DATA NOTEBOOK 2023

FOR CALIFORNIA

BEHAVIORAL HEALTH BOARDS AND COMMISSIONS

Prepared by California Behavioral Health Planning Council, in collaboration with:
California Association of Local Behavioral Health Boards/Commissions

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.

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NOTICE:

This document contains a textual **preview** of the California Behavioral Health Planning Council 2023 Data Notebook survey, as well as supplemental information and resources. It is meant as a **reference document only**. Some of the survey items appear differently on the live survey due to the difference in formatting.

DO NOT RETURN THIS DOCUMENT.

Please use it for preparation purposes only.

To complete your 2023 Data Notebook, please use the following link and fill out the survey online:
https://www.surveymonkey.com/r/DP8XG65

Please note, if you are working from a PDF, scanned image or photocopy, you will need to Copy/Paste or type the above address into your browser bar.

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CBHPC 2023 Data Notebook: Introduction

What is the Data Notebook? 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[1] 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;
- 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

[1] 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[2] 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[3].

Example of Statewide Data for Specialty Mental Health and Access Rates

Tables 1-A and 1-B on the next two pages shows 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[4], demographic metrics presented are not exact, as the dashboard rounds them to the nearest .1 thousand (k) or million (M).

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[2] 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.
[3] 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.
[4] 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,[5] Fiscal Year 2021-22.

	Specialty Mental Health Services		
	FY 21-22		
	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%
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%
Female	130.1k	2.8M	4.6%
Male	114.4k	3M	3.9%
Totals and Average Rates	244.5k	5.8M	4.3%

Notes: The first column presents the demographic groups of interest. Next there are three columns. The first column of numbers shows the number of clients who received one or more services, described as Specialty Mental Health Visits. The second column of numbers is labeled 'Certified Eligibles', which is the number of clients who were deemed eligible and approved to received health care paid by Medi-Cal. The third column of numbers represents the service penetration rates. These penetration rates are taken as one measure of Access. They are calculated by dividing the total number

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

of Clients with MH visits by the total number of Medi-Cal Eligibles, multiply by 100 to express the result as a percentage; this 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.[6]

	Specialty Mental Health Services		
	FY 21-22		
	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%
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%
Female	177.3k	5.3M	3.3%
Male	164.2k	4.2M	3.9%
Totals and Access Rates	341.5k	9.5M	3.6%

Notes: The 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).

[6] For comparison, the population of the state of California was **39,029,342** on April 1, 2020, 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. These numbers show that 39.2 % of all Californians of all age groups received Medi-Cal in FY 2021-22.

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.[7]

The Planning Council would like to examine some county-level data that are not readily available online and for which there is no other public source. Please answer these questions using information for fiscal year (FY) 2021-2022 or the most recent fiscal year for which you have data. Not all counties will have readily available data for some of the questions asked below. In that case, please enter N/A for 'data not available.' 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[8] 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 wants to understand what types of data are currently available at the county level regarding ARFs and Institutions for Mental Diseases (IMDs)[9] available to serve individuals with SMI, and how many of these individuals (for whom the county has financial responsibility) are served in facilities such as ARFs or IMDs. 'Bed day' is

[7] www.mhsoac.ca.gov, see MHSA Transparency Tool, under 'Data and Reports'
[8] Link to Licensed Care directory at California Department of Social Services. https://www.ccld.dss.ca.gov/carefacilitysearch/
[9] Institution for Mental Diseases (IMD) List: https://www.dhcs.ca.gov/services/MH/Pages/IMD-List.aspx

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 treatment.

The following is a text summary of the survey questions for Part I of the 2022 Data Notebook. Please note that the questions are presented here in a different format than the finalized SurveyMonkey online survey. Refer to the PDF preview of the SurveyMonkey survey to see a more accurate presentation of the items.

Questions:

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

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?** (*Text response*)

3) **What is the total number of ARF bed-days paid for these individuals, during the last fiscal year?** (*Text response*)

4) **Unmet needs: how many individuals served by your county behavioral health department need this type of housing but currently are <u>not</u> living in an ARF?** (*Text response*)

5) **Does your county have any 'Institutions for Mental Disease' (IMD)?**
   a. No
   b. Yes. If Yes, how many IMDs? *(Text response*)

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: (*Text response*) Out-of-county: (*Text response*)

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?** (*Text response*)

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[10] 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 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 complete data.

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

Table 3: State of California Estimates of Homeless Individuals Point in Time[11] Count 2022

Summary of Homeless individuals	SHELTERED	UNSHELTERED	TOTAL 2022	Percent Increase over 2022
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 (2020) Homeless Persons in CA	56,030	115,491	171,521	6.2%
Total (2020) Homeless Persons, USA	348,630	233,832	582,462	.3%

[11] 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 who were in homeless shelters and various types of transitional or emergency housing.

Questions, continued:

8) **During fiscal year 2021-2022, 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?** (Mark 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)*

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). 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 CA:

- 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?**
    a. Yes
    b. No. If No, what is your recommendation? Please list or describe briefly. (*Text response*)

10) **Has your county received any children needing "group home" level of care from another county?**
    a. No
    b. Yes. If Yes, how many? (*Text response*)

11) **Has your county placed any children needing "group home" level of care into another county?**
    a. No
    b. Yes. If Yes, how many? (*Text response*)

CBHPC 2023 Data Notebook – Part II:

Stakeholder Engagement in the Public Mental Health System

Context and Background

The topic selected for the 2023 Data Notebook is “stakeholder engagement.” Stakeholder engagement refers to 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 for those seeking support.

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, it 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 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 the following 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 at 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 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
- CALBHBC: Community Engagement PowerPoint
- MHSOAC: CPP Processes - Report of Other Public Community Planning Processes
- MHSOAC: Promising CPP Practices
- SAMHSA: Community Engagement – An Essential Component of an Effective and Equitable Substance Use Prevention Program

Part II: Data Notebook Questions

Please respond by means of the Survey Monkey link provided with this Data Notebook.

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/partnering with other departments or agencies
        - Other (please specify):

13. **Estimate the number of people who participated in your stakeholder processes in fiscal year 2021/2022.** *(Numerical response)*

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** *(please answer with a whole number for each, such that the total of the four amounts to 100)*
    - In-person only:
    - Virtual only:
    - Combination of both in-person and virtual:
    - Written communications (such as online surveys or email questionnaires):

15. **Which of the following languages did your county use to conduct stakeholder meetings or outreach during fiscal year 2021/2022, 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)

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)

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.** *(Text response)*

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.** *(Text response)*

19. **Does your county have a Community Program Planning (CPP) plan in place?**
    - Yes (If yes, describe how you directly involve stakeholders in the development and implementation of this plan)
    - No

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

21. **Does your county provide training for staff on cultural awareness, community outreach, and stakeholder engagement? If yes, how? If no, why not?**
    - Yes (with comment)
    - No (with comment)

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)?** *(Check all that apply)*
    a. General difficulty with reaching stakeholders.
    b. Difficulty conducting community outreach to racial/ethnic communities or other specific communities of interest.
    c. Difficulty reaching stakeholders with disabilities.
    d. Lack of funding or resources for stakeholder engagement efforts.
    e. Shortage of properly trained staff to support and facilitate stakeholder engagement.
    f. Difficulty adapting to virtual meetings/communications.
    g. Difficulty providing accommodations to stakeholders.
    h. Difficulty incorporating stakeholder input in the early stages of programming.
    i. Lack of "buy-in" from decision makers when it comes to implementing stakeholder input.
    j. Other (please specify)

23. **Are your behavioral health board/commission members involved in your county's stakeholder engagement and/or CPP processes? If yes, describe how.**
    a. Yes (with text comment)
    b. No

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

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)*

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

27. **Do you have any other thoughts or comments regarding stakeholder engagement in your county or statewide?** *(Written response)*

Post-Survey Questionnaire

Completion of your Data Notebook helps fulfill the board's requirements for reporting to the California Behavioral Health Planning Council. Questions below ask about operations of mental health boards, and behavioral health boards or commissions, etc.

28. What process was used to complete this Data Notebook? (Please select all that apply)
   a. MH board reviewed WIC 5604.2 regarding the reporting roles of mental health boards and commissions.
   b. MH board completed majority of the Data Notebook.
   c. Data Notebook placed on agenda and discussed at board meeting.
   d. MH board work group or temporary ad hoc committee worked on it.
   e. MH board partnered with county staff or director.
   f. MH board submitted a copy of the Data Notebook to the County Board of Supervisors or other designated body as part of their reporting function.
   g. Other (please specify)

29. Does your board have designated staff to support your activities?
   a. Yes (if yes, please provide their job classification)
   b. No

30. Please provide contact information for this staff member or board liaison.

31. Please provide contact information for your board’s presiding officer (chair, etc.)

32. Do you have any feedback or recommendations to improve the Data Notebook for next year?