OVERVIEW REPORT OF THE 2023 DATA NOTEBOOK PROJECT ON CALIFORNIA BEHAVIORAL HEALTH: STAKEHOLDER ENGAGEMENT IN THE PUBLIC MENTAL HEALTH SYSTEM

California Behavioral Health Planning Council

ADVOCACY • EVALUATION • INCLUSION

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The California Behavioral Health Planning Council (Council) is under federal and state mandate to advocate on behalf of adults with severe mental illness and children with severe emotional disturbance and their families. The Council is also statutorily required

to advise the Legislature on behavioral health issues, policies, and priorities in California. The Council advocates for an accountable system of seamless, responsive services that are strength-based, consumer and family member driven, recovery oriented, culturally, and linguistically responsive and cost effective. Council recommendations promote cross-system collaboration to address the issues of access and effective treatment for the recovery, resilience, and wellness of Californians living with severe mental illness.

Acknowledgements: The 2022 Data Notebook and the Overview Report were developed with the assistance of the Performance Outcomes Committee 2023 – 2024.

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Acknowledgements

We greatly appreciate the local behavioral health boards and commissions and their Departments of Behavioral Health who participated in the preparation and discussion of their 2023 Data Notebook reports (listed below).

Counties That Submitted 2023 Data Notebooks

Reports Received: 51 Data Notebooks (represent 51 Counties + 1 other DN)[1,2]

Small Population[3] Counties (26 reports for 27 counties + 1 report from other MHB)

Alpine, Amador, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Imperial, Inyo, Kings, Lassen, Madera, Mariposa, Mendocino, Modoc, Mono, Napa, Nevada, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter-Yuba, Tuolumne, and one from Tri-City MH Board (a sub-region of LA county).

Medium-sized Population Counties (12 counties)

Butte, Marin, Monterey, Placer, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Sonoma, Stanislaus, Tulare, Yolo

Large and Extra-Large Population Counties (13 counties)

Alameda, Contra Costa, Fresno, Kern, Los Angeles, Orange, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, Santa Clara, and Ventura

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[1] 2023 Data Notebook Summary Notes: These 52 reporting county and Tri-City Behavioral Health Boards represented **98% of the 58 total counties**, and comprised **91.2% of the population** of California in 2023. Sutter and Yuba Counties submitted a joint Data Notebook covering both counties.

[2] Missing data: seven counties did not submit Data Notebook reports for 2023, including: Humboldt, Lake, Merced, Riverside, Solano, Tehama, Trinity.

[3] Numbers for county and statewide population as of July 1, 2023 were taken from the California Department of Finance, www.dof.ca.gov, per their E-1 and E-2 population reports.

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CBHPC 2023 Data Notebook: Introduction

Purpose and Goals

The Data Notebook is a structured format to review information and report on aspects of each county's behavioral health services. A different part of the public behavioral health system is addressed each year, because the overall system is very large and complex. This system includes both mental health and substance use treatment services designed for individuals across the lifespan.

Local behavioral health boards/commissions are required to review performance outcomes data for their county and to report their findings to the California Behavioral Health Planning Council (Planning Council). To provide structure for the report and to make the reporting easier, each year a Data Notebook is created for local behavioral health boards to complete and submit to the Planning Council. Discussion questions seek input from local boards and their departments. These responses are analyzed by Planning Council staff to create annual reports to inform policy makers and the public.

The Data Notebook structure and questions are designed to meet important goals:

- To help local boards meet their legal mandates[4] to review and comment on their county's performance outcome data, and to communicate their findings to the Planning Council,
- To serve as an educational resource on behavioral health data,
- To obtain opinion and thoughts of local board members on specific topics, and
- To identify unmet needs and make recommendations.

In 2019, we developed a section (Part I) with standard questions that are addressed each year to help us detect any trends in critical areas affecting our most vulnerable populations. These include foster youth, homeless individuals, and those with serious mental illness (SMI) who need housing in adult residential facilities (ARFs) and some other settings. These questions assist in the identification of unmet needs or gaps in services that may occur due to changes in population, resources, or public policy.

What's New This Year?

The topic selected for the 2023 Data Notebook is stakeholder engagement. The Planning Council has long supported upholding the principles of the Mental Health Services Act (MHSA) and encourages consumer and family member participation in the

[4] W.I.C. 5604.2, regarding mandated reporting roles of MH Boards and Commissions in California.

stakeholder process for behavioral health services through the Community Program Planning (CPP) process, as well as other stakeholder engagement activities.

How the Data Notebook Project Helps You

Understanding data empowers individuals and groups in their advocacy. The Planning Council encourages all members of local behavioral health boards/commissions to participate in developing the responses for the Data Notebook. This is an opportunity for local boards and their county behavioral health departments to work together to identify important issues in their community. This work informs county and state leadership about local behavioral health (BH) programs, needs, and services. Some local boards use their Data Notebook in their annual report to the County Board of Supervisors.

In addition, the Planning Council will provide our annual 'Overview Report', which is a compilation of information from all of the local behavioral health boards/commissions who completed their Data Notebooks. These reports feature prominently on the website[5] of the California Association of Local Mental Health Boards and Commissions. The Planning Council uses this information in their advocacy to the legislature, and to provide input to the state mental health block grant application to SAMHSA[6].

Example of Statewide Data for Specialty Mental Health and Access Rates

Tables 1-A and 1-B on the next two pages show typical data and demographics for California recipients of Specialty Mental Health Services (SMHS) for fiscal year (FY) 2021-2022. These are the most recent data available at the time this document was prepared. SMHS are intended for adults with serious mental illness (SMI) and for children with serious emotional disorders (SED). The category of 'certified eligibles' means those persons (also called beneficiaries) who are eligible and approved to receive Medi-Cal benefits for health care.

These metrics are from datasets developed in accordance with California Welfare and Institutions code § 14707.7 (added as part of Assembly Bill 470 on 10/7/17). Due to recent changes in how AB 470 data is presented by DHCS in the Behavioral Health Demographic Dashboard[7], demographic metrics presented are not exact, as the dashboard rounds them to the nearest 0.1 thousand (k) or million (M).

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[5] See the annual Overview Reports on the Data Notebook posted at the California Association of Local Mental Health Boards and Commissions, https://www.CALBHBC.org.

[6] SAMHSA: Substance Abuse and Mental Health Services Administration, an agency of the Department of Health and Human Services in the U.S. federal government. For reports, see www.SAMHSA.gov.

[7] AB 470 Mental Health Services Demographics Dashboards, published by California Department of Health Care Services (DHCS) at: https://behavioralhealth-data.dhcs.ca.gov/

Table 1-A. California Children and Youth: Access Rates for Specialty Mental Health Services,[8] Fiscal Year 2021-22.

Age	Number of Clients with MH Visits	Certified Eligibles	Rate
Children 0-2	6.8k	740.9k	0.9%
Children 3-5	15.9k	802.6k	2.0%
Children 6-11	68.5k	1.7m	4.0%
Children 12-17	119.2k	1.8m	6.7%
Youth 18-20	35.1k	79.1k	4.4%

Ethnicity	Number of Clients with MH Visits	Certified Eligibles	Rate
Alaskan Native or American Indian	1k	12.3k	5.5%
Asian or Pacific Islander	7.4k	359.6k	2.0%
Black	23.7k	378.7k	6.3%
Hispanic	146.3k	3.3M	4.4%
Other	12.8k	445.5k	2.9%
Unknown	128.k	548.5k	2.5%
White	40.6k	750.3k	5.4%

Gender	Number of Clients with MH Visits	Certified Eligibles	Rate
Female	130.1k	2.8M	4.6%
Male	114.4k	3M	3.9%

Overall Data	Number of Clients with MH Visits	Certified Eligibles	Rate
Totals and Average Rates	244.5k	5.8M	4.3%

Notes: The first column lists the demographic groups of interest. The next column shows the number of clients who received one or more services described as Specialty Mental Health Visits. The next column, labeled 'Certified Eligibles', is the number of clients who were both eligible and approved to receive health care paid by Medi-Cal.

[8] In contrast, non-specialty Mental Health Services (i.e., Managed Care (MC), Fee-for-Service (FFS), etc.), services are generally designed for people with mild-to-moderate mental health needs.

The last column of numbers shows the service penetration rates, which are taken as one measure of Access. They are calculated by dividing the total number of Clients with MH visits by the total number of Medi-Cal Eligibles, then multiply by 100 to express the result as a percentage. This percentage is taken as the "Access Rate."

Table 1-B. California Adults and Older Adults, Access Rates for Specialty Mental Health Services, Fiscal Year 2021-22.[9]

Age	Number of Clients with MH Visits	Certified Eligibles	Rate
Adults 21-32	102.2k	2.8M	3.6%
Adults 33-44	88.2k	2.3M	3.9%
Adults 45-56	71.5k	1.7M	4.1%
Adults 57-68	6.5k	1.6M	4.1%
Adults 69+	14.6k	1.1M	1.30%

Ethnicity	Number of Clients with MH Visits	Certified Eligibles	Rate
Alaskan Native or American Indian	2.1k	38.8k	5.5%
Asian or Pacific Islander	19.4k	1.1M	1.8%
Black	50.3k	706.3k	7.1%
Hispanic	103.9k	4.1M	2.5%
Other	36.9k	977.8k	3.8%
Unknown	29.8k	684.6k	4.4%
White	99.1k	1.9M	5.1%

Gender	Number of Clients with MH Visits	Certified Eligibles	Rate
Female	177.3k	5.3M	3.3%
Male	164.2k	4.2M	3.9%

Overall Data	Number of Clients with MH Visits	Certified Eligibles	Rate
Totals and Access Rates	341.5k	9.5M	3.6%

[9] For comparison, the population of the state of California was **39,538,223** on April 1, 2020, and by April 1, 2021, it had declined somewhat to 39,029,342 according to the U.S. Census Bureau. https://www.census.gov/quickfacts/CA. Of those residents, 24.3% of Californians were adults (age 21 and above) receiving Med-Cal benefits. Also, 14.9 % of Californians were children or youth ≤ 20 who received Medi-Cal benefits. The data show that 39.2 % of all Californians across all age groups were eligible to receive medical care paid by Medi-Cal in FY 2021-22.

Notes: Data for Adults and Older Adults were calculated similarly to the data for Children and Youth in Figure 1-A. For example, out of all Adult 9.5M Medi-Cal eligibles, a total of 341.5k individuals, i.e., 3.6% received Specialty Mental Health Services (SMHS).

CBHPC 2023 Data Notebook – Part I:

Standard Yearly Data and Questions for Counties and Local Boards

In recent years, changes in data availability permit local boards and other stakeholders to consult some Medi-Cal data online that is provided by the Department of Health Care Services (DHCS). These data include populations that receive Specialty Mental Health Services (SMHS) and substance use disorder (SUD) treatment. Standard data are analyzed each year to evaluate the quality of county programs and those reports can be found at www.CalEQRO.com. Additionally, Mental Health Services Act (MHSA) data are found in the 'MHSA Transparency Tool' presented on the Mental Health Services Oversight and Accountability Commission (MHSOAC) website.[10]

The Planning Council wanted to examine some county-level data that are not readily available online and for which there are no other public resources. The Council asked the Behavioral Health Boards to answer the following questions using information for fiscal year (FY) 2022-2023 or the most recent fiscal year for which data were available. Not all counties would have readily available data for some of the questions asked below. In that case, they were requested to enter N/A for 'data not available.' Thus the "N" for number of counties responding varied slightly for some questions. We acknowledge and appreciate the necessary time and effort provided by local boards and their behavioral health departments to collect and discuss these data.

Adult Residential Care

There is little public data available about who is residing in licensed facilities listed on the website of the Community Care Licensing Division[11] at the CA Department of Social Services. This lack of data makes it difficult to know how many of the licensed Adult Residential Facilities (ARFs) operate with services to meet the needs of adults with chronic and/or serious mental illness (SMI), compared to other adults who have physical or developmental disabilities. In 2020, legislation was signed that requires collection of data from licensed operators about how many residents have SMI and whether these facilities have services to support client recovery or transition to other housing. The response rate from facility operators does not provide an accurate picture for our work.

The Planning Council wanted to understand what types of data are currently available at the county level regarding the continuum of care represented by ARFs and Institutions

[10] www.mhsoac.ca.gov, see MHSA Transparency Tool, under 'Data and Reports'
[11] Link to Licensed Care directory at California Department of Social Services. https://www.ccld.dss.ca.gov/carefacilitysearch/

for Mental Diseases (IMDs)[12] available to serve individuals with SMI. Also, how many of these individuals (for whom the county has financial responsibility) are served in facilities such as ARFs or IMDs? 'Bed day' is defined as an occupancy or treatment slot for one person for one day. One major difference is that IMDs offer mental health treatment services in a psychiatric hospital or certain types of skilled nursing home facilities. In contrast, a non-psychiatric facility such as an ARF is a residential facility that may provide social support services like case management but not psychiatric services.

Next, the following material presents summarized advisory board responses to the major questions which were presented in Part I of the 2023 Data Notebook.

Questions and Responses:

1. Please identify your County / Local Board or Commission.

The responses to this question define our data set. We received 51 Data Notebooks, representing 50 counties and Tri-Cities Behavioral Health Board.[13,14]

- **Small Population[15] Counties** (26 reports for 27 counties + 1 report from other Mental Health Board)

  Alpine, Amador, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Imperial, Inyo, Kings, Lassen, Madera, Mariposa, Mendocino, Modoc, Mono, Napa, Nevada, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter-Yuba, Tuolumne, and one from Tri-City MH Board (a sub-region of Los Angeles County).

- **Medium-sized Population Counties** (12 Counties)

  Butte, Marin, Monterey, Placer, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Sonoma, Stanislaus, Tulare, Yolo

- **Large and Extra-Large Population Counties** (13 Counties)

  Alameda, Contra Costa, Fresno, Kern, Los Angeles, Orange, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, Santa Clara, and Ventura.

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[12] Institution for Mental Diseases (IMD) List: https://www.dhcs.ca.gov/services/MH/Pages/IMD-List.aspx

[13] 2023 Data Notebook Summary Notes: These 52 reporting county and Tri-City Behavioral Health Boards represented **98% of the 58 total counties**, and comprised **91.2% of the population** of California in 2023. Sutter and Yuba Counties submitted a joint Data Notebook covering both counties.

[14] Missing data: seven counties did not submit Data Notebook reports for 2023, including: Humboldt, Lake, Merced, Riverside, Solano, Tehama, Trinity.

[15] Numbers for county and statewide population as of July 1, 2023 were taken from the California Department of Finance, www.dof.ca.gov, per their E-1 and E-2 population reports.

2. For how many individuals did your county behavioral health department pay some or all of the costs to reside in a licensed Adult Residential Care Facility (ARF), during the last fiscal year?

The total reported by 44 of the 50 reporting counties was 8,048 individuals served in an ARF. The remaining 6 small population counties plus the Tri-City agency reported zero persons were served in an ARF.

3. What is the total number of ARF bed-days paid for these individuals, during the last fiscal year?

A total of 1,721,120 ARF bed-days were paid for by 45 of the 50 responding counties. Zero bed-days were reported by 5 responding counties. One small county had reported zero persons, but stated they paid for 2,105 ARF bed-days.

4. Unmet needs: how many persons served by your county behavioral health department need this type of housing but currently do not live in an ARF?

The summed total from the 37 responding counties was 1,429 persons were known to need an ARF. And 14 counties said that they had no data available.

5. Does your county have any 'Institutions for Mental Disease' (IMD)?

a. No: 30 counties (59% of the responding boards/counties, including the Tri-City board in L.A. County).
b. Yes: 21 counties (41% of the reporting counties).
If 'Yes', how many IMDs? These 21 counties reported 59 IMDs.

6. For how many individual clients did your county behavioral health department pay the costs for an IMD stay (either in or out of your county), during the last fiscal year?

In-county: 13,528 in-county IMD clients were served in those 21 counties reporting that they have at least one IMD within their county.

Out-of-county: 7,222 patients were served by IMDs outside of their county.

Total IMD clients reported by the 51 counties/boards: 20,750 clients.

7. What is the total number of IMD bed-days paid for these individuals by your county behavioral health department during the same time period?

A total of 1,531,500 IMD bed-days were paid for during the last fiscal year by the 49 responding counties and 1 agency (Tri-Cities BH). This resulted in an average length of stay of 73.8 bed-days per client.

Homelessness: Programs and Services in California Counties

The Planning Council has a long history of advocacy for individuals with SMI who are homeless, or who are at-risk of becoming homeless. California's recent natural disasters and public health emergency have exacerbated the affordable housing crisis and homelessness. Federal funding was provided to states that could be used for temporary housing for individuals living on the streets as a method to stop the spread of the COVID-19 virus. Additional policy changes were made to mitigate the rate of evictions for persons who became unemployed as a result of the public health crisis.

Studies indicate that only one in three individuals who are homeless also have serious mental illness and/or a substance use disorder. The Planning Council does not endorse the idea that homelessness is caused by mental illness, nor that the public BH system is responsible to fix homelessness, financially or otherwise. However, we do know that recovery happens best when an individual has a safe, stable place to live.

The issue of homelessness is very complex and involves multiple systems and layers of interaction. Therefore, the Council will continue to track and report on the programs and supports offered by counties to assist homeless individuals who have SMI and/or SUD. Causes and contributory factors are complex, and thus our solutions will need to address numerous multidimensional and multi-systemic challenges.

Every year, the states, counties, and many cities perform a "Point-in-Time" count[16] of the homeless individuals in their counties, usually on a specific date in January. Such data are key to state and federal policy and funding decisions. The pandemic disrupted both the methods and the regular schedule for the count in 2021, during which there was no data collected for California's unsheltered population due to Covid-19 protocols. Those preliminary data were taken down subsequently by HUD for further review before re-posting. Therefore, the "percent increase" column for this table compares the 2022 totals with the totals for 2020, for which there was a complete data set.

[16] Link to data for yearly Point-in-Time Count:
https://files.hudexchange.info/reports/published/CoC_PopSub_NatlTerrDC_2022.pdf

Table 3: California Estimates of Homeless Individuals Point in Time[17] Count, 2022

Summary of Homeless individuals	SHELTERED	UNSHELTERED	TOTAL 2022	Percent Increase over 2020
Persons in households without children	34,545	110,888	145,433	7.7%
Persons in households with children	21,253	4,285	25,538	-0.9%
Unaccompanied homeless youth	2,828	6,762	9,590	-21.2%
Veterans	3,003	7,392	10,395	-8.8%
Chronically homeless individuals	15,773	45,132	60,905	17.6%
Total (2022) Homeless Persons in CA	56,030	115,491	171,521	6.2%
Total (2022) Homeless Persons, USA	348,630	233,832	582,462	0.3%

[17] PIT Count = yearly January Point-in-Time Count of Homeless Individuals, conducted according to the guidance of the U.S. Department of Housing and Urban Development (www.HUD.gov). Sheltered persons include those in homeless shelters and various types of transitional or emergency housing.

Questions, continued:

8. During fiscal year 2022-2023, what new programs were implemented, or existing programs were expanded, in your county to serve persons who are both homeless and have severe mental illness? (Select all that apply.)

a. Emergency Shelter
b. Temporary Housing
c. Transitional Housing
d. Housing/Motel Vouchers
e. Supportive Housing
f. Safe Parking Lots
g. Rapid Re-Housing
h. Adult Residential Care Patch/Subsidy
i. Other (*Please specify).*

The overall responses from 50 counties and/or their boards are summarized below.

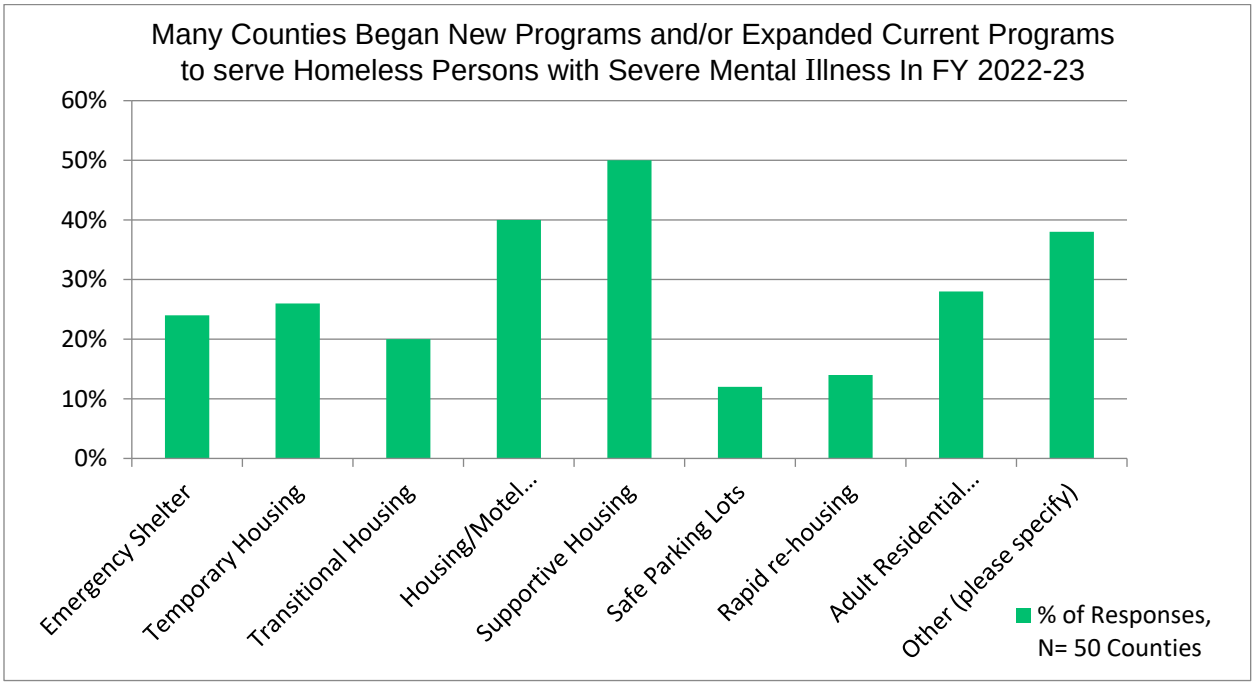


Figure 1. Many county departments of behavioral health, often in partnership with other departments or agencies, initiated new services or programs or expanded existing services for homeless persons with severe mental illness in FY 2022-23. The vertical bars represent the percent of responses received from 50 counties. The most frequent responses were increases in housing/motel vouchers and supportive housing, followed by 'other'. A variety of additional responses for 'other' were presented.

Child Welfare Services: Foster Children in Certain Types of Congregate Care

In California, about 60,000 children under the age of 18 are in foster care. They were removed from their homes because county child welfare departments, in conjunction with juvenile dependency courts, determined that these children could not live safely with their caregiver(s). Most children are placed with a family who receive foster children, but a small number of the children need a higher level of care and are placed in a setting with more sophisticated services.

California is striving to move away from facilities formerly known as long-term group homes, and prefers to place all youth in family settings, if possible. Regulations have revised the treatment facilities for children whose needs cannot be met safely in a family setting. The new facility type is called a Short-Term Residential Treatment Program (STRTP). These STRTPs are designed to provide short-term placement that includes intensive behavioral health services.

All of California's counties are working toward closing long-term group homes and are establishing licensed STRTPs. This transition will take time and it is important for your board to talk with your county director about what is happening in your county for children in foster care who are not yet able to be placed in a family setting, or who are in a family setting and experience a crisis that requires short-term intensive treatment.

Some counties do not yet have STRTPs and may place children/youth in another county or even out-of-state. Recent legislation (AB 1299) directs that the Medi-Cal eligibility of the child be transferred to the receiving county. This means, the county receiving the child now becomes financially responsible for his/her Medi-Cal costs.

Examples of the foster care CDSS data for Q4, 2020, in California:

- Total foster youth and children: 53,180
- Total placed in an STRTP: 2,444 (or 4.6% of foster youth)
- Total STRTP placed out-of-county: 1174 (or 2.2% of foster youth)
- Total STRTP placed out-of-state: 66 (or 0.12 % of foster youth)

Questions (continued):

9. Do you think your county is doing enough to serve the foster children and youth in group care?

Yes: 25 counties 49 %.

No. 26 counties 51%.

If 'No', what is your recommendation? Twenty-six Behavioral Health Boards responded, either in brief or more expansively, as listed in the data in Appendix 1, at the end of this report.

10. Has your county received any children needing "group home" level of care from another county?

No: 21 counties/boards 41%.

Yes: 30 counties 59%.

If ‘Yes’, how many? Total: 1,066 foster youth were transferred into these 30 counties.

11. Has your county placed any children needing “group home” level of care into another county? (Note: includes out of state transfers).

No: 8 counties/boards 16%

Yes: 43 counties 84%

If ‘Yes’, how many? Total: 1,366 foster youth were transferred out of these 43 counties.

CBHPC 2023 Data Notebook – Part II:

Stakeholder Engagement in the Public Mental Health System

Context and Background

The focus topic selected for the 2023 Data Notebook is “stakeholder engagement.” Stakeholder engagement is the active involvement of individuals or groups with a vested interest in the mental health system. These stakeholders include consumers of mental health services, their families, mental health professionals, government agencies, community organizations, advocacy groups, and policymakers. Engaging these stakeholders fosters a participatory approach, giving voice to diverse perspectives and enabling collective decision-making. Stakeholder engagement is integral to the implementation of the Mental Health Services Act (MHSA) in California. By involving a wide range of voices, the MHSA can develop and deliver programs and services that are responsive to community needs, ultimately improving mental health outcomes and well-being in California.

Stakeholder engagement offers numerous benefits in the context of mental health. Firstly, it enhances service delivery by allowing the mental health system to address the specific needs and preferences of individuals with mental health conditions. Through collaborative decision-making, services can be designed to be more accessible, culturally sensitive, and person-centered, ultimately leading to improved outcomes.

Secondly, stakeholder engagement empowers the community by providing opportunities for active participation and involvement in the development of mental health policies and programs. By valuing the perspectives of diverse stakeholders, the system becomes more responsive to the concerns, priorities, and aspirations of the community it serves. This active involvement fosters a sense of ownership and empowerment among community members, enabling them to contribute to shaping the mental health services available to them.

Thirdly, this interaction plays a crucial role in ensuring accountability within the mental health system. By involving stakeholders, a system of checks and balances is created, promoting transparency and holding the system accountable for its actions and outcomes. This involvement helps to guarantee that resources are allocated effectively and efficiently, maximizing their impact and addressing any potential issues or discrepancies that may arise.

Overall, stakeholder engagement in mental health has far-reaching benefits. It leads to improved service delivery that is tailored to individual needs, empowers the community by involving them in decision-making processes, and ensures accountability and transparency within the mental health system. By actively engaging stakeholders, mental health organizations can create a more inclusive and effective system that ultimately improves the well-being of individuals experiencing mental health conditions.

Challenges and Barriers

The effective engagement of stakeholders in the California public mental health system faces several barriers and challenges. One of the primary challenges is ensuring diverse representation among stakeholders. Overcoming language barriers, cultural differences, and limited outreach resources is crucial to capture a wide range of perspectives. Inadequate funding and staffing also pose significant challenges, hindering the capacity to hold regular meetings, conduct outreach efforts, and provide necessary support to stakeholders.

Some other potential barriers include:

- Stigma and discrimination surrounding mental health create additional obstacles to stakeholder engagement. Addressing stigma requires targeted educational campaigns, anti-stigma initiatives, and the creation of safe spaces that foster open dialogue and inclusivity.
- Power imbalances among stakeholders can also impede effective engagement. Achieving equitable representation and providing mechanisms to address power differentials are essential to foster an inclusive and democratic stakeholder engagement process.
- The complexity and fragmentation of the California public mental health system further present challenges. Effective communication strategies, standardized protocols, and clear channels of collaboration are necessary to engage stakeholders from different sectors and align their efforts.
- Limited accessibility poses another barrier to meaningful stakeholder engagement. Proactive measures such as providing accommodations, utilizing virtual platforms for remote participation, and ensuring inclusive physical spaces are essential to address accessibility barriers.
- Stakeholder engagement processes can be time-consuming and may lead to engagement fatigue over time. Balancing the need for sustained engagement with stakeholders' limited time and competing priorities requires clear goals, efficient processes, and recognition of stakeholders' contributions to maintain their interest and involvement.

Overcoming these barriers and challenges necessitates a comprehensive approach. By addressing these challenges, the California public mental health system can cultivate inclusive, responsive, and impactful mental health policies and programs.

Key Stakeholders

In the public mental health system, various stakeholders play vital roles in shaping policies, programs, and services. The California Code of Regulations provides the following definition of “stakeholders” within the public mental health system:

> **Cal. Code Regs. Tit. 9, § 3200.270 - Stakeholders**

> "Stakeholders" means individuals or entities with an interest in mental health services in the State of California, including but not limited to: individuals with serious mental illness and/or serious emotional disturbance and/or their families; providers of mental health and/or related services such as physical health care and/or social services; educators and/or representatives of education; representatives of law enforcement; and any other organization that represents the interests of individuals with serious mental illness/ and/or serious emotional disturbance and/or their families.

Additionally, California Welfare and Institutions Code provides a list of stakeholders for the Community Program Planning (CPP) Process:

> **California Code, Welfare and Institutions Code - WIC § 5848 (a)**
> Each three-year program and expenditure plan and update shall be developed with local stakeholders, including 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. Counties shall demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation, and budget allocations.

Using these sources, we can identify key stakeholder groups for engagement. Here is a more detailed list of these key stakeholders:

Adults and Seniors with severe mental illness SMI: This group represents individuals who are directly impacted by mental health conditions. Their perspectives and experiences are essential in understanding the unique challenges they face and in developing services that meet their specific needs. Engaging adults and seniors with SMI ensures their voices are heard and helps tailor interventions to improve their overall well-being and recovery.

Families of children, adults, and seniors with SMI: Family members are crucial stakeholders as they provide support, care, and advocacy for their loved ones with mental illness. Their insights offer a valuable perspective on the challenges faced by individuals with SMI and the impact on the family unit. Involving families in decision-making processes helps ensure that services are holistic, family-centered, and responsive to the needs of both the individual and their support network.

Providers of Mental Health and/or Related Services: Mental health professionals, including psychiatrists, psychologists, counselors, and social workers, are instrumental in delivering quality care and support. Their expertise and frontline experience provide valuable input on service gaps, best practices, and areas for improvement within the mental health system. Engaging with mental health providers ensures that policies and

programs are evidence-based, align with professional standards, and promote quality outcomes.

Law Enforcement Agencies: Law enforcement agencies often come into contact with individuals experiencing mental health crises. Their involvement in stakeholder engagement facilitates collaboration between mental health services and law enforcement, aiming to improve crisis intervention and diversion programs. This partnership can enhance community safety, reduce unnecessary arrests and incarcerations, and facilitate appropriate referrals to mental health services.

Educators and/or Representatives of Education: Educators play a significant role in identifying and supporting students with mental health needs. Their involvement as stakeholders contributes to the development of early intervention strategies, mental health promotion programs, and the implementation of appropriate supports within educational settings. Collaborating with educators helps create a nurturing environment that supports the academic, social, and emotional well-being of students.

Social Services Agencies: Social services agencies, such as those involved in housing, employment, and welfare, intersect with the mental health system. Their participation in stakeholder engagement ensures coordination and integration of services, addressing the complex needs of individuals with mental health conditions holistically. Collaboration with social services agencies supports efforts to provide stable housing, employment opportunities, and social support networks to promote recovery and community integration.

Veterans: Veterans, particularly those who have served in combat or experienced traumatic events, often face mental health challenges such as post-traumatic stress disorder (PTSD) and depression. Engaging veterans as stakeholders enables the mental health system to address their unique needs and develop specialized programs tailored to their experiences. This collaboration ensures that mental health services for veterans are comprehensive, accessible, and culturally sensitive.

Representatives from Veterans Organizations: Representatives from veterans' organizations, such as advocacy groups or support networks, provide a platform for veterans' voices and perspectives to be heard. Their involvement in stakeholder engagement fosters collaboration and helps shape policies, programs, and services that meet the specific needs of veterans.

Providers of Alcohol and Drug Services: Substance use disorders frequently co-occur with mental health conditions, requiring integrated care approaches. Engaging providers of alcohol and drug services as stakeholders promotes collaboration between mental health and addiction treatment providers. This collaboration ensures a comprehensive approach to addressing the complex needs of individuals with co-occurring disorders, facilitating recovery and reducing barriers to treatment.

Health Care Organizations: Health care organizations, including hospitals, clinics, and primary care providers, are essential stakeholders in the mental health system.

Collaboration with these organizations helps integrate mental health care into primary care settings, reduce stigma, and improve access to services. Involving health care organizations enhances the coordination of care and strengthens the overall continuum of mental health support.

Other important Interests: The mental health system involves numerous other stakeholders, such as policymakers, researchers, community leaders, advocacy groups, and philanthropic organizations. Each brings unique perspectives, expertise, and resources to the table. Their involvement in stakeholder engagement ensures that policies and programs are informed by evidence, responsive to community needs, and adequately resourced.

By engaging and involving these diverse stakeholders, the public mental health system can benefit from a comprehensive range of insights, expertise, and perspectives. This collaborative approach leads to more effective, inclusive, and person-centered mental health services that better serve the needs of individuals, families, and communities.

Best Practices for Stakeholder Engagement

There are many resources available regarding promising and best practices for stakeholder engagement. Some commonly identified guiding principles and best practices are:

1. **Inclusive Approach:** Ensure that the stakeholder engagement process is inclusive and representative of diverse perspectives. Include individuals with lived experience, family members, behavioral health service providers, advocacy groups, community organizations, and policymakers. Embrace diversity and strive for equity in representation.
2. **Early and Ongoing Engagement:** Engage stakeholders early in the decision-making process and maintain ongoing communication throughout the planning, implementation, and evaluation stages. Provide opportunities for input, collaboration, and feedback at various stages to ensure meaningful participation.
3. **Purposeful Communication:** Foster open and transparent communication with stakeholders. Provide clear information about goals, processes, and timelines. Use plain language and avoid jargon to ensure that all stakeholders can easily understand and contribute to the conversation. Likewise, practice active listening when stakeholders are speaking. Rather than assuming what they mean, ask follow-up questions to ensure that their input is understood.
4. **Collaboration and Co-creation:** Foster a collaborative environment that encourages stakeholders to actively participate in decision-making. Co-create solutions by involving stakeholders in the design and implementation of programs, policies, and services. Value their expertise and insights.
5. **Training and Education:** Provide stakeholders with relevant training and education to enhance their understanding of behavioral health issues, policies, and practices. Equip them with the knowledge necessary to contribute effectively and make informed decisions.

6. **Flexibility and Adaptability:** Recognize that stakeholders may have different levels of expertise, resources, and availability. Provide flexibility in engagement methods to accommodate diverse needs, such as offering virtual options, providing written materials, and conducting surveys or focus groups.
7. **Data-Informed Decision Making:** Use data and evidence to inform discussions and decision-making processes. Share relevant data with stakeholders to foster informed dialogue and facilitate collaborative problem-solving.
8. **Empowerment and Shared Leadership:** Empower stakeholders to actively contribute and take ownership of the process. Promote shared leadership by involving stakeholders in the development of agendas, facilitating meetings, and encouraging their participation in decision-making.
9. **Recognition and Appreciation:** Recognize and appreciate the contributions of stakeholders. Acknowledge their time, effort, and expertise. Provide opportunities for public recognition, such as featuring success stories or highlighting stakeholder involvement in reports and presentations.
10. **Evaluation and Continuous Improvement:** Regularly evaluate the effectiveness of stakeholder engagement efforts and seek feedback from participants. Use this feedback to refine engagement strategies and improve future processes.

These are just some of the many suggested best practices and guiding principles for quality stakeholder engagement. By incorporating these and other best practices, behavioral health systems can effectively engage stakeholders, leverage their expertise, and create more responsive, person-centered, and equitable services and policies.

MHSA Community Program Planning Process

One of the major ways that the MHSA includes stakeholder engagement is the MHSA Community Program Planning (CPP) Process. This state-mandated participatory process is a collaborative approach used in California to develop and refine mental health programs funded by the MHSA. Counties use the CPP process in the development of Three-Year Program and Expenditure Plans and updates. Counties work alongside stakeholders to analyze current community mental health needs, issues resulting from any lack of community services, and current system capacity, as well as evaluate priorities and strategies to meet the needs of the community.

California Codes and Regulations dictate that the MHSA CPP process should be:

- Based in community collaboration (CCR, 9 CA §3320 and 3200.060).
- Culturally competent (CCR, 9 CA §3320 and 3200.100).
- Client and family driven (CCR, 9 CA §3320, 3200.050 and 3200.120).
- Wellness, recovery and resilience-focused (CA WIC § 5813.5(d)).
- Focused on providing an integrated service experience for clients and their families (CCR, 9 CA §3320 and 3200.190).

MHSA CPP Processes must include the following regarding stakeholder participants:

- **Stakeholders** (as previously defined/discussed based on WIC, § 5848a).

- **Underserved populations.** Representatives from unserved and/or underserved populations and family members of unserved/underserved populations (CCR, 9 CA § 3300).
- **Diversity.** Participants that "reflect the diversity of the demographics of the County, including but not limited to, geographic location, age, gender, and race/ethnicity" (CCR, 9 CA § 3300).

Additionally, the CPP process should, at a minimum include the following things:

- Staffing for positions and/or units to facilitate the CPP process.
- Training for stakeholders and county staff.
- Outreach to consumers with SMI and their family members to ensure the opportunity to participate.
- A local review process that includes a 30-day public comment period prior to submitting the Three-Year Program and Expenditure Plans or Annual Updates.

The MHSA currently allows counties to use **up to 5% of their total Community Services and Support (CSS) funds** to facilitate a robust planning process. This includes using funding to accommodate stakeholder participation in the CPP process. All counties are required to use the CPP process and document the Three-Year Program and Expenditure Plans and Annual Updates. This document includes descriptions of the methods used to collect stakeholder input, documentation that a public hearing was held, summary and analysis and a description of changes made based on community input.

The local MH/BH boards and commissions have responsibilities in this process:

- Review and approve the procedures used to ensure stakeholder involvement in all stages of the planning process.
- Review the adopted plan or update and make recommendations.
- Conduct MHSA public hearings after the close of the 30-day public comment periods.

Overall, the MHSA Community Program Planning Process fosters a participatory and community-driven approach to mental health program development. By engaging stakeholders and leveraging their expertise and insights, the CPP Process aims to create programs that are responsive, culturally sensitive, and tailored to the unique needs of the community. This collaborative effort ultimately leads to the implementation of effective and impactful mental health services in California communities.

While the MHSA CPP process is an important (and legally required) example of stakeholder engagement, the principles and practices of stakeholder engagement can be applied to many different programs and processes. This includes but is not limited to mental/behavioral health board/commission meetings, EQRO focus groups, and SAMHSA funded programs.

Resources

The following resources (with embedded links) all pertain to stakeholder engagement in mental health, including the CPP process. We encourage counties to utilize these resources to learn more about responsive and effective engagement practices.

- CALBHBC: MHSA CPP One-Pager[18]
- CALBHBC: Community Engagement PowerPoint[19]
- MHSOAC: CPP Processes - Report of Other Public Community Planning Processes[20]
- MHSOAC: Promising CPP Practices[21]
- SAMHSA: Community Engagement – An Essential Component of an Effective and Equitable Substance Use Prevention Program[22]

The Performance Outcomes Committee of the Planning Council developed a series of discussion questions based on the background material above. The Data Notebook Survey was released and sent to the County Departments of Behavioral Health and the local advisory board/commission members were requested to respond, using the provided Survey Monkey link.

Next, this report presents the questions as originally asked, followed by a brief figure, table, or descriptive summary of the aggregated responses received by May 6, 2024. Several counties requested extensions, some brief, others less so. The importance of this focus topic to the stakeholder community encouraged supporting those requests.

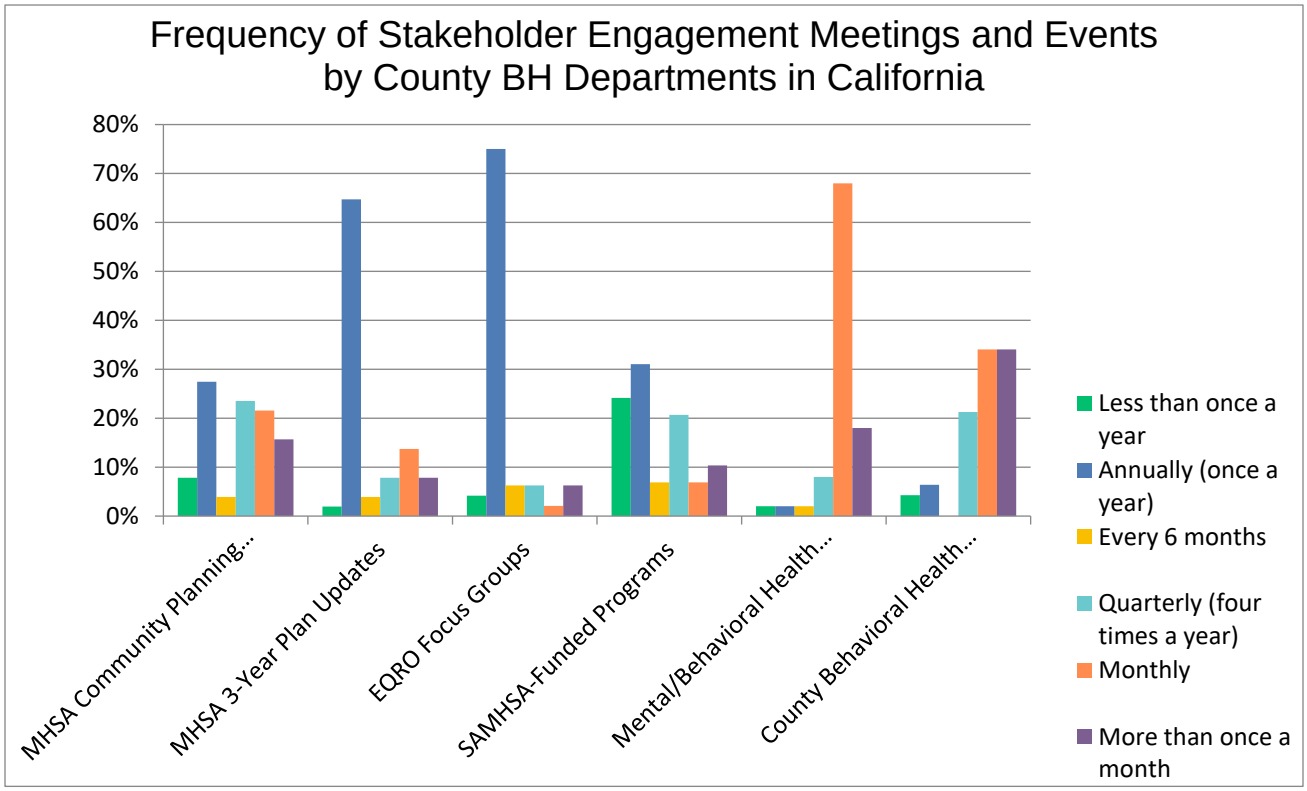
[18] https://www.calbhbc.org/uploads/5/8/5/3/58536227/community_program_planning_cpp.pdf. CALBHBC: MHSA Community Program Planning 'CPP One-pager'.
[19] https://www.calbhbc.org/uploads/5/8/5/3/58536227/community_engagement_2022.pdf. CALBHBC: Community Engagement PowerPoint (2022).
[20] https://www.mhsoac.ca.gov/sites/default/files/documents/2016-04/eval_deliv_4_approved[1].pdf. MHSOAC: CPP Processes – Report of Other Public Community Planning Processes.
[21] https://www.mhsoac.ca.gov/sites/defaults/files/documents/2016-04/oac_093014_9a_rdareport_d6[1].pdf. MHSOAC: Promising CPP Practices.
[22] https://store.samhsa.govsites/default/files/pep22-06-01-005.pdf. SAMHSA: Community Engagement – An Essential Component of an Effective and Equitable Substance Use Prevention Program.

Part II: Data Notebook Questions and Responses

12. For each of the following categories, please choose the option from the dropdown menu that best describes how often your county organizes stakeholder engagement meetings or events.

- **Dropdown menu options:**
  - Less than once a year
  - Annually (once a year)
  - Every 6 months
  - Quarterly (four times a year)
  - Monthly
  - More than once a month
- **Categories:**
  - MHSA Community Planning Process (CPP)
  - MHSA 3-year plan updates
  - EQRO focus groups.
  - SAMHSA-funded programs
  - Mental/Behavioral Health Board/Commission Meetings
  - County Behavioral Health co-sponsoring or partnering with other departments or agencies.
  - Other (please specify).

Figure 2. The overall results are summarized in the following graph. 51 Responses were received from 50 Counties plus the Tri-Cities Board.



From the data shown above, we see that meetings that were held once each year or somewhat more frequently included community planning processes for MHSA programs, the annual update of the MHSA 3-year plans, EQRO focus groups, and the reviews of SAMHSA-funded grant programs. Local Behavioral Health advisory boards typically meet once/month, as do some meetings with other departments or agencies co-sponsored by county Behavioral Health.

13. Estimate the number of people who participated in your stakeholder processes in fiscal year 2022-2023.

The total estimate was 54,595 individuals, based on data submitted by 50 counties/boards. However, there were many comments about meetings for which no 'count' was obtained, and some numbers were estimated. From the overall comments, the total given above is likely an undercount of the true numbers, but nonetheless indicate there is significant stakeholder participation in our state.

14. Approximately what percentage of stakeholder engagement events or efforts in your county were in-person only, virtual only, a combination of both in-person and virtual, or written communications.

- In-person only: 41 counties, 1404 events, 82% of total counties responding.
- Virtual only: 41 counties, 1407 events, from 82% of total counties responding.
- Combination of both in-person and virtual: 45 counties, 1499 events, 90% of total counties responding.
- Written communications (such as online surveys or email questionnaires): 42 counties, 699 outreach projects, 84% of counties responded.

From these data, we concluded that there were 4,310 outreach events of all types (in-person + virtual + hybrid), plus the 699 written and survey outreach projects conducted by the 51 counties/boards that responded to this question. These data provide evidence for a robust and widespread stakeholder process across the state.

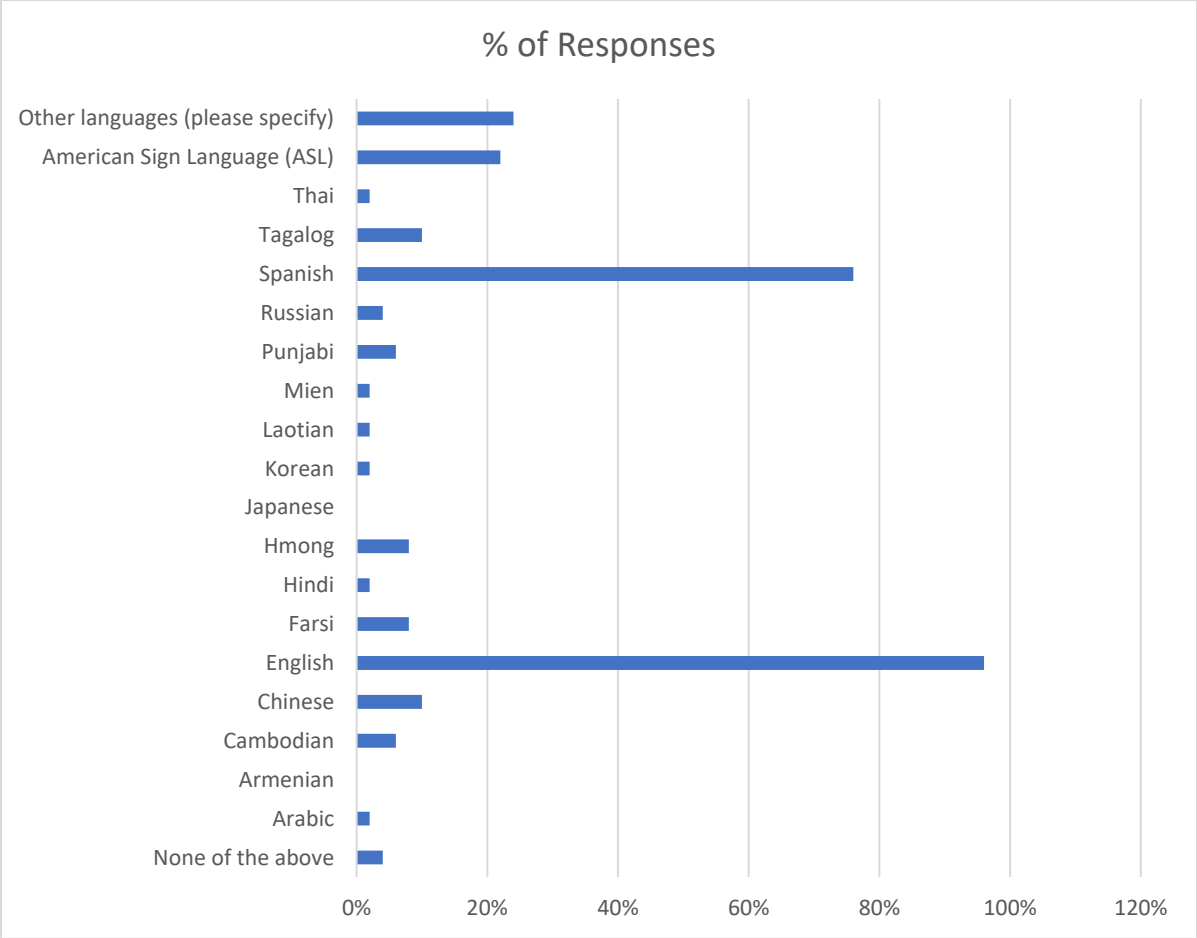
15. Which of the following languages did your county use to conduct stakeholder meetings or outreach during fiscal year 2022-2023, with or without the use of interpreters? *(Check all that apply).*

- Arabic
- Armenian
- Cambodian
- Chinese,
- English
- Farsi
- Hindi
- Hmong
- Japanese

- Korean
- Laotian
- Mien
- Punjabi
- Russian
- Spanish
- Tagalog
- Thai
- American Sign Language (ASL)
- Other languages (please specify)

This list of languages reflects the threshold and concentration languages for all counties as of July 2021 from the following DHCS document: Threshold and Concentration Languages (ca.gov).

Figure 3. Most Frequently Used Languages for Stakeholder Engagement Events and Outreach by California County Departments of Behavioral Health, as reported by 50 Counties, FY 2022-2023.



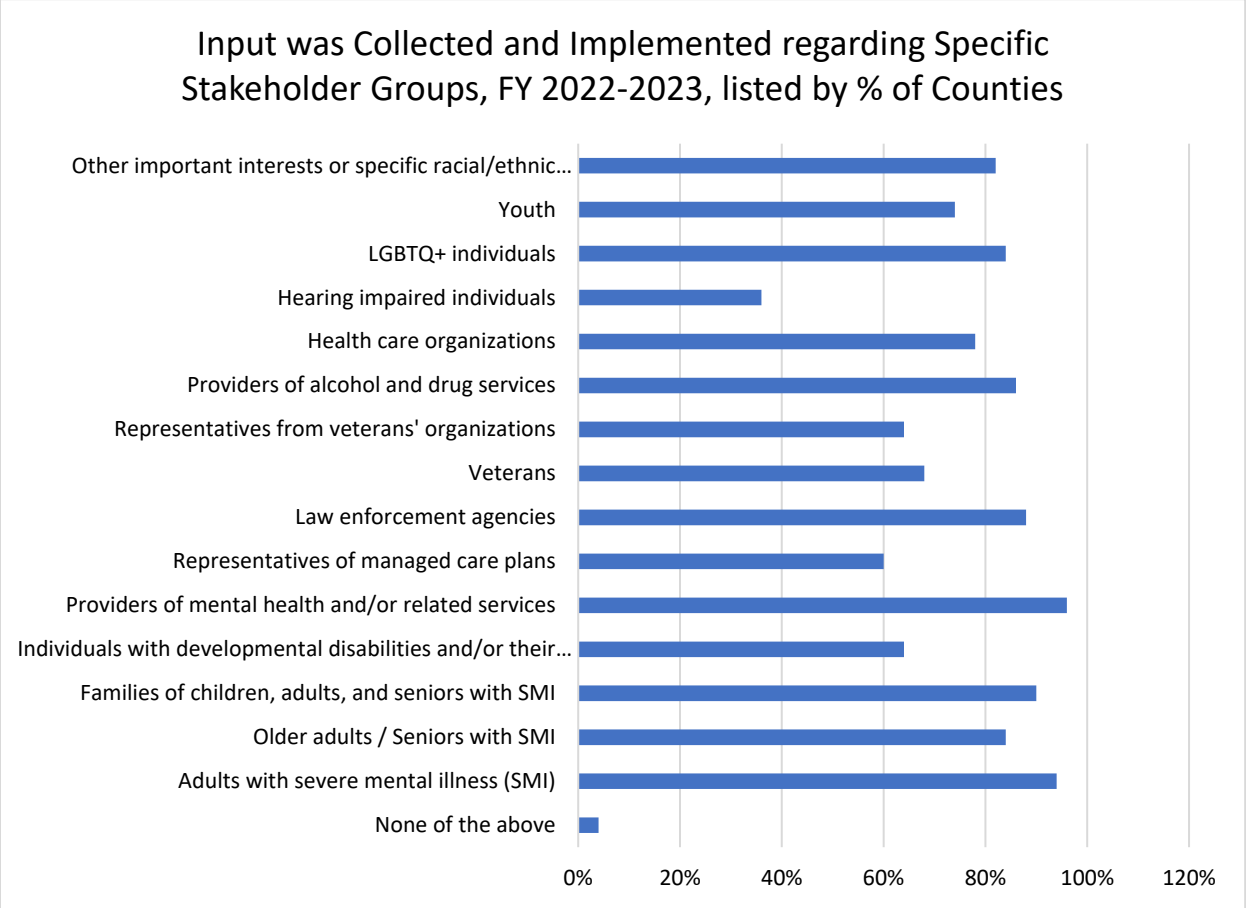
These data show that the most frequent languages used in outreach events besides English were Spanish (76% of counties), American Sign Language (22% of counties), Chinese and Tagalog (each cited by 10% of counties). Several languages were listed by 12 % of counties under “other”:

- Vietnamese, 7 counties
- Mixteco, 1 or more counties
- Dari, 2 counties
- Pashto, Tajik, Assyrian, Persian: 1 county each.

16. Which of the following stakeholder groups have you collected and implemented input from within the last year? *(Check all that apply)*

- Adults with severe mental illness (SMI)
- Older adults / Seniors with SMI
- Families of children, adults and seniors with SMI
- Individuals with developmental disabilities and/or their representatives
- Providers of mental health and/or related services
- Representatives of managed care plans
- Law enforcement agencies
- Educators and/or representatives of education
- Social services agencies
- Veterans
- Representative from veterans’ organizations
- Providers of alcohol and drug services
- Health care organizations
- Hearing impaired individuals
- LGBTQ+ individuals
- Youth
- Other important interests (please specify)
- Specific racial/Ethnic groups (please specify)

Figure 4. Input was collected and implemented from these identified stakeholder groups within the last year by California County Departments of Behavioral Health, FY 2022-23. Responses from 50 Counties/Boards.



The data above can be roughly separated into groups of stakeholders that are clients or family members of clients who receive or need to receive services, and into groups of stakeholders that include those with a community role that involves these services, such as provides of mental health and/or substance use treatment services, law enforcement, representatives of managed care plans, or health care organizations. At least 74% of the responding counties listed all the forgoing groups of community-involved entities as being sources of input that was implemented in county programs or services. And 64% of counties received input from representatives of veterans' services. With respect to clients of services and their family members, at least 74% of counties indicated that they obtained feedback that was implemented in their programs from individuals with SMI, including youth, adults and older adults, LGBTQ+ individuals, members of historically underserved minority groups and their family members. Only 64% of counties received input regarding services for developmentally disabled individuals. Only 36% of counties received input regarding services for hearing-impaired individuals.

17. Please describe how stakeholder input is communicated to the behavioral health director, the mental/behavioral health board/commission, and any other agencies or groups for informing policy.

From the aggregated responses, it appears that counties have multiple pathways by which information gets to the various levels of the behavioral health departments, their directors, and eventually to the county boards of supervisors. Some of the information may come from meetings of the behavioral health boards and any of their issue-related work groups, and from public stakeholder engagement meetings held in the county, or in writing as part of meeting minutes, short reports, or issue briefings. Planning Council members commented that sometimes an important program or area of BH need has to be introduced multiple times, by different people, in different settings, to different audiences, before the ideas coalesce organically into tangible proposals and programs. Participant comments emphasized the importance of active listening skills at multiple levels of leadership and advocacy.

18. Please describe how your county implements collected stakeholder input to actively inform policy and programs. Include how the county decides what ideas to implement or actions to take. (Descriptive data responses were received from 50 of 51 counties/boards).

<u>Examples of responses from both small and large counties</u>:

- Input is collected through public comments, surveys (e.g. Consumer Perception Surveys and others), stakeholder email lists and listening sessions. The county decides to implement ideas based on feedback received from stakeholders and the community, ensuring all required rules and regulations are met and followed.
- The Behavioral Health Coordinator reports out the stakeholder input at the Behavioral Health Advisory Board meetings, of which the director attends and implements. Funding is a large driver as to what ideas can be implemented.
- Stakeholder input is gathered through a variety of community listening sessions, the departmental strategic planning, and outreach activities. These occur during in-person events, provider or collaborative/interagency meetings, through scheduled virtual activities, or through surveys. This information is organized by unit, division, or system of care and reviewed with the Department of BH executive or operational teams, as well as the Director. Department of BH will often post or distribute the results of these events and/or the Office of the BH Director will provide a summary to system stakeholders. Should feedback be incorporated into policy, that information is vetted and approved through the department's policy development process.
- Our MHSA team contracts with an outside evaluator: "Evalcorp" to perform analyses of the community input from community and stakeholder surveys, focus groups, and community listening sessions. These reports are distributed to internal staff, including leadership, BH Commission, Board of Supervisors, and to external service providers and public.
- The BH Director has adopted several approaches over the years to compile ideas into actions and programs. Stakeholder input has been used to develop Requests for Proposals (for contracts) to provide services to specific unserved/underserved populations, to address needs identified by stakeholders

and the BH Division as priorities, and to address specific needs/gaps identified through the Community Planning Process.

19. Does your county have a Community Program Planning (CPP) plan in place?

- No: 7 counties/boards (14% of responses)
- Yes: 44 counties (86% of responses)
- If yes, describe how you directly involve stakeholders in the development and implementation of this plan. Descriptive responses were received from 45 counties/boards.

Examples of responses from both large and small counties:

- This is a part of the MHSA 3-year plan and Annual Update process. Community meetings are held in each of the main communities in the county and stakeholder feedback is taken during these meetings and plans for the upcoming year are developed based on the community feedback and input.
- Stakeholder surveys distributed through email, Survey Monkey, and at Community Wellness sites; in-person and Zoom meetings. Translation provided in Spanish. We provide training about MHSA standards and current programs we offer. This is also an ongoing process within our county to ensure that we continue to encourage community engagement in these processes.
- To ensure that the Mental Health Services Act (MHSA) is effectively implemented, designated staff and leadership are provided with training on MHSA. Feedback is then gathered to create a stakeholder list that accurately reflects the diversity and demographics of the County. An MHSA survey is created, and designated staff reach out to stakeholders to schedule meetings with them. During these meetings, presentations are provided to stakeholders, and their feedback is solicited. This process helps to ensure that a comprehensive and inclusive approach is taken toward the implementation of developing the MHSA Three-Plan or Annual Update.
- The County considers the planning process to be continual which influences annual updates and the three-year plan. Trends are used to inform planning.
- Our county utilizes the following methods: Mental Health Policy Public comments during Mental Health Commission meetings, Governing Board meetings and other stakeholder events, Program Planning and Implementation, Stakeholder and Orientation meetings, MHSA Workgroups, Community Planning Survey, Cultural Wellness Advisory Committees, Monitoring Stakeholder/Orientation Meetings, Review outcomes for programs, 30 day comment period for MHSA plans and updates, Comments made during MHSA Public Hearing, Quality Improvement Annual Community Planning Survey, Surveys completed following trainings, webinars and presentations, Cultural Wellness Committees, Evaluation of Stakeholder and Orientation Meetings, Opportunity for questions at MHSA workgroups.
- Meetings are held in our remote cities as appropriate, interpreters are provided, as well as two local locations in the County Seat in our mostly rural locale. All partner organizations are personally invited, and a general advertising of the meetings and purpose is published as well. A larger venue with food and activity

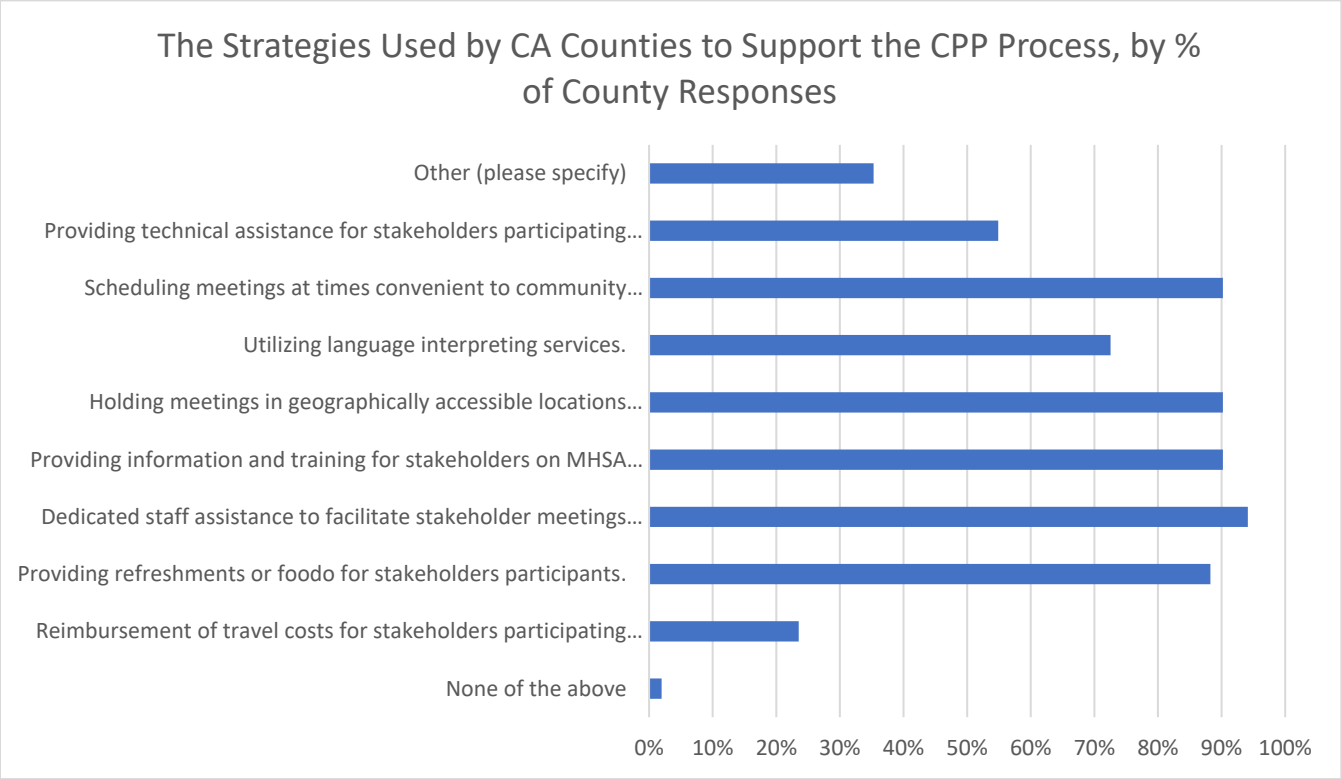
for children is provided after work hours as well for community stakeholders of Behavioral Health.

- A Community Engagement (CE) Subcommittee of the county's Behavioral Health Advisory Board (BHAB) was formed in 2022-2023 and meetings of that Subcommittee and other BHAB Subcommittees have served as primary settings to involve stakeholders in the development and implementation of strategies for community programming. Most recently, for example the CE Subcommittee, was presented with proposed strategies to be implemented for 2023-2024, and the group discussed what they would like to see, particularly in relation to the MHSA Community Program Planning Process. In effect, this group is building pieces of the plan slowly, but as a collective group. Outside of these convenings, members of the department's Communication & Engagement Team meet with stakeholders to learn what they would like to see from the department.

20. Is your county supporting the CPP process in any of the following ways?
(Please select all that apply)

a) Reimbursement of travel costs for stakeholders participating in in-person meetings or events.
b) Providing refreshments or food for stakeholder participants
c) Dedicated staff assistance to facilitate stakeholder meetings and events.
d) Providing information and training for stakeholders on MHSA programs, regulations, and procedures.
e) Holding meetings in physically/geographically accessible locations around the county.
f) Utilizing language interpreting services.
g) Holding meetings at times convenient to community stakeholders' schedules.
h) Providing technical assistance for stakeholders participating in webinars or teleconferences.
i) Other (please specify)
j) None of the above

Figure 5. Strategies Used by County Departments of Behavioral Health to Support the Community Planning Process (CPP). Responses from 51 Counties/Boards.



The data shown above indicate that 90% of the responding counties/boards use strategies that include scheduling meetings at times convenient to the community, hold meetings in geographical accessible locations around the county, designate staff assistance to facilitate meetings, provide information and training for stakeholders on MHSA programs, regulations, and procedures, and provide refreshments and/or food for participants. About 70% of counties use language translation services. About 55% of counties provided technical assistance to stakeholders participating in webinars, etc. Only 24% of counties were able to provide reimbursement for travel costs for participants, due to strict policies limiting this activity.

21. Does your county provide training for staff on cultural awareness, community outreach, and stakeholder engagement?
If yes, how? If no, why not?

- No: 2 percent (response from 1 board) (no explanatory comment was supplied).
- Yes: 98 % (response from 50 counties/boards)

- If yes, describe how? All 50 counties supplied descriptive comments. These comments are summarized as follows.

Virtually all counties provide training in 'CLAS' (culturally and linguistically appropriate services), and they require a minimum of one training annually. The exact number of trainings and total hours required vary with the county. Training is typically required of all BH department staff and contracted staff. Some of the training is conducted in-person and other training uses an online-platform such as 'Relias,' which provides over 30 options of different cultural and bias training topics that employees can choose. These training sessions may include topics labeled as 'cultural awareness,' 'cultural humility,' 'implicit bias training', use of interpreter services including sign language, etc. Some counties specifically include training during new employee orientation about the 'principles of the MHSA.' Some counties may require quarterly training; some require up to seven sessions or topics. Also, as part of informal training, many counties encourage staff members to attend community outreach efforts, community listening sessions, or other community engagement events. Training on community engagement and outreach tends to be less formal and may involve mentorship. One county suggested that if formal training were available, they would encourage their employees to participate.

The goals of implementing CLAS standards are to advance health equity, improve quality of services and programs, and to help eliminate health care inequities. Those goals are also served by training and attention to methods of stakeholder engagement and outreach with local communities. Planning Council committee member discussions emphasized the importance of genuine cultural humility and active listening in all forms of outreach, engagement, and service delivery.

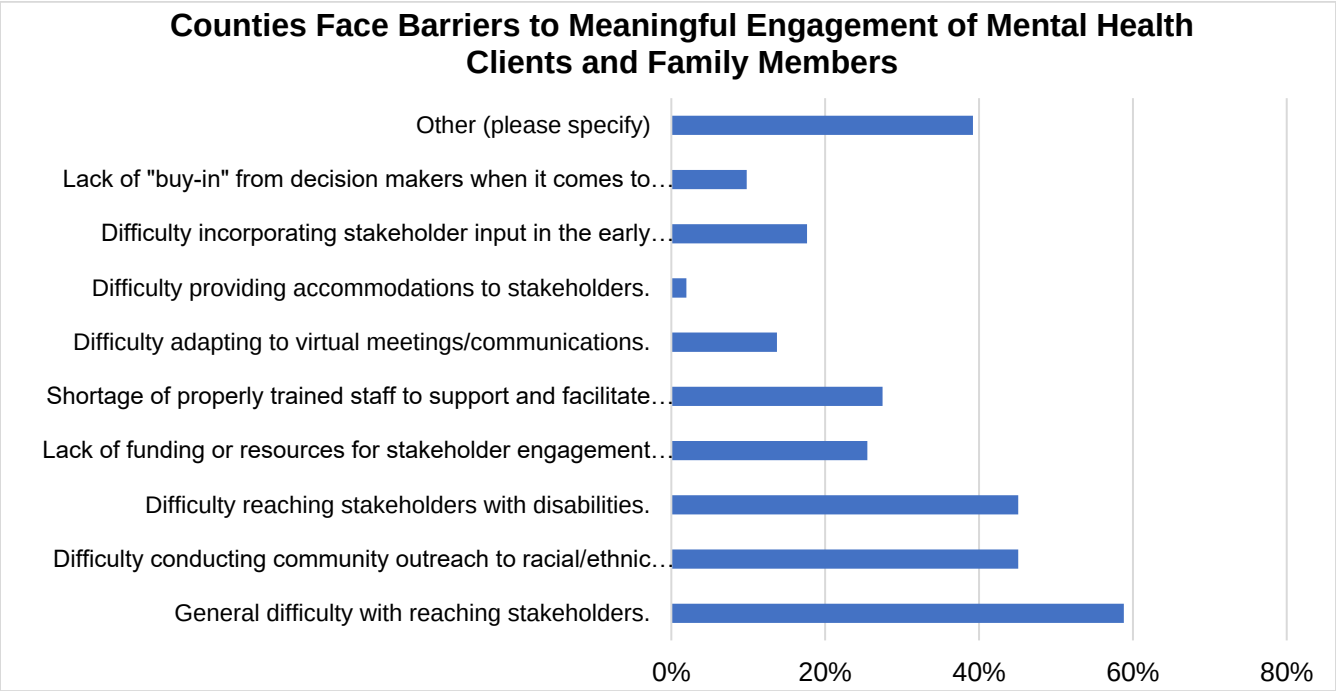
22. Which of the following barriers does your county face regarding achieving meaningful and impactful engagement of stakeholders (specifically, mental health consumers and family members)? Respondents were asked to check all that apply. 51 counties/boards provided responses.

a. 59% General difficulty with reaching stakeholders.
b. 45% Difficulty conducting community outreach to racial/ethnic communities or other specific communities of interest.
c. 45% Difficulty reaching stakeholders with disabilities.
d. 25% Lack of funding or resources for stakeholder engagement efforts.
e. 27% Shortage of properly trained staff to support and facilitate stakeholder engagement.
f. 14% Difficulty adapting to virtual meetings/communications.
g. 2% Difficulty providing accommodations to stakeholders.
h. 18% Difficulty incorporating stakeholder input in the early stages of programming.
i. 10% Lack of "buy-in" from decision makers when it comes to implementing stakeholder input.
j. 39% Other please specify

Some comments received under "Other":

- Resources of time, language, availability of staff time to participate; virtual meetings are difficult for community members to participate; time of day for meeting scheduled – evening may be more accessible for some, but not others**.**
- We have not effectively highlighted for the community where stakeholder feedback has been adopted and incorporated into departmental changes.
- Since public transportation is discontinued or slowed after 6PM, stakeholders are unlikely to attend. Some stakeholders might attend meetings held during the day.
- Some SMI persons may not be able to operate video meeting instructions, whereas others who are more proficient may experience Zoom fatigue.
- Behavioral Health works with Cultural Collaboratives that serve the community in our county to provide outreach and education around Mental Health Services.
- Behavioral Health is currently working with these Cultural Collaboratives and current stakeholders to identify other stakeholders living with disabilities or those who advocate on their behalf.
- The department has collected feedback from current stakeholders to identify approaches and practices to best reach diverse racial/ethnic stakeholders in the community to ensure a more robust stakeholder group.
- Our biggest difficulty is engaging rural populations and specific ethnic/racial groups in the County that aren't involved directly with our department or with behavioral health advocacy.

Figure 6. Several barriers are faced by counties to meaningful engagement with stakeholders, specifically BH consumers and family members. For those who prefer to get a visual overview of the data, the horizontal bars shown below represent the responses as given by a percent of the responding counties/boards. 51 counties/boards provided responses.



23. Are your behavioral health board/commission members involved in your county's stakeholder engagement and/or CPP processes? If yes, describe how.

Yes: 49 Counties/boards (96%) (with text comment)
No: 2 counties/boards (4%)

If 'Yes", describe how. Detailed descriptions were provided by 49 counties.

Most commonly, members of the BH boards/commissions participate as stakeholders in the CPP review process during presentations about the annual MHSA review and the three-year reviews. The presentations are given by county staff, including the MHSA Coordinator or MHSA team members, or other program experts. Public hearings are a key feature of the Community Program Planning Process under the Mental Health Services Act (MHSA, becoming BHSA). Typically, the presenters seek out feedback from the board members and other stakeholders during these public meetings. They may provide additional surveys for participants to complete, which is helpful for those reluctant to speak in a public meeting due to privacy concerns. There is usually a specific timeline (e.g. 30 days) to allow for public review and further feedback, before BH board members are asked for a final vote of approval. After that vote, the plan is forwarded to the County Board of Supervisors for their final approval. At least one

county reported that if the Board of Supervisors made any significant changes (either additions or subtractions) in the original stakeholder-approved plan, that the document would be sent back for further stakeholder engagement, including review and an additional vote by BH board members.

Small population counties may have only a few Board members or other stakeholders to participate in this process, but they try to recruit additional stakeholders in the county, especially from potentially underserved communities. Some of the smaller BH boards may have one or two members who volunteer to attend other county stakeholder meetings and community health outreach events such as community 'fairs'.

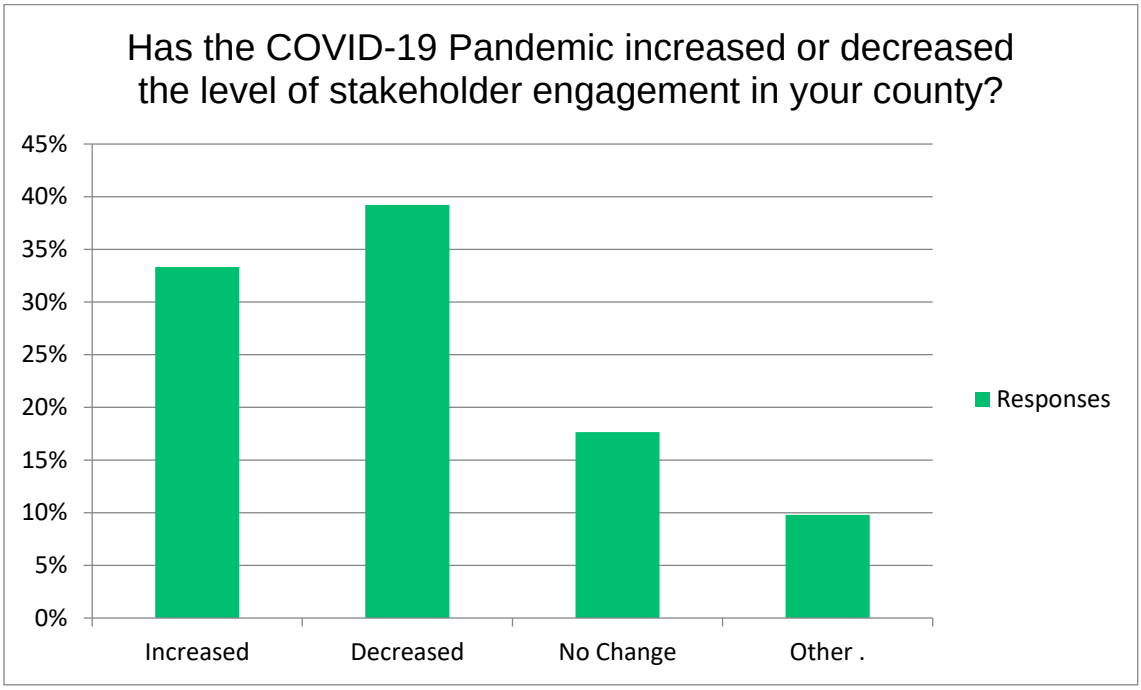
BH board/commission members in medium and large-population counties, depending on their personal interests and time, may have more opportunities to engage in stakeholder meetings beyond the CPP Process and the MHSA, including BH Quality Improvement Committee, an EQRO focus group, Family focus Groups, County Suicide Prevention Council meetings, County-hosted Fentanyl Town Halls, Continuum of Care work groups, Homeless Committee, and NAMI. One BH Advisory Board hosts monthly study sessions in addition to their general meeting, where BH programs, policies, finance, valuation and implementation are discussed in more detail than usually presented.

Note: *California WIC 5892 allocates Mental Health Services Funds for county mental health programs to pay for the expenses of mental health board members to perform their duties, and to pay for the costs of consumers, family members, and other stakeholders to participate in the planning process. This includes 5% of total CSS funds to support a robust CPP process with community stakeholders.*

24. Has the COVID-19 pandemic increased or decreased the level of stakeholder engagement and input in your county?

a. Increased
b. Decreased
c. No change
d. Other

Figure 7. County BH departments' perceptions vary regarding the effects of the Covid-19 pandemic affected the level of stakeholder engagement (below). These data are based on responses from 51 counties/boards. Those that selected 'other' indicated that the level of engagement or participation decreased during the early parts of the pandemic but tended to increase somewhat when options for virtual meetings became available, and then increased further when Covid vaccines became readily available.



25. Is there a fear or perception in your county that spending time, money, or other resources on stakeholder engagement conflicts with the need to provide direct services? *(Yes/No)*

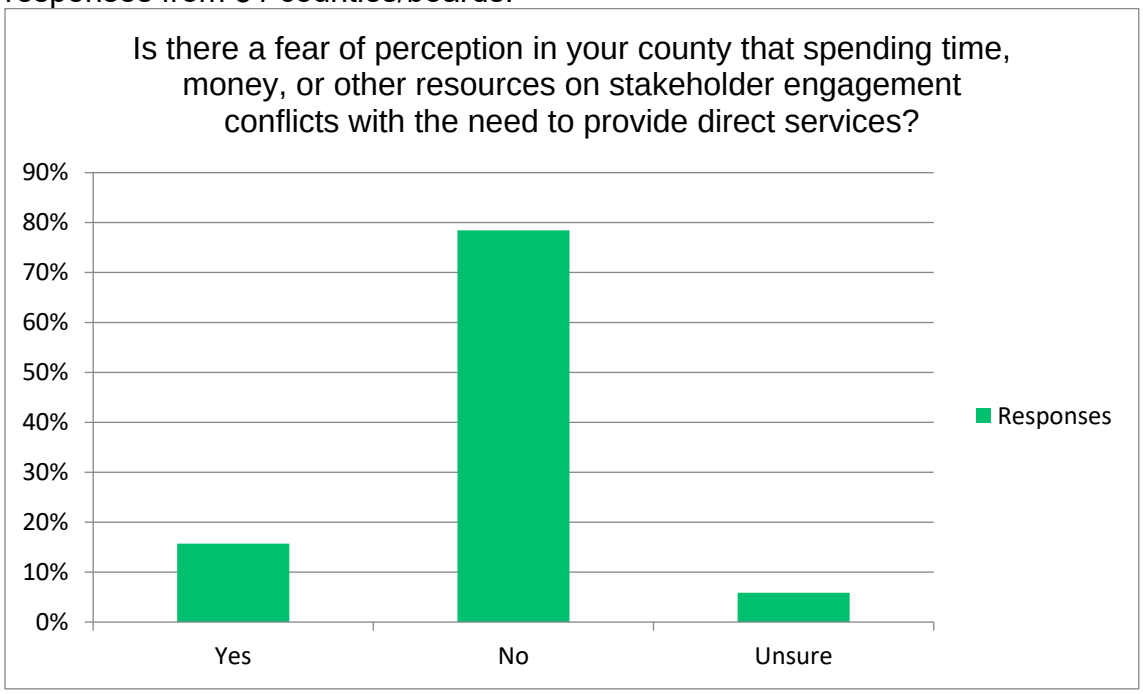
Interestingly, 40 counties (78%) answered 'No.'

Respondents were also offered the option to add a comment.

These data can be taken as a positive or optimistic finding, as evidenced by the responses from nearly four-fifths of the counties/boards.

Figure 8. Fears and perceptions about the possibility that staff time engaged in stakeholder engagement might conflict with their availability to provide direct

services to mental health clients/consumers (below). These data are based on responses from 51 counties/boards.



26. What is one change or improvement regarding stakeholder engagement that your county would like to make within the next fiscal year?

Responses: 50 of 51 counties offered substantive comments regarding specific changes that they would like to see regarding processes for stakeholder engagement in the coming year.

Examples submitted in county Data Notebook reports included:

- Incentivize stakeholder engagement by providing mileage, per diem or gift card incentives. Support changes in state law that would assist such expenditures.
- Implement a transparency dashboard with statistical information for public access and develop text surveys.
- Greater involvement of youth, veterans, and LGBTQ.
- Consider recommendations/making changes based upon feedback from the fall 2023 Client Satisfaction Survey
- Opportunities to expand youth input, services, and activities to promote youth engagement and feedback. Engage students at schools to provide input on needed services and supports.
- Improve collaboration and communication across county agencies, including public health, which may share some overlapping goals for public health education and outreach programs.
- Improving stakeholder participation for Substance Use Services and inviting more stakeholders to the Fentanyl Town Halls.

- Improving transportation options for meeting/event participants; county is rural and spread out.
- Improve hybrid meeting technology and necessary resources.
- Start the CPP planning process two years in advance of the next annual review update and include stakeholders who use BH services ('lived experience').
- Establishing a Peer Advisory Council for more outreach with community organizations that serve racial/ethnic minorities who are underserved by the county. Need more outreach on MHSA and changes expected with Proposition 1.
- Improve outreach to Latino/x and Spanish-speaking communities, partner with agencies or community organizations.
- Coordination and alignment of the BHRS/MHSA Community Planning with the wider HHS Equity Strategic Planning process that is beginning this coming year.

27. Do you have any other thoughts or comments regarding stakeholder engagement in your county or statewide?

Responses: Of the 46 counties/boards that responded to this question, 29 listed comments, and the remaining 17 counties/boards listed "no" or "not at this time".

Representative examples of comments:

- Offer focus groups in the community and other existing meetings. Expand services, and activities in the evenings and/or weekends. Also, engaging seniors and reaching out to them; supporting caregivers; addressing suicide risk for seniors.

- L.A. County DMH has implemented a satisfaction survey with stakeholders at each meeting for quality improvement purposes. The feedback can be used to show progress (or lack thereof) over time and trends.

- Quality Care included community partners in the QIC Community Experience Subcommittee. Quality Care is going to invite community partners to attend the 'Community Resiliency Model Training;' Spanish interpretation was provided.

- One county stated that "we are experiencing a very different culture when it comes to volunteers and community engagement. It is difficult to bring people together in one large group. So, we are pivoting to engaging multiple smaller groups which allow us to go out into the community and have meaningful conversations that we hope will yield feedback that is both timely and relevant to the people we serve."

- One response noted that "the Advisory Board has had some concerns about the need for more representation and input from the client/consumer community, i.e., those who are receiving or have received behavioral health services. While there is a local consumer-run Enrichment Center, not all consumers use the Enrichment Center. This is the perfect location to seek their engagement. There is a monthly "coffee talk" that

is held for the purpose of discussing what consumers would like to discuss, and an opportunity to engage with the staff of behavioral health."

- More than one response suggested: "provide childcare on-site."

- One BH Board commented: "what does seem to be missing, however, is a 'consumer-led' stakeholder process. The principles of recovery and resiliency need to be emphasized more, and this can be accomplished through targeted stakeholder training for consumers. The same can also be said for families of consumers. The local NAMI organization holds meetings and has guest speakers. The Advisory Board would like to encourage more input from this stakeholder group."

- The Advisory Board has received some public comments about the location of some community meetings and that of the Advisory Board meetings as well. The comments include lack of signage to direct the public to the meeting location, lack of public transportation close to the meeting location, and the physical set up and poor acoustics of the building/meeting location. The Board of Supervisor representative to the Advisory Board has also suggested that the county engage an advertising firm to help develop a "communications strategy" for community stakeholder input.

- Our County is so small, stakeholder engagement is difficult to achieve as there is fear of identification of the individual making the comments.

- Our community is a working-class community which does not have time to attend and participate in stakeholder engagement opportunities. Perhaps if there were some incentives (e.g. gift cards, gas cards, or bus passes) for individuals there would be an increase in participation.

Conclusion, Summary of Findings, and Recommendations

There are two or three main conclusions to be drawn from the aggregated data submitted by fifty counties (out of 58) plus one non-county mental health board.

First, each county is an individual entity and has its own culture and practices that affect how they deliver services and how the counties engage with the public. That engagement can be directed in part to activities that provide public information and outreach to prospective clients and families that may need Behavioral Health services. In addition, there are other activities for outreach and engagement with stakeholders to obtain feedback on quality and type of services needed, and whether there are service gaps in terms of communities that are not being adequately or appropriately served. Some of the outreach to stakeholders involves members of the public who are involved in some aspect of providing services and assist in safety matters when individuals and/or their families experience a crisis indicating an urgent need for behavioral health

services. These other stakeholders include providers of therapeutic services, emergency department physicians, educators and counselors in schools who may assist students who need help, and social services agencies who manage foster care placements, and they also help in connecting homeless individuals to safe shelters and other services. Law enforcement officers also play a role when public safety issues arise during a crisis, and they are also stakeholders in county Behavioral Health policies and services. Many of the changes in crisis services during the last five years, such as mobile crisis units with clinical staff, or crisis respite centers, and other care options, were the result of persistent and long-term advocacy across the state.

Second, based on responses to question we asked about policies and practices designed to acquire information and feedback from stakeholders. Then we asked further, 'how is that information transmitted through the different offices and layers of organization within County Departments of Behavioral Health, the local advisory boards, the office of the Director and their staff. And finally, how does all this feedback get formulated in specific recommendations from the Department to the County Board of Supervisors? That is the penultimate step before specific plans can be drawn up and requests for funds made so that new programs and service improvements can actually be implemented. And again, from the responses received, we see the effects of individual culture and practices in different counties across the state, due to different populations and local circumstances. (e.g. rural and agrarian based counties versus those that are predominantly urban or suburban; each of these have different needs and availability of resources trained to meet their cultural needs).

Third, we received evidence in our data of a widespread and vibrant culture of stakeholder engagement across the state. These outreach and engagement efforts utilized both in-person and virtual (e.g. 'Zoom') meetings and those conducted using both methods in a hybrid approach. Further, there are many online surveys and questionnaires presented by counties, as well as printed/written material and brochures, many of which are translated into the most common threshold languages in that county or region. Many of the counties also conduct meetings at which there are translation services available, especially Spanish and American Sign Language, and translators of other threshold languages, depending on local need and interest.

However, the statement regarding the existence of a widespread culture of stakeholder engagement does not account for those counties with limited resources or small populations spread out of a large geographic area. For example, at least 7 counties stated that they do not have a CPP planning process that takes place on a regular basis. And there were 8 other counties that did not submit a Data Notebook this year, so we are missing their potential data on this topic. We encourage and recommend that further research should examine trends and practices at the county level in more detail.