2=Some	3=Very little
Making the system more recovery/resilience-oriented?	1	2	3
Reducing ethnic disparities in access to services?	1	2	3
Making services more culturally competent?	1	2	3
Increasing consumer involvement?	1	2	3
Increasing parent/caregiver involvement?	1	2	3
Improving mental health's coordination with other organizations and agencies?	1	2	3

10. How involved were you in the STATE-LEVEL planning process?

- Extremely involved
- Very involved
- Somewhat involved
- Only a little involved
- Not involved

11. The STATE-LEVEL planning process for the CSS part of MHSA was very extensive. Do you think the future planning for the other components of the MHSA should be as extensive?

- YES
- NO

Additional comment:

12. It would help us to better understand how the planning process went if we could know a little about you. SKIP ANY OF THE FOLLOWING QUESTIONS WHICH YOU PREFER NOT TO ANSWER.

	1=Yes	2=No
Do you work in a mental health program?	1	2
Do you work in county mental health administration or management?	1	2
Do you represent a state of county association?	1	2
Do you work for a state department or agency?	1	2
Do you work in a non-mental health program or organization?	1	2
Are you a consumer of public mental health services?	1	2
Are you a family member or caregiver of a consumer of public mental health services?	1	2

13. What is your age?

- 16–25
- 26–40
- 41–59
- Over 60

14. What is your ethnicity?

- African American
- Latino
- Caucasian
- Asian or Pacific Islander
- Native American
- Other, please specify

15. What else would you like us to know about how you think the STATE-LEVEL planning and early implementation of the CSS part of MHSA is going?

APPENDIX B

Stakeholder Organizations and Individuals

Interviewed Stakeholder Organizations and Individuals

California Alliance of Child and Family Services	Carroll Schroeder
California Association of Social Rehabilitation Agencies.....	Betty Dahlquist
California Council of Community Mental Health Agencies	Rusty Selix
California Department of Alcohol and Drug Programs.....	Carmen Delgado
California Department of Education	Linda Rivera
California Hispanic Commission on Alcohol and Drug Abuse.....	James Hernandez
California Hospital Association.....	Sheree Kruckenberg
California Network of Mental Health Clients	Sally Zinman
California Mental Health Association	Rusty Selix
California Mental Health Directors Association.....	Pat Ryan
California Mental Health Planning Council.....	Sandy Lyon
California Primary Care Association.....	Nora O'Brien
California Protection and Advocacy Inc. CA	Dan Brozvic
California Psychiatric Association	Randall Hagar
California Rural Health Policy Council	Kathleen Maestas
California Rural Indian Health Board	Mark Lebeau
California State Sheriffs Association	Steve Szaley
California United Advocates for Children	Pam Hawkins
California Youth Connection	Tiffany Johnson
Center for Aging Resources.....	Cynthia Jackson
Corporation for Supportive Housing	Carol Wilkins
NAMI California.....	Ralph Nelson
Pacific Clinics.....	Gladys Lee
San Diego Sheriff's Office	Ann Suzaki Madigan
Service Employees International Union—California State Council	Lisa Chin

Other Informed Public Stakeholders

- Jerry Doyle
- Richard Van Horn

California Department of Mental Health

- Steve Mayberg
- Carol Hood
- Rachel Guerro
- Michael Borunda
- Dave Nielsen
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Pacific Health Consulting Group

- Bobbi Wunsch, Planning Process Consultant

From Plan Review Teams

- Six consumers and family members
- Two cultural competence experts

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