MHSA Community Program Planning Processes

Deliverable 4: Report of Other Public Community Planning Processes

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Introduction

The purpose of the Mental Health Services Act (MHSA) Community Program Planning (CPP) Process Evaluation (herein "Evaluation") is to use a participatory research process to measure the impact and effectiveness of CPP processes in California's 58 counties and two municipalities that provide public mental health services (herein "California counties"). The Evaluation will identify Promising MHSA CPP Practices, which will be incorporated into a curriculum and trainings that will be made available to California counties and taught to stakeholders throughout the State of California.

This document supports the Evaluation aims by investigating public Community Planning processes, including their theoretical underpinnings, principles, frameworks and specific methods and activities, in arenas other than public mental health departments. Practices gleaned from this report may be used by MHSA CPP stakeholders to inform future MHSA CPP processes.

In preparation of this report, the Evaluation Team conducted a review of relevant literature, interviewed nine informants, and identified frameworks, models, principles and practices that could apply to MHSA CPP process advancement. The evaluation team reviewed literature and interviewed informants with knowledge of community and neighborhood development, land use, disaster and emergency planning, education, the environment, housing, public health, transportation, and violence prevention. The key informant interviews targeted academics, researchers and practitioners knowledgeable about comparable public community planning processes, including individuals with experience working in the U.S. and internationally. Key informants were asked to describe examples of effective community-based program planning processes and to recommend theoretical frameworks and additional thought-leaders and practitioners of community planning processes for the evaluation team to research. The selected case studies derive from our literature review as well as recommendations from the key informants and represent a breadth of community planning processes across multiple fields that use a variety of approaches.

This report includes three chapters and an attached bibliography. The first chapter provides an overview of the principles and requirements of the MHSA CPP process, as articulated in California legislative codes and regulations. The second chapter offers theoretical frameworks, models, and case studies of public community planning processes facilitated by public agencies and institutions outside of mental health. The third chapter describes the ways in which comparable public community planning processes could be considered by MHSA planners and stakeholders. The bibliography includes documents accessed in the preparation of this report.

Chapter 1: MHSA-Defined CPP Principles and Practices

The MHSA Community Program Planning process is defined in California Codes and Regulations. By law, County MHSA CPP processes must adhere to the following general standards:

- **Community Collaboration** is a process by which clients and/or families receiving services, other community members, agencies, organizations, and businesses work together to share information and resources in order to fulfill a shared vision and goals (Title 9, California Code of Regulations, §§3320 and 3200.060).

- **Cultural Competence** means that equal access is provided to equal quality of services to all racial/ethnic, cultural and linguistic communities. Disparities are identified and strategies developed to eliminate disparities. Cultural competence means that program planning and service delivery takes into account diverse belief systems and the impact of historic forms of racism and discrimination on the mental health of community members. Services and supports utilize strengths and forms of healing that are unique to an individual's racial/ethnic, cultural and linguistic community. Service providers are trained to understand and address the needs and values of the particular communities they serve, and strategies are developed and implemented to promote equal opportunities for those involved in service delivery who share the cultural characteristics of individuals with SMI/SED in the community (summarized from Title 9, California Code of Regulations, §§3320 and 3200.100).

- **Integrated Services Experience** means the client, and when appropriate the client's family, accesses a full range of services provided by multiple agencies, programs and funding sources in a comprehensive and coordinated manner (Title 9, California Code of Regulations, §§3320 and 3200.190).

- **Client Driven** means that the client has the primary decision-making role in identifying his/her needs, preferences and strengths and a shared decision-making role in determining the services and supports that are most effective and helpful for him/her. Client-driven programs/services use clients' input as the main factor for planning, policies, procedures, service delivery, evaluation, and the definition and determination of outcomes (Title 9, California Code of Regulations, §§3320 and 3200.050).

- **Family Driven** means that families of children and youth with serious emotional disturbance have a primary decision-making role in the care of their own children, including the identification of needs, preferences, and strengths, and a shared decision-making role in determining the services and supports that would be most effective and helpful for their children. Family-driven programs/services use the input of families as the main factor for planning, policies, procedures, service delivery, evaluation, and the definition and determination of outcomes (Title 9, California Code of Regulations, §§3320 and 3200.120).

- **Wellness, Recovery and Resilience** focused means that planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health

consumers: "To promote concepts key to the recovery for individuals who have mental illness: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination. To promote consumer-operated services as a way to support recovery." (MHSA Section 7, W&I §5813.5(d))

MHSA CPP processes, per legislation and regulations, must include the following participants and processes:

- **Clients and family members:** Involvement of clients with serious mental illness and/ or serious emotional disturbance and their family members in all aspects of the Community Program Planning Process (WIC, § 5848(a)).
- **Broad-based constituents**: Participation of stakeholders defined by Welfare and Institution Code Section 5848a as adults and seniors with severe mental illness, families of children, adults, and seniors with severe mental illness, providers of services, law enforcement agencies, education, social services agencies, veterans, representatives from veterans organizations, providers of alcohol and drug services, health care organizations, and other important interests (WIC, § 5848a).
- **Underserved populations:** Participation from representatives of unserved and/or underserved populations and family members of unserved/underserved populations (CCR, 9 CA § 3300).
- **Diversity:** Stakeholders that "reflect the diversity of the demographics of the County, including but not limited to, geographic location, age, gender, and race/ethnicity, and have the opportunity to participate in the Community Program Planning Process" (CCR, 9 CA § 3300).

MHSA CPP processes, per regulation must include:

- **Training** (CCR, 9 CA §3300).
- **Outreach** to clients with serious mental illness and/or serious emotional disturbance, and their family members, to ensure the opportunity to participate (CCR, 9 CA §3300).
- **A local review process** prior to submitting the Three-Year Program and Expenditure Plans or Annual Updates that includes a 30-day public comment period (CCR, 9 CA § 3315).

Counties must submit documentation of Three-Year Program and Expenditure Plans and Annual Updates that includes:

- **A description of methods** used to circulate copies of the draft Three-Year Program and Expenditure Plan or Annual Update to representatives of stakeholders' interests and any other interested parties who request the draft for the purpose of public comment.
- **Documentation that a public hearing was held** by the local mental health board/commission, including the date of the hearing.

- **A summary and analysis** of any substantive recommendations.
- **A description of any substantive changes** made to the proposed Three-Year Program and Expenditure Plan or annual update that was circulated (CCR, 9 CA § 3315).

Chapter 2: Public Community Planning Theory, Frameworks, Models and Case Studies

Other than the legal regulations described in Chapter 1 of this report, no commonly agreed upon description of MHSA CPP theories of change, goals, principles, or frameworks exists. Aside from guidance provided in Three-Year Program and Expenditure Reports and subsequent Annual Update instructions, no description of best or promising practices exist. For this reason, we look to the literature as well as to experts in community development and organizing, municipal planning, public health and other fields for examples of frameworks, theories of change, models and case studies. Our research found that many community planning processes are developed without theories of change and without plans for evaluating processes or outcomes. While we were able to identify numerous planning frameworks and case studies loosely or tightly linked to the framework, none of the frameworks or case studies included rigorous evaluations of process or outcomes, and more specifically, none demonstrated significant associations between specific activities, methods or practices and predefined outcomes. More will be said about the challenges associated with and opportunities for evaluating community planning processes later on in this report.

The following frameworks, therefore, were selected because they are currently or have recently been used by local government entities to engage broad-based stakeholders in planning local government and nonprofit services, infrastructure and systems. Many of the frameworks we identified differed only slightly or in name only, or differed only in how they were applied in the particular field. The following were selected to demonstrate a breadth of applications (e.g., land use, education, and public health) and a diversity of principles, theories of change, methods of engagement and degrees of participation.

1. **Community Engagement:** used by public health professionals, healthcare providers, and other stakeholders in health research, planning, and health improvement efforts.
2. **Community Readiness:** a practical tool to help communities plan and implement prevention programs.
3. **The Active Community Engagement Continuum (ACE)**: used to plan for and evaluate participatory public health initiatives.
4. **Community Based Participatory Research:** a collaborative approach to conducting research *with*, rather than *on*, communities; builds community capacity to act for social change.
5. **Neighborhood Planning**: a process by which residents develop a shared vision and a plan to solve neighborhood problems.
6. **Public Engagement in Education**: a collaborative, inclusive, participatory approach to bringing about meaningful change in public schools.
7. **Mobilizing for Action through Planning and Partnership (MAPP):** developed by The National Association of County and City Health Officials (NACCHO) to improve community health.

8. **Health Impact Assessment:** a specific model that engages community stakeholders in reviewing plans, policies and projects before they are implemented.

9. **Participatory Budgeting:** used by municipalities to engage residents in democratic decision-making and fiscal planning.

10. **Community COPE**: a quality improvement model used in the assessment and planning of local health care systems.

11. **Use of Technology in Participatory Planning:** bringing the tools of planning to the people to democratize and ensure that those who are most affected are empowered to participate in the decisions that affect their lives.

For each of these theoretical frameworks, to the extent possible, we describe the historical underpinnings, purpose and theory of change, principles and approaches. When possible, we describe the outcomes of the project and methods by which the processes and outcomes were measured. We also provide case studies that describe how the principles and practices described in the theoretical frameworks were operationalized, as well as the recorded outcomes of the project.

Research and Application Limitations

This literature review does not pretend to capture the full range of public community planning frameworks or models. Participatory or community-based planning has a long and rich history; theories and practices cross paths with a variety of disciplines, that range from purely academic anthropological pursuits that engage study targets in collecting and interpreting data, to community and labor organizing and other social movements that engage historically disenfranchised communities in planning and action for political, economic and social justice. Nor does this literature review consider the rich history of mental health recovery consumer and family member movements, which must also be studied to understand how advocacy-oriented planning and activism has influenced mental health service delivery systems and programs.

The theoretical frameworks and processes described in the following case studies, furthermore, should not be construed as *promising MHSA practices*, as defined by an ability to predict or be associated with positive MHSA goals and outcomes. In part, this is because of the unique contexts within which MHSA planning occurs, and perhaps more importantly, due to the shortage of research on the predictability of outcomes of public community planning processes.

A 2006 report from Canada explores what was known at the time about the degree to which public participation goals have been achieved, and found the following: “Scholars within different fields of study are unanimous in their conclusions about the paucity of good quality research evidence about public participation and its effects” (Albelson, 2006). Similarly, a report out of the United Kingdom, which reviewed public engagement in education planning from 2000 to 2008, arrived at the following conclusion: “Formal research of public involvement was rare. The literature was replete with enthusiastic

reports and reflections, but with little or no detail about public involvement, and often little attempt at objectivity" (Hart, 2009).

We found the same lack of evidence about the effects of participatory processes when researching individual frameworks and case studies. In most cases, no rigorous evaluations were found, and in particular, no promising practices were identified using statistical associations. In some cases, the lack of research was cited. A 2011 publication, from which we drew a community-based participatory research case study, states the following: "The use of community-based participatory research (CBPR) to address health disparities in underrepresented communities has been widely regarded as a promising practice." Yet, in the same paragraph, "A challenge to understanding the impact of CBPR partnerships and participation in healthy research, whether it be epidemiology, intervention or policy, is the paucity of conceptual models of CBPR that are empirically tested and validated," and, "Little is known, however, about CBPR pathways of change and how these academic-community collaborations may contribute to successful outcomes" (Sandoval, 2011). Problems with evaluating CPP processes are documented in several meta-analyses of evaluation. They include: diverse and often contradictory perceptions of what constitutes a positive outcome (Abelson, 2006); contextual differences (Abelson, 2006; Connell, 1995); lack of consensus on process and outcome measures (Abelson, 2006); uncertainty on how to measure the effects of democratic processes (Agger and Lofgren, 2008); disagreement on distal outcomes (Abelson, 2006); lack of control group (Uddin, 2002; Abelson, 2006); measurement problems (Sandoval, 2011 and Abelson, 2006); and horizontal and vertical complexity within planning environments (Connell, 1995).

Due to the paucity of evaluative evidence regarding promising practices, this literature review seeks to identify widely recognized, theoretically-based principles of participatory/community-based program planning which may be applied by public mental health systems to improve services and achieve MHSA goals. The final chapter also provides some practical strategies that emerge from the principles and that are practiced within the case studies, but we do not make the case that these practical applications are associated with positive outcomes.

Community Engagement Framework

In recognition that community engagement and mobilization efforts may lead to the development of effective programs for addressing obesity, cancer, smoking cessation, and heart disease, and to better understand how these efforts lead to improving health outcomes, in 1995 the Centers for Disease Control and Prevention (CDE) established the Committee on Community Engagement. In 1997, the Committee produced the first edition of *Principles of Community Engagement* (CDC/ATSDR). The report defined community engagement as:

> *The process of working collaboratively with and through groups affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people. It is a powerful vehicle for bringing about environmental and behavioral change that will improve the health of the community and its members. It often involves partnerships and coalitions that help mobilize resources and influence systems, change*

relationships among partners, and serve as catalysts for changing policies, programs and practices. (CDC/ATSDR, 1997).

In 2011, the National Institutes for Health (NIH) released the Second Edition of Principles of Community Engagement, which provides public health professionals, healthcare providers, and other stakeholders with additional theoretical underpinnings and guidance for engaging in health research, planning, and health improvement efforts.

Community Engagement, according to the Second Edition, can take many forms, but is frequently measured on a continuum from lesser to greater degrees of engagement:

- **Outreach:** whereby communication flows from one entity to another; used to inform.
- **Consult:** which seeks to get information and feedback from the community.
- **Involve:** whereby information flows both ways; partnerships are created.
- **Collaborate:** where partnerships are developed to plan and implement a strategy.
- **Share leadership:** where decision making occurs at the community level.

Defining the Community

The second edition of *Principles of Community Engagement* recognizes two definitions of community, which influence how planning practitioners select participant stakeholders. Community can be understood as those individuals and groups that are most effected by the health issue being addressed. In this context, the community, by definition, includes those who have historically been left out of health improvement efforts. The second definition of community includes a broader range of stakeholders, such as public health professionals, academics and elected officials and policymakers. The second edition places a greater emphasis on the first definition, the engagement of those community members who are most affected by the health issue, suggesting that their participation is the lynchpin of successful community engagement and planning efforts (Clinical and Translational Science Awards Consortium, 2011).

History and Current Application

Community Engagement theory emerges from earlier principles of community organizing, which recognize social justice, fairness and equity, empowerment and self-determination. Theorists that help define community engagement include Saul Alinsky, whose groundbreaking book, *Rules for Radicals* (Alinsky*, 1971)*, helped define principles of community organizing. Other critical theorists include Paulo Freire, a Brazilian philosopher and educator most known for *Pedagogy of the Oppressed (Freire, 1970)*, which outlines the critical pedagogy movement. Pedagogy of the Oppressed suggested that educational efforts should be a liberating force that empowers oppressed peoples to overcome their conditions. Freire emphasized the importance of dialogue and informed action. Other important contributors include

Myles Horton, who founded the Highlander Folk School (1932), a center for adult education, civil rights, and community empowerment in Tennessee (Adams, 1975).

Most recently, Community Engagement as an approach is reflected in a variety of federal initiatives, including the CDC's Prevention Research Centers, which is a network of community, public health and academic partners who conduct applied public health research (http://www.cdc.gov/prc/); U.S. Department of Health and Human Services' Agency for Healthcare Research and Quality (http://www.ahrq.gov/); Healthy People 2020 (http://www.healthypeople.gov), a 10-year initiative to improve the health of all Americans, whose national objectives emphasize collaboration among diverse groups to develop strategies for health improvement; Clinical and Translational Science Awards and Research Centers, which helps to make findings from science useful for practical applications (http://www.ncats.nih.gov/research/cts/ctsa/ctsa.htm); and Minority Institutions Programs of the National Institutes of Health, which develops and strengthens research capacities of minority institutions (http://www.nimhd.nih.gov/our_programs/research_centers.asp).

Principles of Community Engagement includes a chapter on evaluation, and suggests that evaluation approaches should engage stakeholders. They describe participatory evaluation, which actively engages stakeholders at all stages of the evaluation, and empowerment evaluation, which helps program staff develop skills to ensure that their programs operate effectively. The chapter provides a rudimentary description of qualitative and quantitative methods for determining if programs are participatory in nature. They recommend asking the following process-oriented questions:

- Are the right community members at the table?
- Does the process and structure of meetings allow for all voices to be heard and equally valued?
- How are community members involved in developing the program or intervention?
- How are community members involved in implementing the program or intervention?
- How are community members involved in program evaluation or data analysis?
- What kind of learning has occurred, for both the community and academics?

Principles of Community Engagement

The authors of *Principles of Community Engagement* (2011) draw on their experience, theoretical frameworks and models from the literature to develop a set of principles to help practitioners plan, implement and evaluate community engagement efforts. These 9 principles are organized into three sections: 1) what practitioners need to consider before engagement; 2) what is necessary to consider during the engagement effort and 3) how to ensure successful engagement efforts.

Before starting a community engagement effort:

1. Be clear about the purpose and goals of the engagement effort and the populations and/or communities you want to engage.

2. Become knowledgeable about the community's culture, economic conditions, social networks, political and power structures, norms and values, demographic trends, history, and experience with efforts by outside groups to engage it in various programs.

For engagement to occur:

3. Go to the community, establish relationships, build trust, work with the formal and informal leadership, and seek commitment from community organizations and leaders to create processes for mobilizing the community.

4. Remember and accept that collective self-determination is the responsibility and right of all people in the community. No external entity should assume it can bestow on a community the power to act in its own self-interest.

For engagement to succeed:

5. Partnering with the community is necessary to create change and improve health.

6. All aspects of engagement must recognize and respect the diversity of the community. Awareness of various cultures of a community and other factors affecting diversity must be paramount in planning, designing, and implementing approaches to engage a community.

7. Community engagement can only be sustained by identifying and mobilizing community assets and strengths and by developing the community's capacity and resources to make decisions and take action.

8. Organizations that wish to engage a community as well as individuals seeking to effect change must be prepared to release control of actions or interventions to the community and be flexible enough to meet its changing needs.

9. Community collaboration requires long-term commitment by the engaging organization and its partners.

The principles of community engagement described above could be considered by MHSA planning coordinators and stakeholders. Understanding that the CPP processes may benefit from pre-planning investment in learning about behavioral health constituents; reaching out and developing trust among representatives of community-based organizations who have longstanding relationships with diverse constituents; and respecting consumer and family strengths and desires for self-determination may strengthen community planning processes.

Community Readiness Framework

The Community Readiness Model was developed as a practical tool to help communities plan, implement and evaluate prevention programs. The model is based on the theory that all communities are at different levels of readiness for developing and implementing programs. For example, attitudes vary across communities—in some communities a strategy for social transformation may be recognized as productive and in another perceived as counterproductive. Other examples of ways in which different communities are at different levels of readiness have to do with the amounts and types of resources available for change and the differing levels of political support for change. The Community Readiness theory emerged in the early 1990s, in part, thanks to the work of Mary Ann Pentz, of the Midwest Prevention Project (Pentz, 1999). She argued that unless a community was ready, implementation of a prevention program would likely lead to failure. Pentz's work led researchers at Tri-Ethnic Center, in Fort Collins Colorado to focus on the question of community readiness. The model is based on a theory of change that suggests:

> *…efforts by local people are likely to have the greatest and most sustainable impact in solving local problems and in setting local norms. When community resources are tapped, efforts are more likely to be based on concepts and ideas that are theoretically and culturally appropriate for that unique community. Successful prevention programs are "owned" by the target community itself* (Edwards, 2000).

To achieve the greatest and most sustainable impact, communities must be ready. Researchers identified 9 stages of readiness, and specific strategies at each stage to help communities advance along the continuum. Stages include:

1. **No awareness:** Community members don't recognize the problem or that there is something that can be done.
2. **Denial/resistance:** Little recognition that the problem occurs locally (i.e., "It's not our problem").
3. **Vague awareness:** General feeling in the community that something should be done, but no motivation to do something or identifiable leaders or agents of change.
4. **Preplanning:** There is an awareness that something should be done and leaders are mobilized, but there is no strategy or focused plan for action.
5. **Preparation:** Community leaders begin planning; the community offers modest support.
6. **Initiation:** Enough information exists to support action. Activities have started and there is great enthusiasm because no problems associated with implementation have been experienced. No active resistance at this phase.
7. **Stabilization:** Programs are running and supported. Little perceived need for change or expansions. No evaluation.

8. **Confirmation/Expansion:** Community members feel comfortable using services. Initial implementation has been evaluated and modified.

9. **Professionalization:** Detailed knowledge about the problem exists; highly trained staff are running programs; leaders are supportive and community is involved. Community members hold program accountable.

In 2006, the Tri-Ethnic Center produced a community readiness handbook, which identifies specific strategies to determine community readiness and advances along the nine-stage continuum (Plested, 2006). The handbook includes a Community Readiness Assessment, which involves conducting a minimum of 4 - 5 key informant interviews with individuals in the community, and asking 36 specific questions related to: 1) knowledge in the community about the issue; 2) extent of community efforts to address an issue; 3) knowledge of local efforts to address the issue; 4) existence of community leadership who are interested in the issue; 5) perceived attitude in the community towards the issue; and 6) availability of local resources to support efforts. The interview is then scored along the 6 dimensions and overall. The overall score determines the degree of community readiness, which then allows planners to develop specific planning and program implementation strategies that are appropriate for the community. The model provides examples of strategies for each level of community readiness: For communities that are at the first stage—no awareness—the goal is to raise awareness of the issue, and the authors of the model point to the need to visit with individual leaders and small groups to inform them of the issue. During the fifth stage—preparation, for example—planners seek to gather information to help form a plan. During this stage, strategies include: conducting surveys; sponsoring a community picnic to initiate the planning effort; and presenting data. During the final professionalization stage, the goal is to maintain momentum and continue to grow the initiative. During this phase, funding sources are diversified; external evaluation helps determine if progress has been made, and if and how programs should be modified (Plested, 2006).

The Community Readiness Handbook (Plested, 2006) describes ways in which the model can be used for program evaluation, particularly related to shifts in community norms. In Oklahoma, ten counties developed a program to improve services to seriously emotionally disturbed Native American children and their families. The model was used to measure community readiness before and after program implementation, and saw advancement along the continuum.

The authors of the Community Readiness model describe challenges associated with establishing validity. Specifically finding measures with similar intent is difficult because “each application is unique and the constructs or ideas that the tool is measuring have not been addressed by other measures.” They did, however, establish construct validity via hypothesis testing and argue that widespread acceptance lends credence to its validity.

The authors also note that Community Readiness “does not lend itself well to traditional measures of reliability, partcularly test-retest reliability, because readiness levels are not typically static.” However, the authors note that they have seen consistent patterns in community readiness over time, which reflect on the reliability of the stages. Additionally, they did see consistency among

respondents in rating community readiness (92% inter-reater reliability), but note that each respondent has a unique role in the community and, as such, they expect different perspectives on community readiness (Plested, 2006).

Community Readiness could be an effective framework to measure MHSA stakeholder involvement in planning for universal prevention programs and to measure the degree to which stakeholders are able to collectively address community norms and issues such as mental health stigma. By measuring readiness at various intervals, MHSA planners may be able to develop effective strategies that are relevant to current community readiness for change.

Community Engagement and Community Readiness Case Study

Healing the Canoe

Time Period: 2005-2013.

Jurisdiction: Port Madison Indian Reservation, Washington State.

Stakeholders: Members of the Suquamish Tribe, including tribal elders and youth, service providers, and other community members.

Lead Public Agency or Organization: The Suquamish Tribe's Wellness Program and University of Washington's Alcohol and Drug Abuse Institute.

Types of Services or Uses Planned: Youth Development Curriculum.

Description of Process, and Outcome and Findings: The Healing of the Canoe Project, funded by the NIH's National Center on Minority Health and Health Disparities, was a multi-year participatory research and planning effort to reduce health disparities by: assessing community needs; prioritizing health disparities of greatest concern to the community; identifying resources from within the community; and developing and piloting appropriate and culturally relevant interventions. The project launched with interviews of key stakeholders and focus groups with tribal elders, youth, service providers, and other community members to determine project readiness and issues of concern. The participants identified the prevalence of substance abuse among Suquamish youth and the need for the development of tribal identity and a sense of belonging. By engaging and preparing the community, the project achieved the development of a culturally-grounded curriculum called "Holding Up Our Youth," which incorporates traditional practices, values, teachings and stories to provide youth with skills necessary to avoid drug and alcohol use (Healing of the Canoe Project, 2013).

The Healing of the Canoe Project demonstrated adherence to a number of strategies outlined in the Community Readiness and the Community Engagement models. First, the project assessed community readiness via sixteen key informant interviews using an adaptation of the Tri-Ethnic Prevention Research Center's community readiness interview guide. The interviewers asked informants to identify the three areas of greatest concern to the community, and to assess community readiness, including community efforts to address the concern to date, community knowledge of the issue, the level of leadership and commitment to addressing the issue, and the resources available to address the issue (Healing of the Canoe Project, 2013).

According to the CDC's handbook on Community Engagement (Clinical and Translational Science Awards Consortium, 2011), the Project also demonstrated practical applications of the principles outlined in the Community Engagement model. Principle #4, which affirms the right to community self-determination, was demonstrated by the community identifying the issues that were most critical to them. Principle #5, the necessity of partnering with the community, was achieved in part through the hiring of a tribal member with a master's degree in social work as a co-investigator. Principle #7, which calls for the mobilizing of community strengths and assets, was met with the development of curriculum that relies on the knowledge and experience of tribal elders, the resiliency of tribal youth, and the rich Suquamish culture and traditions. Principle #8, calling for release of control to the community, was addressed by the researchers, who submitted a report on the interviews and focus groups to the Suquamish Cultural Cooperative, for feedback, suggestions, and approval. The foundation for Principle #9, to prepare for the long-haul by engaging community organizations, was demonstrated by including the Tribe in all aspects of the project (Healing of the Canoe Project, 2013).

The Active Community Engagement (ACE) Continuum

As outlined above, in 1997, the CDC's Committee on Community Engagement developed principles for community engagement in public health. These principles provided the basis for the development of the ACE Continuum, which provides a conceptual framework for engaging communities in reproductive health (RH) and family planning (FP), and for developing indicators for the measurement of community engagement and empowerment (CDC/ATSDR, 1997).

The ACE Continuum includes three levels of community engagement that move from 1) consultative, to 2) cooperative, to 3) collaborative. At the first level, community members are targets of change, and public community planning activities are likely to consist of outreach and messaging. Community empowerment increases at each subsequent level towards community members becoming agents rather than targets of change. The theory of change suggests that the more involved and informed the community is in planning for services, the more likely the resulting services will be sustained. At Level 3, the service delivery system reaches a high level of collaboration with the community; activities are likely to include participatory exploration of power relationships and collaborative decision-making (CDC/ATSDR, 1997). Jane Wickstrom, a Senior Manager at EngenderHealth, an aid organization concerned with international health, describes the ACE continuum as a tool used by EngenderHealth to "check in" and monitor progress. Wickstrom states, "…it is really helpful in that it encourages people to focus on what we mean by community involvement, and how it works. There are so many levels we can talk about, so the model can be a descriptor. It helps because people have different expectations about community involvement" (2013).

ACE uses five characteristics of empowerment, adapted from the World Bank (Naryan, 2002). These include: 1) inclusion of communities in preprogram assessment; 2) access of communities to information; 3) inclusion of communities in decision making; 4) development of local organizational capacity to make demands on institutions and governing structure; and 5) accountability of institutions to the public. For each of the five characteristics of empowerment, the model establishes indicators or characteristics at each of the three level of engagement (Russell et. al., 2008).

Characteristics of community engagement	Level 1	Level 1	Level 3
Community involvement in assessment	General information from community meetings used to refine programs.	As in Level 1 plus: Discussions with leaders regarding RH and FP issues.	Level 1 & 2 plus: Participatory exploration of community power relationships and social contest.
Access to information	Accurate RH/FP messages disseminated through media and government structures.	As in Level l, plus: Community agents disseminate messages with limited interpersonal interaction.	As at Levels 1and 2, plus: Community agents facilitate dialogue on FP/RH and its relevance to daily life.
Inclusion in decision making	Input/approval solicited from influential community leaders at start of project.	As in Level 1, plus: Leaders and advisory groups involved as ongoing partners in decision-making.	As in Levels 1 and 2, plus: Community-based organizations (CBOs) and groups collaborate in decision making.
Local capacity to advocate to institutions and governing structures	Strengthen FP service delivery through community outreach.	As in Level 1, plus: Build capacity of local leadership and advisory groups to oversee quality of RH/FP services.	As in Levels 1 and 2, plus: Build capacity of CBOs and foster organizational linkages to advocate for quality RH/FP services and policies.
Accountability of institutions to the public	Health services/policies informed by providers and governments with limited community input.	As in Level 1, plus: Health services/policies have systems for citizen participation (e.g. health advisory groups).	As in Levels 1 and 2, plus: Health services/policies ensure equitable input from community to inform RH/FP resource allocation.

ACE defines community engagement as "the process of working collaboratively with groups of people affiliated by geographic proximity, special interests, or similar situations with respect to issues affecting their well-being" (Russell et. al., 2008 p.1).

1. **Value partnerships, and their unique contributions, from the global to the community levels**. Each partner, from governmental organizations to local CBOs, may have different missions, but to make the partnership work, each partner needs to value the strengths of the others, finding points of agreement.

2. **Be clear about the purposes and goals of community engagement before starting**. All partners must agree on what community engagement means before beginning the project. Understanding the level of engagement and the roles that community members are to play will allow the partners to agree on indicators and on methods for documentation and evaluation.

3. **Define from the beginning such terms as participation, communication, engagement, mobilization, and empowerment as they apply to the project**. These terms are often used interchangeably. Indeed, they are very similar. The distinctions between them are small, but it is important that everyone agree on what they mean before starting a project. All of these actions are interrelated and ongoing.

4. **Understand that flexibility (of donors, organizations, and communities) is needed to collaborate and share power at all levels of community engagement**. Due to the dynamic nature of community engagement, processes and outcomes can change. All partners, including donors, need to be flexible, to adjust to the changes that may occur.

5. **Be willing to determine the level of engagement, including key capacity-building interventions and the time frame, before starting a project.** All partners need to agree to these details before beginning a project so that expectations are clear for everyone.

6. **Agree on clear indicators with expected outcomes and on a documentation process that will reflect both RH/FP outcomes and levels of engagement**. Some partners may see an empowered community as an outcome in itself. Others will only value a health outcome. When using an engagement process, however, it is important to document both the engagement process and the health outcome.

7. **Expect to engage and then reengage throughout the life of the project, as communities are dynamic and behavior change is not linear**. Community engagement is a dynamic process in which leadership and needs are constantly changing. The engagement process is continuous. It can move from level to level or stay at one level, but it constantly must be reevaluated to ensure that indicators are appropriate and met.

8. **Plan the time frame and budget for maintaining community involvement from the start of the project**. It is important that time frames match the needs of the desired outcomes and appropriate activities. Budgeting to ensure that the community engagement process lasts the life of the project is important but is sometimes forgotten (Russell et. al., 2008 pp.5-6).

Similar to the Community Readiness model of measuring stakeholder preparedness for change, the ACE model could be used by MHSA CPP planners to measure the degree to which stakeholders are engaged in MHSA planning. By developing collaborative principles of planning, such as those described above, ACE hypothesizes that stakeholders can become increasingly empowered agents of change, which is consistent with the principles of MHSA.

ACE Case Study

Using ACE Continuum to Address Health Inequities in an Urban Area: Los Angeles County

Time Period: 2006-2011.

Jurisdiction: Los Angeles County – Second Supervisorial District.

Stakeholders: Program staff, community leaders from school, CBO, and faith based organizations.

Lead Public Agency or Organization: Los Angeles County Sexually Transmitted Disease (STD) Program.

Types of Services or Uses Planned: STD testing.

Description of Process, and Outcome and Findings: In 2006, Los Angeles County's Sexually Transmitted Disease Program began mobilizing community leaders to plan and implement prevention strategies to reduce the disparities in chlamydia and gonorrhea rates among youth of color in the city's Second Supervisorial District. At the 2012 National STD Prevention Conference, using the ACE Continuum framework, staff (Magee, 2012) presented methods they used to engage the community in 2006. The presentation showed that planning efforts to include stakeholders in assessing health needs involved community leaders at Level 2—town hall meetings were held to hear the opinions of leaders from school, CBO and faith based organizations. By 2011, assessment efforts had achieved Level 3—whereby meetings with stakeholders and community leaders were being held to identify social determinants related to STD disparities. Similarly, in 2006, community advocacy had achieved Level 1—whereby community organizations approached the Los Angeles County Public Health Department (DPH) to provide STD testing outside STD clinics. In 2011, advocacy efforts had achieved Level 3—a community Advisory Group provides oversight to DPH and seeks funding to expand STD testing capacity. This case study demonstrates how the ACE Continuum can be used to measure the success of community engagement efforts by using an established framework. Community planning activities are mapped on a hierarchical grid to see the degree to which their efforts have achieved standards of empowerment and engagement. The ACE framework was used post-planning to show the degree to which efforts had contributed to community engagement and empowerment, but the framework can also be used to establish benchmarks and milestones of success upon launch of a public community planning initiative (Magee, 2012).

Community Based Participatory Research

Community Based Participatory Research (CBPR) is a collaborative approach to conducting research that "equitably involves all partners in the research process and recognizes the unique strengths that each brings" (Minkler et. al., 2008, p. 7). CBPR conducts research *with*, rather than *on*, communities, and seeks to build community capacity to act for social change at the same time as studying locally relevant issues or problems. Inherent in CBCR is the notion that the same individuals who conduct the research also participate in planning and the implementation of programs and policies to improve community wellbeing (Minkler et. al., 2008).

The concept of CBPR, referred to interchangeably as "participatory action research," "participatory research," "action research," and "community based research," have theoretical underpinnings that emerge from an understanding that social, economic and environmental factors contribute to health status, and that these factors have a disproportionate impact on poor and marginalized communities. Such communities exhibit numerous strengths and skills and resources that can be leveraged to address social problems and promote health and wellbeing. CBPR is one way to leverage such community resources. Key principles of CBPR include:

- Build on the strengths and resources of the community.
- Involve all participants equally in all phases of research and action.
- Promote co-learning and empowerment to address social inequity.
- Disseminate findings to all participants.
- Promote long-term commitment by all participants (Israel, 1998).

Most research on the impacts of CBPR has occurred outside the United States. One study, entitled Promoting Healthy Public Policy through Community-Based Participatory Research: Ten Case Studies, funded by W.K. Kellogg Foundation and produced by PolicyLink in partnership with University of California Berkeley School of Public Health (2008), provides some useful findings on the policy outcomes of CBPR for initiatives in the United States. The study reviewed 80 cases of purported CBPR initiatives but found that only 27 met criteria such as: 1) being participatory and empowering; 2) promoting systems change; 3) fostering co-learning and capacity building; and 4) balancing research and action.

The PolicyLink study focused on 10 such cases, all of which appear to have contributed to systems- or policy-level change. However, authors cite that the emphasis on coalition-building and the involvement of numerous change agents made singling out CBPR's role in policy victories nearly impossible. Rather, the study focused on ways in which CBPR appeared to contribute to change. They were not able to attribute outcomes to the CBPR initiatives alone (Minkler et al., 2008).

The report found that several factors contributed to the success of a CBPR partnership, including:

- The presence of a strong, autonomous organization prior to the development of the partnership.

- A high level of mutual respect and trust among the partners and an appreciation of the complimentary skills and resources that each partner brought.
- Appreciation by all partners of the need for solid scientific data as a prerequisite for making the case for policy action.
- Commitment to "doing your homework"—finding out what other communities had done, who holds decision-making authority, key leverage points, etc.
- Facility for and commitment to building strong collaborations and alliances with diverse stakeholders beyond the formal partnership (Minkler et al., 2008, pp. 8-9).

The report also captured a variety of recommendations for ensuring that CBPR contributed to health-promoting policy change. Thirteen such recommendations were made; the following are most relevant to MHSA planning efforts, especially those that involve stakeholder involvement in identifying community mental health issues:

- Build leadership by being genuinely community-driven. Particularly, start with a "hot-button issue" that the community is committed to helping research and mobilize around.
- Use a mix of research methods, people's stories as well as facts and statistics.
- Produce high-quality research but make results easily accessible.
- Use approaches that reflect stakeholder culture, even if it slows the process down.
- Increase stakeholder understanding of policymaking and issues through training, web-based tools and other resources, including academia.
- Offer solutions, not just complaints.
- Recognize that policy change takes a long time and commit to staying involved for the long-haul (Minkler et al., 2008, pp. 9-10).

The principles of CBPR are applicable to MHSA CPP because they are strength-based and seek to develop individual as well as community capacity. This is entirely consistent with the principle of wellness, recovery, and resiliency. The recovery movement's concept of "nothing about us without us" also applies to CBPR, in that stakeholders are included in studying persistent community problems, reflecting on the data to make informed choices, and participating in implementing solutions. CPP practitioners could model their activities based on CBPR by encouraging stakeholders to collectively investigate a mental health issue, develop strategies, participate in implementation, and measure success.

Community Based Participatory Research Case Study

Reintegrating Drug Users Leaving Jail and Prison

Time Period: 1996-2004.

Jurisdiction: Harlem, New York City.

Stakeholders: Local service providers, city health organizations, advocacy groups, community residents, and former inmates.

Lead Public Agency or Organization: Harlem Community and Academic Partnership (HCAP) comprised of New York City Department of Health, New York Academy of Medicine, and a Community Action Board.

Types of Services or Uses Planned: Reintegration programs for inmates leaving jails and prisons.

Description of Process, and Outcome and Findings: Launched with funding from a CDC Urban Research Center Grant to promote innovative strategies to improve the health of low income and urban populations, HCAP leadership initially sought to address substance abuse in the Harlem neighborhood. Having begun the initiative with few local connections, the leadership formed a Community Action Board comprised of representatives from local service providers, city health organizations, advocacy groups and residents. Through several iterations of research and planning, the partnership defined its focus on addressing the local challenge of reintegrate drug users leaving jail and prison. Specifically, the data suggested that over 6,000 inmates were released into Central and East Harlem every year, and half were re-incarcerated within a year.

The partnership conducted a literature review and secondary source data analysis on incarceration and substance abuse. They facilitated focus groups with 36 substance abuse service providers and former inmates and added a question to a poll of NYC residents related to public opinion on reentry. Findings from the research suggested that people leaving prison and jail were not prepared for release and did not have adequate support. Following the study, the partnership shared their findings with an even broader range of stakeholders within the community, generating strong local interest in developing an action plan for addressing reintegration issues. The partnership advocated for and then used research from a city-sponsored cost analysis, which showed that the City would save money by supporting reintegration programs. Members spoke at city council meetings, produced policy reports and developed a set of 12 recommendations. Several outcomes are attributed to the work of the partnership including: 1) Department of Corrections releases more inmates during daylight hours; and 2) expanded housing, drug treatment, and employment services for people leaving jail and prison. In addition the partnership is credited with having helped pass legislation to reinstate Medicaid coverage to newly-released inmates (Minkler et al., 2008).

Neighborhood Planning Framework

Neighborhood Planning is a process by which residents in a particular geographic area develop a shared vision and a plan to solve neighborhood problems. A report out of Cleveland State University defines neighborhood planning as:

> *…a process whereby residents and other stakeholders learn about their neighborhood, envision a shared future, and develop strategies to shape it for the better and sustain it for the long term. The process results in a plan that encourages and directs future social and economic investments toward the development of a healthy neighborhood* (Burkholder, Chupp & Star, 2003, p. 1).

The concept of Neighborhood Planning has emerged over time, taking flight in recent years as many federal programs now require citizen participation in planning for land use and social services. Community Development Block Grants (CDBG), established in 1974, for example, require that grantees provide adequate opportunities for residents to participate in planning, implementation and evaluation. In the early 1900s, the settlement house approach emerged to address urban problems by focusing on social and economic solutions to the problems of poverty. Later, from the 1920s to the 1960s, community action focused on the physical environment of neighborhoods. Between the 1960s and 1970s, neighborhood actions focused on political means to address poverty. Most recently, neighborhood planning has focused on attempts to coordinate political, social and physical approaches to solve poverty and related social issues (Burkholder, Chupp & Star, 2003).

Neighborhood Planning is based on Community Development Theory, the principles of which include democratic decision-making by the people whose lives are most affected, engaging community members in learning about community issues, and the development of local leadership. The authors of the Ohio report cite a range of guiding principles for Neighborhood Planning:

- Thoughtful, deliberate preparation.
- Identification and development of neighborhood assets.
- An inclusive process for a specific, agreed upon area.
- Resident involvement in the development and approval of the plan.
- Defined and appropriate roles for all participants.
- Transparency in planning processes.
- Democratic decision-making.
- Development of a vision of what the neighborhood can become.
- Collection of data to inform the process.

- Recognition of market dynamics.
- Feasible implementation plans (Burkholder, Chupp & Star, 2003).

Neighborhood Planning theorizes that when local residents and other stakeholders are involved in planning, the quality of decision making improves and the resulting plan reflects resident needs and vision. "The process creates a sense of community and can empower residents by building their confidence, capabilities, skills and ability to cooperate" (Burkholder, Chupp & Star, 2003, p. 7). Neighborhood Planning yields greater legitimacy. "… a greater sense of ownership of the plan often translates into greater determination to implement the plan" (p. 7). Additionally, when residents are involved in implementation of a plan, they feel more connected to their community, and are better able to manage and maintain their neighborhoods, for example, leading to reductions in vandalism and neglect. Daniel Lacofano, Principal and CEO of MIG, a planning and design firm committed to "sustaining environments that support human development," emphasizes the necessity of inclusiveness and true engagement of participants for successful planning efforts: "Inclusiveness…A commitment to working through problems, some very technical. Not just asking for stakeholder opinions" (2013).

There are two broad-based approaches to Neighborhood Planning. In one approach—*community-initiated planning*—community development corporations, advocacy and other CBOs plan programs and influence government. The other approach, perhaps more applicable to MHSA planning, is *city-initiated planning*. In this approach, city governments initiate planning in a particular neighborhood, and staff the planning effort themselves or empower consultants or community organizations to participate in various ways, from reviewing plans and budgets to actively developing strategies and participating in decision making (Burkholder, Chupp & Star, 2003).

In 2013, the United States Environmental Protection Agency (EPA) produced a report outlining strategies for creating equitable, healthy and sustainable communities (McConville, 2013). One of the primary principles, which aligns seamlessly with the Neighborhood Planning model, is to: "facilitate meaningful Community Engagement in Planning and Land Use Decisions." The EPA suggests that meaningful community participation and leadership can ensure that revitalization efforts are based on local values and address resident needs. The EPA submits that early and consistent stakeholder involvement is critical to effective engagement. Additionally,

> *Inclusive involvement results in planning and development decisions that have been improved by a variety of perspectives, have authentic support from a broad range of constituents, and are more enduring and better for the community as a whole. Obtaining input from groups not historically engaged in planning can help reduce the disproportionate environmental harms and health impacts they often face and make sure that future development brings fair access to new opportunities* (McConville, 2013, p. 17).

The EPA report outlines three principal strategies for facilitating meaningful community engagement:

1. **Conduct Multilingual Outreach**: Increasing participation to those who have typically been left out of the process produces better solutions. For example, by reaching out to non-

English-speaking groups, transportation authorities are finding that ridership and public support for public transit increases. In the Othello neighborhood of Seattle, the City employed outreach liaisons to reach Cambodian, Somali, Vietnamese, Latino, Amharic residents, as well as Native American, African Americans, youth and persons with disabilities. Before public meetings, the liaisons translated materials and held breakout sessions with their constituents to ensure they could effectively participate. Using this strategy, attendance grew from 10 - 400 residents per public meeting.

2. **Conduct Community Assessments:** Many planning processes do not understand the specific geographic region nor resident priorities and needs. Community Assessments engage residents in gathering, analyzing, and reporting information about current conditions and available resources. Examples include walkability audits, which measure the safety and convenience of walking in a particular neighborhood. In Santa Clara County, the Public Health Department engaged local college students in assessing street segments in predominantly Latino neighborhoods to identify opportunities to reduce high rates of obesity and diabetes among Latino residents.

3. **Hold Community Planning and Visioning Workshops**: One of the first steps in Neighborhood Planning should be to define a shared vision and set of goals. Community workshops are often led by professional facilitators who lead structured discussions and exercises and often produce visual representations of a desired future. Maps and drawings can be used. Local decision-makers should participate in the workshop to learn about community needs and goals. Elected officials in Gary Indiana, for example joined residents in a neighborhood design workshop to revitalize the Broadway corridor of a predominantly African American community. The resulting plan called for strengthening cultural heritage sites, improving transportation, and reusing vacant parcels of land (McConville, 2013).

The theory of Neighborhood Planning, which suggests that when local residents and other stakeholders are involved in planning, the quality of decision making improves, applies to MHSA planning as well. While the mental health community is only loosely defined geographically (i.e. countywide) stakeholders are bound by a common desire to improve mental health outcomes. In theory, when stakeholders collectively learn about mental health issues, envision a healthy community, and develop strategies for achieving their vision—like neighborhood residents— the process helps to build their confidence, capabilities, and skills. Participatory planning under these conditions leads to the development of leadership's commitment to effective implementation.

Neighborhood Planning Case Study

Strong Neighborhood Initiative (SNI)

Time Period: 2000-2010.

Jurisdiction: San Jose, California.

Stakeholders: Neighborhood leaders, residents, business owners and other community members.

Lead Public Agency or Organization**:** City of San Jose and San Jose Redevelopment Agency.

Description of Process, and Outcome and Findings: Between 2000 and 2010, the SNI partnership sought to strengthen communities by building strong, clean and safe neighborhoods, and capable, independent and sustainable neighborhood organizations. The partnership coordinated resources from property and business owners, community leaders, and private-public partnerships to help communities reach their full potential. There were 19 active Strong Neighborhoods throughout the City seeking to leverage community assets and bring in dedicated resources. Service priorities included affordable housing, neighborhood safety, economic development, and parks and recreation. SNI included two phases: planning and implementation.

Planning Process: A neighborhood advisory committee (NAC) served as a lynchpin in each neighborhood, and was comprised of neighborhood leaders, residents, business owners, and other stakeholders. Each SNI was tasked with developing or revising their neighborhood improvement plan by establishing a vision and a set of ten priority action plans. During the planning phase, which lasted between 8 - 12 months, the NACs facilitated monthly public planning meetings and workshops. The NACs continued to meet during the implementation phase, overseeing plans and providing input. One neighborhood, Five Wounds/Brookwood Terrace, used the SNI to help maintain their small-town atmosphere, redevelop commercial areas, improve streetscapes, and add more recreational corridors and parks. Other services planned included the rehabilitation of housing and programs for local teenagers.

Outcomes: In 2008, the National League of Cities presented SNI with a Municipal Excellence award. A December 2009 progress report on SNI stated that the existing projects succeeded in improving neighborhood conditions, enhancing community safety, expanding community facilities, and reducing blight. SNI and Redevelopment Agency staff convened community conversations with 140 neighborhood leaders and staff asking, “What is most important for building strong neighborhoods?” According to the progress report, their answer was to focus on: 1) removing barriers to neighborhood action; 2) stabilizing neighborhoods in crisis; 3) mobilizing neighborhood action; and 4) connecting resources to priorities. (Redevelopment Agency Board, 2010). In June 2010, following the defunding of state and local redevelopment agencies, SNI ended. In its 10-year span, SNI funded streetlights, community centers, revamped sewer systems, sidewalks, parks, and crime-plagued shopping centers. In our research on SNI, we did not find evaluation literature linking specific community planning activities to specific outcomes.

According to Urban Land Institute, a nonprofit land use and real estate education and research institute, a variety of lessons emerged from the SNI planning processes, including: 1) City departments should organize programs by neighborhoods; neighborhoods are the building blocks for planning and implementation. 2) Plans should be developed on neighborhood strengths and assets. 3) Neighborhoods should establish clear priorities (for example, the development of ten priority action plans).Specific individuals or institutions should be responsible for implementation. 4) Neighborhood priorities and city budgets should be aligned to avoid conflicts and maximize impact. 5) Elected officials and other city leadership must be developed to support the collaborative planning and implementation efforts. 6) Planning efforts must maintain momentum (Myerson, 2004).

Public Engagement in Education

The Public Engagement model of planning for public education is a collaborative, inclusive, participatory approach to bringing about meaningful change in public schools that emphasizes substantive community involvement in all phases of school planning. Although U.S. schools have traditionally sought input from community stakeholders, such as Parent Teacher Associations (PTAs), these relationships are often unequal partnerships, with community groups placed in roles of support for the educational ideas and policies as decided by school administrators. The Public Engagement Model turns this notion on its head, and suggests that instead of seeking community input in the form of support for existing ideas, schools and school districts actively engage the public more meaningfully and substantially in order to generate new ideas, participate in consensus-based decision-making processes, and ultimately shape local educational policy in partnership. Proponents of the Public Engagement Model seek active and inclusive school-community partnerships, but not for the purpose of bringing current policies and those who implement those policies more power. Rather, proponents seek to decrease this centralized power by increasing the role and control of the community: "not gaining control, but giving it up" (Michigan Association of School Boards, 2006, p.2). According to the Public Engagement model, community participation in school planning is viewed as essential to school reform, resulting in greater trust, parent involvement, increased funding, and "the potential to build learning environments that are more inclusive, extensive, and integrated into the community as a whole" (Bingler, 2003, p.3).

The Public Engagement approach follows from the work of seminal education theorist Paolo Freire, who suggested a horizontal, rather than a vertical approach to participatory action, particularly as it related to educational policies and planning. For Freire, a horizontal relationship based on empathy between the parties involved enables them to engage in inclusive, trusting, and critical dialogue, which will lead to a true understanding of the educational needs of the community, as well as the processes for satisfying them (Freire, 1974). Further, in his concept of praxis, Freire emphasized the importance of going beyond this dialogue to unified action, stating, "It is not enough for people to come together in dialogue in order to gain knowledge of their social reality. They must act together upon their environment in order critically to reflect upon their reality and so transform it through further action and critical reflection" (Freire, 1970).

Following from this, the Public Engagement Model for education identifies four key components to community engagement for the purposes of educational planning: 1) active listening, 2) deliberation, 3) collaboration, and 4) shared responsibility.

In order for schools to move from more traditional communication models to a public engagement orientation, some general guidelines are suggested:

1. Begin with the right issue: According to a traditional model, this first step—the choice of an issue to focus on—would be decided by school staff, faculty, administrators and school board members. Working within a Public Engagement Model, schools and the community share an equal voice, with schools considered as a part of the broader community. To decide on the appropriate issue to be addressed, a school-community steering committee might be formed to guide the selection of this choice and may

include school staff, students, parents, local residents and business people, and other interested stakeholders.

2. Frame the issue: Whereas traditionally, the way the issue is framed would come from only one viewpoint—that of the school—the Public Engagement Model emphasizes the need to consider all viewpoints, including those of the school, parents, students, and the broader community. A working meeting with representatives from all stakeholder groups to determine how the issue will be framed for a broader discussion is one approach to this step.

3. Create community conversation: Face-to-face interaction is at the core of the Public Engagement Model; for this reason it is essential to provide an opportunity for all stakeholders to be heard and for multiple approaches to the issue be considered. Educators are encouraged to participate but not drive these conversations. Participants must feel that everyone has a stake in the issue, and therefore everyone has a responsibility for its solution. An action plan is often developed in this stage, and tasks divided among participants. This conversation may take the form of a large community forum.

4. Reconvene stakeholders: After significant time has passed, stakeholders may be reconvened to revisit conversation on the issue, and review any action taken. This meeting may take the form of a fair, and increased community participation may be sought (Michigan Association of School Boards, 2006)

Ten principles to authentic community engagement:

1. Involve all sectors of the community.
2. The community will be engaged on important questions, and the views and contributions of the community will be acknowledged.
3. The community will be involved early in the process.
4. Opportunities for people to gather at convenient and comfortable locations and a variety of times will be offered.
5. More than one meeting will take place, and enough time will be offered to make informed judgments.
6. The community's values and aspirations for the future will inform discussion and action.
7. The process should have a learning component that helps build community awareness and knowledge about the subject at hand.
8. The process should allow for sustained involvement by community stakeholders.
9. Community partnerships and expertise will be utilized.
10. Clear, open, and consistent communication will be employed (Michigan Association of School Boards, 2006)

The public engagement model in education entails a shift in traditional power relationships whereby stakeholder groups actively generate new ideas, participate in decision-making processes, and shape policy. This model can be applied to MHSA processes to the extent that departmental leadership is willing and able to decentralize power and increase the role of stakeholders. This shift need not occur overnight; the model hypothesizes, however, that such transition will lead to greater trust and community integration.

Public Engagement Case Study

New Facility for Capitol Elementary School

Time Period: Beginning 1994.

Jurisdiction: Phoenix, AZ.

Stakeholders: School staff, faculty, and administrators, parents, students, local business people, and residents.

Lead Public Agency or Organization**:** Phoenix Elementary School District #1.

Types of Services or Uses Planned: Improved school facility and programs.

Description of Process, and Outcome and Findings: Located in one of the most economically disadvantaged neighborhoods in downtown Phoenix, Capitol Elementary School had been operating out of small, dilapidated portable classrooms, with no windows, insulation or air-conditioning. According to the principal at the time, Cora Garrido, "The district viewed us as a dying community." Teachers felt burnt out, disconnected, parents felt equally disaffected; and attendance was among the worst in the district. In 1994, at the principal's request, voters approved a $6.2 million bond measure to build a new school.

At the principal's request, a committee comprised of parents, school staff, local business owners, and district personnel assumed responsibility for planning the new school, which surprised many traditional school planning stakeholders, including professional educators, architects, and engineers. Looking back, the school district's director of facilities, Greg Johnson, thought "What do these people know about construction?" Nonetheless, the committee met each week to discuss educational philosophy and best practices, forming a set of educational goals the new facility was intended to support. Some of the "experts" found the process slow and irrelevant. "What's to talk about," recalled Johnson, "Let's just build a square box that's easily maintained." Ultimately, however, an architectural firm was selected to lead the design process, to help translate the school's educational goals into a new school building. The committee expanded the planning process to the broader community, who worked with the architect to develop design goals.

The school was built according to the collaborative design developed as a result of the participatory process. The community envisioned a school which would: 1) be colorful; 2) have plenty of natural light, foster a sense of community with its design, with many gathering places; 3) have ample space for large projects, and encourage cross-classroom learning and collaboration; 4) include shared office space for teachers, to encourage and facilitate common planning; and 5) encourage integration of technology. Project architects stayed true to these goals, and the new Capitol Elementary School facility includes non-traditional colors, skylights, classrooms arranged in a circular fashion around a shared activity area with movable classroom walls, shared office areas for teachers, and computer areas in all of the classrooms. The outdoor area of the school includes a large, inviting circular courtyard which has naturally developed into a gathering place for children, teachers and families. Other school gathering places include a multi-purpose room and a community room, where parents often work on projects for classroom teachers. The school design also includes a small health center for students and their families, with one full time nurse, and one half time nurse practitioner.

The success of the project reached beyond the grounds of the school itself, and extended into the local neighborhood, with neighbors reporting a reduction in crime, an increase in home and neighborhood beautification projects, and a new sense of pride in the community, as a result of the planning and construction of the new school (Furger, 2003).

Mobilizing for Action through Planning and Partnerships (MAPP)

A community assessment is a method of identifying local problems, needs, strengths and assets. The assessment is used to establish priorities and explore strategies for action. Mobilizing for Action through Planning and Partnerships (MAPP) is a community-driven, place-based public health assessment and planning process developed between 1997-2000 by the National Association of County and City Health Officials (NACCHO), and the Centers for Disease Control and Prevention (CDC). Stakeholders in the MAPP process include public health professionals, other health and human service providers, policy makers, public servants, service recipients, and neighborhood residents (National Association of County & City Health Officials, 2013).

The MAPP model emerged from a 1988 report that argued that public health in the U.S. was in "disarray." A predecessor model developed in 1991, called Assessment Protocol for Excellence in Public Health (APEXPH), no longer receives CDC funding. According to MAPP's lead program analyst, MAPP distinguishes itself from predecessors and from many other public community planning models because of its focus on "strategy, inclusiveness and a commitment to effectiveness" (Allee, 2013).

MAPP envisions "communities achieving improved health and quality of life by mobilizing partnerships and taking strategic action." Other goals of the MAPP process are to increase awareness and knowledge of public health issues, strengthen public health infrastructure, develop a sense of community ownership of public health issues, and better manage and respond to environmental changes (National Association of County & City Health Officials, 2013).

MAPP uses a step-by-step process that includes the following phases:

1. **Organizing the planning process and developing planning partnerships.** The purpose of this phase is to engage public health stakeholders and develop their commitment to the planning process.

2. **Visioning.** During this phase, participants develop a shared vision about what an ideal future would look like. The visioning process helps establish common values.

3. **The 4 assessments.** Participants collectively engage in collecting and interpreting data on four topics:

    a. Community themes and strengths—*"What is important to our community*?" and *"What assets do we have that can be used to improve community health?"*

    b. Local Public Health System Assessment—*"How are essential services being provided to the community?"* and "*What are the activities and capacities of the local public health system?"*

    c. Community Health Status Assessment—*"How healthy are our residents?"*

d. Forces of Change Assessment—*"What is occurring or might occur that affects the health of our community or the local public health system?"*

4. **Identifying strategic issues.** During this phase, participants review assessment data and develop a list of the most important issues facing their community.

5. **Developing goals and strategies:** Participants develop goals and strategies after identifying the most important issues.

6. **Action Cycle:** During this phase, the local public health system develops and implements the action plan. This phase includes an evaluation of the actions taken to improve health (National Association of County & City Health Officials, 2013).

MAPP operates from the following seven principles:

1. *Systems thinking*: to promote an appreciation for the dynamic interrelationship of all components of the local public health system required to develop a vision of a healthy community.

2. *Dialogue:* to ensure respect for diverse voices and perspectives during the collaborative process.

3. *Shared vision:* to form the foundation for building a healthy future.

4. *Data:* to inform each step of the process.

5. *Partnerships and collaboration:* to optimize performance through shared resources and responsibility.

6. *Strategic thinking* — to foster a proactive response to the issues and opportunities facing the system.

7. *Celebration of successes:* to ensure that contributions are recognized and to sustain excitement for the process (National Association of County & City Health Officials, 2013).

The MAPP process broadens the definition of public health stakeholders to include many groups other than public health department employees. All public health stakeholders, from local business leaders, faith community, service providers, and recipients, can engage in planning and action. MHSA coordinators may consider a MAPP or similar framework for their CPP processes by guiding a broad range of stakeholders through a step-by-step approach to establishing a vision, conducting an assessment, identifying issues from the data, developing strategies, and engaging stakeholders in the implementation or action phases. The MAPP process entails a leap from research to planning, and then another leap from planning to action. To engage mental health stakeholders in a MAPP-like process, the department will need to commit to engaging stakeholders not only in planning, but in implementing strategies.

MAPP Case Study:

San Francisco Healthy Homes

Time Period: 2011-2012.

Jurisdiction: San Francisco, CA.

Stakeholders: Public and community-based health care providers, government agency representatives, the local YMCA, community advocates, and residents of low-income housing developments.

Lead Public Agency or Organization**:** San Francisco Department of the Environment in collaboration with San Francisco Department of Public Health.

Types of Services or Uses Planned: Strategies to address health inequities Description of Process, and Outcome and Findings**:** Funded by a grant from the CDC's Racial and Ethnic Approaches to Community Health program, the Department of the Environment (SFE) launched San Francisco Healthy Homes (SFHH). SFHH sought to address health inequities in the Bay View Hunters Point and surrounding neighborhoods by "transforming the community's vision of healthy homes and neighborhoods into achievable goals and actions." SFHH participants included public and community-based health care providers, community advocates, and residents of low-income housing developments. The local YMCA served as a key partner by training and stipending local residents to help conduct the assessments and engage in strategic planning. Through the assessment and planning phases, SFHH participants identified the following four goals: 1) Address post-traumatic stress disorders (PTSD) among children, youth and families; 2) Reduce violence in Bayview Hunters Point and surrounding neighborhoods; 3) Reduce preventable health inequities in chronic disease and infant health; and 4) Reduce injury and chronic health conditions by addressing substandard housing conditions.

In July 2012, SFHH entered into MAPP Phase 6, the Action Cycle. Four planning meetings engaged government agency representatives, service providers, residents, and community based organizations, and discussed current initiatives and existing services, gaps and needs, potential strategies and activities, and potential impacts of the activities. Two strategies, along with more detailed tasks, emerged to address health inequities: Support training and employment of local community health promoters and Improve partnerships and communications between local public health system providers, the community, and police (San Francisco Department of the Environment, 2013).

Resource Development Associates (RDA) provided technical assistance and conducted a brief process evaluation using satisfaction surveys and focus groups with participants. The evaluation determined that one of the greatest strengths of the process was the engagement of the Resident Committee, whose members came from low income and public housing developments. During the first year, between 14 and 20 participants attended a total of 6 meetings. Resident Committee members helped collect data, including over 400 resident surveys. During the first year, several challenges were identified: the shortage of Spanish- and Chinese-speaking Resident Committee members resulted in fewer respondents from these demographic groups. Residents described that in the future, it would be useful to spend more time strengthening personal bonds between each other and between the facilitators, and to work on building trust. Ultimately, residents reported feeling very proud about participating in the process. Several reflected on the significance of having their names written into the acknowledgement section. Others stated that they hoped they would continue to meet and support the actions outlined in the final plan (Resource Development Associates, 2013).

Community Dialogue in Health Impact Assessments

Health Impact Assessment (HIA) is a highly structured means for examining the intended, and often unintended, health effects of proposed policies, plans and projects in land use, transportation, housing, agricultural, energy and other infrastructure arenas. HIAs help to determine if a proposed program or project should be approved, and when conducted in a principled manner, examine the physical, social and mental wellbeing of community members using a broad, systems based approach that includes evidence from a variety of sources (UCLA School of Public Health, 2003-2006). Meredith Minkler, Professor of Health and Social Behavior at the University of California at Berkeley, suggests Health Impact Assessments as a participatory planning method worth further exploration (Oct, 2013).

There are three basic methods to conducting an HIA: 1) Community Dialogue; 2) Quantitative Analysis; and 3) Bureaucratic Pragmatism. Not all of these HIA methods emphasize stakeholder participation. For instance, HIAs which utilize the Quantitative Analysis approach alone focus on the numerical measurement of the impacts of policies and projects on health outcomes. Quantitative Analysis applies methods from risk analysis, epidemiology, economics, and toxicology. The Bureaucratic Pragmatism approach is utilized by government agencies required to assess health impacts as specified by agency regulations or rules. These HIAs use the analytical methods which the governing agency requires, and emphasize efficiency, expediency, and adherence to regulations. Tools which encourage community input such as community meetings may be included, but are not common with this approach (UCLA School of Public Health, 2003-2006).

The community dialogue approach to HIA focuses on public participation in decision making, with the belief that the broad inclusion of stakeholders allows for a close alignment with the four core values which guide HIAs. These core values, as set forth by the World Health Organization, are democracy, equity, sustainable development, and the ethical use of evidence (World Health Organization, 2013). The theory behind the dialogue approach to HIAs suggests that stakeholder involvement and leadership help to promote the goals of inclusive, healthy, and equitable communities. According to the Stakeholder Participation Workgroup of the 2010 HIA in the Americas Workshop, convened in Oakland, California, in 2010, "In such communities, positive health outcomes are equitably distributed; low-income people, communities of color and other vulnerable populations have access to the opportunities necessary to thrive; and the democratic process empowers all to participate in the decision-making processes that impact their lives" (Stakeholder Participation Working Group of the 2010 HIA of the Americas Workshop, 2012, p. 2). Human Impact Partners (HIP), a public health advocacy organization, use Health Impact Assessments as their primary analytical tool. Johnathan Heller, Co-Director of HIP, discusses the need for tools like HIAs to promote democratic planning processes, "Agencies need to think about power. Are they just filling in the boxes or are they interested in promoting democracy? Participation is necessary to promote democracy" (2013).

The Stakeholder Participation Workgroup described stakeholders as those individuals who stand to gain or lose from the policy, plan or project. These include CBOs, residents, service providers, elected officials, small businesses, industry and big business, developers, public agencies, advocacy organizations and academics. Some specific recommendations related to involving stakeholders emerged:

- Ensure stakeholder participation is diverse in order to understand the community and political realities related to the policy, project or program being studied.
- Involve stakeholders affiliated with organizations rather than independently engaged residents who are only representing their personal interests.
- Pay special attention to those representing vulnerable populations, including low-income people, communities of color, people with disabilities, children, and seniors.
- Due to the diversity of interests among potential stakeholders the workgroup notes that "no single approach can be prescribed for stakeholder participation" (Stakeholder Participation Working Group of the 2010 HIA of the Americas Workshop, 2012).

While HIAs focus on the impact of land-use decisions on individuals who stand to gain or lose from the decisions, HIA principles could be applied to MHSA community planning processes. Departmental leadership can engage stakeholders in dialogue about the impact of new programs and policies, paying special attention to feedback received by those who have historically been left out or inappropriately served. Implicit in the concept of dialogue is a commitment to leveling the playing field so that all stakeholders can participate without fear of reprisals. Creating a safe space is therefore critical to CPP planning based on the HIA model. Finally, the idea that no single approach can be prescribed for stakeholder participation is a critical concept, which counties must take seriously when developing their CPP processes. The principle suggests that there are no cookie cutter practices, but that the CPP processes themselves should derive and evolve from dialogue with stakeholders.

Health Impact Assessment Case Study

Adams Park: A Catalyst for Community Revitalization and Health

Time Period: 2011.

Jurisdiction: City of Omaha, Nebraska.

Stakeholders: Neighborhood residents.

Lead Public Agency or Organization: Douglas County Health Department, Omaha, Nebraska.

Types of Services or Uses Planned: Parks and Recreation.

Description of Process, and Outcome and Findings: North Omaha, a once thriving African American Neighborhood and birthplace of Malcolm X, in recent years has experienced economic disinvestment, and insufficient employment and housing options. Community-based planning efforts resulted in a neighborhood revitalization plan that centers on the improvement of the 68-acre Adams Park. The plan seeks to attract visitors, improve recreational options for residents and attract investment. At the heart of the plan is a community garden and urban farm, which the Douglas County Health Department (DCHD) feels could help support resident access to healthy foods (Centers for Disease Control and Prevention, 2013).

In 2011, the CDC funded a Health Impact Assessment to measure the effect the 10- to 20-year Adams Park Plan would have on the wellbeing of the surrounding community. The DCHD collected and analyzed demographic, health and food access, crime, and traffic condition data. Empirical data collection focused on expert informers and scientific research. The African American Empowerment Network and North Omaha Neighborhood Alliance, two local organizations, offered information about resident priorities and concerns. "We saw the opportunity to bring health and health equity into the revitalization effort around Adams Park," said Andy Wessel, a planner for the DCHD. "In the beginning, a lot of people were skeptical about HIA because they felt it would slow down the [planning] process. At the end of the day, the Adams Park HIA showed how including health and community concerns was a real benefit for decision-makers" (Centers for Disease Control and Prevention, 2013).Ultimately, the HIA showed that if the plan were adopted, the park would improve the health of North Omaha residents. The farming and garden center would improve access to affordable and healthy foods and the park would allow for greater social interaction, recreation, and exercise.

This case study shows the Adams Park HIA's commitment to capturing the vision and desires of the stakeholders most impacted by the project—the neighborhood residents. As recommended in the Stakeholder Participation Workgroup, the planners relied on CBO input rather than individual community members. While there was no indication that stakeholders were involved in data collection, interpretation or decision making, Wessel described the project contributing to democracy and equity due to the questions that were asked by the planners, such as "What are the hopes and concerns of the people most affected by this decision?" and "How is this decision likely to affect the lives of those who are already struggling" (Centers for Disease Control and Prevention, 2013).

Participatory Budgeting

Participatory Budgeting is a democratic process that engages community members in decision-making about how to spend part of a public budget. The process was developed in Porto Alegre in 1989 during the first year of Brazilian democracy following a military dictatorship. The Workers' Party, upon electoral victory, started Participatory Budgeting as a result of community organizations' demands for greater inclusion in financial planning and decision-making. The concept of participatory budgeting soon took flight. In 2012, approximately 1,500 municipalities around the world use participatory budgeting (Tian, 2013).

The Participatory Budgeting Process: Municipal governments invite residents to neighborhood assemblies and facilitate a discussion about problems and solutions that can be funded through the city's discretionary budget. The community delegates an individual or group to research concerns and solutions, and return with a slate of project proposals for participants to vote on. The top projects are sent to the city council for approval. The process was first used in the United States in 2009, when Alderman Joe Moore of Chicago's 49th Ward decided to implement Participatory Budgeting. He set aside $1.3 million for the process, which engaged 1,427 residents (Tian, 2013).

A 2002 World Bank study on Participatory Budgeting in Porto Alegre (Bhatnagar & Rathor, 2002, as cited in Tian, 2013) found that the process empowered residents in four critical ways:

1. **Information:** Participants learn about their communities.
2. **Inclusion/participation**: Community members who might not otherwise be included in decision making engage fully in the process.
3. **Accountability:** Municipal leaders are held accountable for sharing financial information and monitoring the status of selected projects.
4. **Local organizational capacity:** Community organizations that form to help influence the budget build capacity and experience.

The report cited that a number of improvements occurred in Porto Alegre between 1986 and 1989, following participatory budgeting, including the development of new public housing units, new sewer and water connections, and new schools. The share of budget allocations dedicated to participatory budgeting grew from 17% in 1992 to 21% in 1999. Another indicator of success has to do with the level of participation. In 1990, 1,000 residents participated in the process. In 1999, 40,000 residents participated.

A recent published essay highlights three core principles of Participatory Budgeting. The first principle—*active citizen participation*—places citizens in a position to make decisions that affect not only their lives, but also the lives of others. As a result, participants learn "social justice" discourse. The second principle—*increased citizen authority*—moves citizen involvement beyond consultive to deliberative roles. They join the realm of "state-sanctioned" decision-makers. In the consultive role, citizens provide feedback to the government, but there is no explicit requirement that the government implements projects selected by citizens. In participatory budgeting, citizens hold the decision-making authority. The

third principle—*reallocation of resources*—suggests that by expanding voice and vote to those who have traditionally been excluded from deliberative roles, Participatory Budgeting helps to redistribute resources, which leads to social justice. Finally, the essay describes the principle of *Improved Transparency*, which suggests that Participatory Budgeting helps to reform local administrative processes. Bureaucrats and policymakers directly engage with citizens, and ongoing conversation results in direct oversight by citizens over the allocation of public resources (Wampler, 2012).

Participatory budgeting could be applied to MHSA community program planning if counties have the authority to relinquish decision-making authority related to budgetary decisions. A county could engage stakeholders in budgetary recommendations using PB approaches but the authority might need to remain within the jurisdiction of county staff and board of supervisors. To understand how PB could be used in CPP planning, a greater understanding of budgetary decision-making authority is needed.

Participatory Budgeting Case Study

Participatory Budgeting New York City

Time Period: 2011 – 2013.

Jurisdiction: New York City, NY.

Stakeholders: between 8,000 and 13,000 residents from four to eight Council districts annually, including youth under 18, people of color, low income earners, immigrants and ex-offenders.

Lead Public Agency or Organization: City of New York.

Types of Services or Uses Planned: City budget development.

Description of Process: In FY 2011-12, 8,000 New York City residents from four districts voted on how to spend $6 million in public funds. In FY 2012-13, the Participatory Budgeting process expanded to over 13,000 resident participants, in eight districts, voting on nearly $10 million in public money. Typically, in February of each year, the Mayor releases a preliminary budget and the City Council holds a hearing where community members can testify. This is the only citizen involvement in the budgetary process. Through participatory budgeting, between September and November, City Council members present information on the budget at neighborhood assemblies in each jurisdiction. In FY 12/13, over 1,500 people participated in 41 assemblies. Residents then brainstorm project ideas and select delegates. Between November and March, delegates meet in committees to transform initial project ideas into proposals, with support from Council staff and other experts. In March, delegates present their proposals and receive feedback in Project Expos, and in April, over 13,000 people residents vote on project proposals. PB represents only a small fraction (0.014%) of the total NYC budget and only 1.8% of discretionary capital funds.

Evaluation and Outcomes: An evaluation of year-two of New York's PB involved 8,200 collected surveys, 30 meeting observations, and 63 in-depth interviews. An evaluation report included a citywide section and detailed breakdowns for each of the eight districts. The evaluation focused on who participated and why, attitudes toward local government and civic engagement, and how City Council members believed they benefitted from the process. The evaluation identified

Measures of civic participation: The evaluation found that PB mobilized long-term residents, many of whom had never worked in their communities to solve a problem. Participation was diverse, with higher proportions of African Americans, low-income earners, and women than the population as a whole. Participants who traditionally are barred included immigrants, youth under age 18 and formerly incarcerated.

Decision-making outcomes: Schools were the big PB winners, with 24% of budget directed toward school improvement. The evaluation found that schools can have disproportionate influence, since they have significant institutional power, and many who got involved in the process were school volunteers. Some delegates pushed for projects in their child's school.

Outreach: Participants heard about PB through social networks, community organization, Council Members and by email. Word of mouth and flyers were most common.

Benefits to City Council Members: Council members reported heightened visibility in the media, deeper connections to constituents and increased awareness of issues.

Community COPE

Community COPE is a model used in the assessment and planning of local healthcare systems in poor communities in the U.S. and internationally. The model emerged from a quality improvement initiative, COPE®—"client-oriented, provider-efficient", developed in 1988 by EngenderHealth, an international aid organization seeking to support family planning, reproductive and maternal health projects, improve quality of care, and advocate for evidence based practices. COPE® is a process and set of tools that health professionals can use to assess, plan, implement and evaluate program and site-level improvements. Since the development of COPE, many health programs have come to recognize the importance of involving community members in the quality improvement process. They argue that by not paying sufficient attention to community and client perspectives, service providers risk clients discontinuing services and potential clients avoiding seeking services. This is because staff members and clients perspectives on the quality of services often differ (EngenderHealth, 2003). Community COPE responds to this concern and theorizes that through community involvement:

1. Community members achieve a greater level of commitment toward and ownership of quality improvement efforts at a particular healthcare site.
2. Healthcare sites achieve access to community resources, such as human effort and time, which may contribute to more in-depth analysis and effective solutions.
3. Sites and communities experience a sense of teamwork and ongoing communication.
4. Community members think about ways to avoid health problems before they become health problems.
5. Community members better understand the problems faced by the healthcare site (EngenderHealth, 2002).

While traditional COPE seeks feedback from existing clients, Community COPE provides outreach to potential clients and other community stakeholders to gather feedback for systems planning efforts, and simultaneously educates the community on their rights and "the ways they can influence the content and quality of health services" (EngenderHealth 2002: vi). The use of the Community COPE model is recommended for health care service delivery sites that wish to increase the involvement of the community in planning and decision making processes. For example, in one Community COPE project in Kenya, interviews, group discussions, and community meetings revealed the following community priorities: 1) access (wait time, distance); 2) client-provider interaction (unfriendly staff); 3) safety (inadequate cleanliness, rats in mortuary); and 4) privacy (crowded/co-ed wards, insufficient screens). As a result, the following changes were identified and implemented: 1) shorten waiting times; 2) increase specialized services; 3) outreach services; 4) improve staff attentiveness and friendliness; 5) clarify charges; 6) address blood shortage; 7) improve cleanliness; 8) clean and renovate mortuary; and 9) install screens and curtains for privacy. From this case study as well as another project in Senegal, the following lessons were learned:

- The community is not a uniform group; it is comprised of diverse groups with different needs.
- Participatory community assessment activities revealed more information than client interviews.
- Community involvement is more than soliciting the community perspective on services; it includes community members in the action planning process as well.

Community Cope uses a Community Based Participatory Research framework for the purposes of quality improvement, outlining nine distinct steps in 3 phases: 1) orientation and preparation; 2) information gathering and action plan development; and 3) implementation and follow-up:

Orientation and Planning

1. Orient staff to the Community COPE process.
2. Identify groups for community activities.
3. Meet with local community leaders to determine level of interest and seek support.
4. Select and plan participatory activities, which may include Individual interviews, group discussions, site walk through, participatory mapping, and other methods. Ensure that the methods chosen reflect the needs of the community participants.

Information Gathering and Action Plan Development

5. Conduct the participatory activities to gather information about community members' views of services, their health concerns, and recommendations for improving services. Identify problems to be solved and the root causes of problems. Celebrate successes.
6. Conduct action planning with the community and prioritize recommendations.
7. Form a Quality Improvement Committee with appropriate community representatives ensuring two-way communication between health site and community and accountability.

Implementation and Follow-Up

8. Implement the action plan; plans may be implemented by staff alone or with community members.
9. Provide ongoing monitoring and feedback. Emphasize the use of local resources; keep records of progress made; communicate progress with communities through local media; follow up quickly on action plan recommendations and revise plan. Community involvement process should be repeated at least once per year.

The Community COPE model assumes that community activities should not take the place of traditional quality assurance activities that involve staff and outside experts. The initiative recognizes both the rights of clients as well as the needs of healthcare staff. Rights of clients include: access to information and services; informed choice; safe services; privacy and confidentiality; dignity, comfort and expression of

opinion; and continuity of care. The needs of staff include quality supervision and management; information, training and development; and sufficient supplies, equipment and infrastructure (EngenderHealth, 2002).

As part of their annual CPP processes, counties could adopt a community-oriented approach to investigating community mental health issues, service gaps and barriers. Community COPE reminds practitioners that stakeholders, including those who are not involved in planning or receiving services, have critical knowledge about community needs and may be most useful in understanding the challenges and barriers to seeking, obtaining and maintaining services and supports. The Community COPE framework and interview tools may also be modified and used by MHSA coordinators when seeking input from stakeholders, including those who have historically not participated in services or planning for services.

Community COPE Case Study

Centro Diagnóstico

Time Period: 2001-2002.

Jurisdiction: Santo Domingo, Dominican Republic.

Stakeholders: Reproductive health clinic clients, clinic staff, and members of the neighborhoods surrounding the clinic.

Lead Public Agency or Organization**:** The Dominican Republic Family Planning Association (ADOPLAFAM).

Types of Services or Uses Planned: Reproductive health services.

Description of Process, and Outcome and Findings: Centro Diagnóstico is a family planning and reproductive health clinic that serves low income neighborhoods on the outskirts of Santo Domingo. One of the clinic's major donors is the United States Agency for International Development (USAID). USAID, via its performance improvement program, PRIME II, funded the *Integrating Consumer Perspectives* (ICP) initiative in an effort to promote the clinic's financial sustainability. Upon the opening of Centro Diagnóstico in 2001, only 28% of clients were paying for their services. Within a year, following the PRIME initiative, the number of clients doubled and 83% were paying for their services.

Multiple reports credit PRIME II's participatory processes for the success of the clinic. According to PRIME II, "The willingness of consumers to pay for family planning and reproductive health services can be related to the perceived quality of those services. Developing mechanisms for consumers to provide regular feedback on service quality is a key component of PRIME II's Consumer-Driven Quality (CDQ) approach" (PRIME II).

The project looked to improve performance of primary providers through the integration of consumer perspectives into protocols for service delivery. For this purpose, Centro Diagnóstico designed an ongoing mechanism for listening to customer feedback and incorporating what they had learned into quality improvement action plans. This collaborative, ongoing activity then acted to shape ongoing relationships between consumers and providers.

PRIME II organized 5 community meetings in neighborhoods surrounding the clinic in order introduce community leaders to the quality improvement project. Using Community COPE methodology, they collected consumer feedback about reproductive health needs and service delivery barriers and identified community spokespersons to serve on a Clinic-Community Committee. The data from this process was integrated into a quality improvement plan, which, during the implementation stage, was continually monitored by the Committee. The Committee also ensured ongoing dialogue between community members and the clinic staff.

The resulting action plan produced many changes to Centro Diagnóstico, including an increase of open clinic hours, a wider array of services, additional services and staffing, increased privacy, and improved client/provider interactions. Over the course of the intervention, between December 2001 and December 2002, the perception that the clinic provided necessary services and that clients can ask questions of their providers rose nearly 100%. Additionally, the number of clients attending the clinic more than doubled, and the proportion of those paying for their services rose from 28% to 83%. According to the clinic's director, Dr. Jose Gregorio Aponte, "Involving people from the community is critical because they will always have the best idea of how to better their own quality of life" (Voices from the Field: Involving Communities In Quality Services, 2002).

Use of Technology in Community Planning

The growth in recent years of information and communication technologies has led to the development of innovative tools that have the potential to change the way people engage in public processes, allowing for unprecedented levels of community engagement, especially among groups historically excluded from planning processes. By bringing the tools of planning to the people, through new and readily available technologies, planning can be democratized, and ensure that those who are most affected are empowered to participate in the decisions that affect their lives (Chin et al., 2010; Xie, 2013). Technological strategies used in participatory planning processes, often referred to as "Planning Support Systems," do not commonly displace more traditional tools of community engagement, such as town hall meetings, but rather are used to supplement and enhance these traditional participatory methods, promoting a broader base of citizen participation.

Planning Support Systems can be used to enhance participatory processes in a number of ways. Emerging technologies have the potential to *increase participants' understanding* of the issues at hand, leading to more informed decision-making and an increase in consensus building. Planning Support Systems also *facilitate communication* among participants, enhancing the collaborative aspects of community-oriented planning, and building community among participants. The use of technology also makes possible *real-time capabilities* for conversation and debate, data capture, and analysis (Slotterback & Hourdos, 2009).

Several factors potentially limit the use of technology for community planning purposes. Constraints include limited technological capacity of some participants; resistance to change; limited access to training; costs associated with new systems; and limited access to technology. Additionally, while Planning Support Systems can lead to broader stakeholder participation in general, evidence suggests that these technologies may not be as effective in engaging marginalized or disenfranchised populations (Chin et al. 2010).

Planning support systems may be used at various phases of community planning, including during the preparation, execution and analysis of participatory processes, and for the dissemination of their results. A multitude of technologies have been identified for use during all phases. Some examples of these include:

Project Websites: According to researchers, project websites are most useful for those engaged in community planning processes for their ability to attract participants, their broad availability, and their ease of understanding (Slotterback & Hourdos, 2009). Project websites are effective in communicating information and encouraging immediate, real time participation. One example of a website associated with participatory planning efforts is ImproveSF.com, which is an online platform used by the City and County of San Francisco, designed to "provide opportunities for government and citizens to work together by connecting civic challenges to community problem-solvers" (ImproveSF, About, 2013). A current initiative on the ImproveSF website, implemented by the Mayor's Office of Civic Innovation and the San Francisco Planning Department, seeks to revitalize public spaces in the city. The project, called Living Innovation Zones (LIZ), asks San Francisco residents to submit ideas on ways in which the city's Market Street may be reimagined "as a showcase for new ideas, technologies, interactive projects, and

more" (ImproveSF, Living Innovation Zones, 2013). Participants submit ideas in an open forum, where others are able to read and vote on the projects they like. Ideas are ultimately chosen through a collaboration between the city, city partners, and community input gained through the interactive website.

Geographic Information System (GIS): GIS is a computer system designed for capturing, visualizing, manipulating, analyzing, and interpreting all types of geographical data. Until recently, GIS has been used almost exclusively by experts and academics in fields such as urban planning, cartography, environmental impact assessment, and natural resources management. In recent years, GIS has been identified as a powerful tool for use in participatory planning processes, for its ability to translate complex spatial information into a simple visual language, easily understood by all categories of stakeholders. GIS was used in an inclusive neighborhood planning project conducted by the University of Illinois at Chicago, in the Pilsen section of that city. Planners designed a technique which used GIS in combination with artists' renderings of residents' perceptions of their neighborhood, which was used during planning sessions to provide immediate and interactive access to images of neighborhood characteristics. The resulting spatial and artistic images assisted participants to easily and immediately visualize their neighborhood in its current conditions and what they hoped it would be in the future, which enhanced their ability to direct planners. This process was developed by the University planners as a result of their commitment to active and meaningful community participation. They proposed, "this technique not only allowed community members to truly participate in designing revitalization projects in their neighborhood, but also gave them confidence that the University would be an equal partner, rather than a unilateral decision maker, in the process" (Al-Kodmany, 1999, p. 29). James Rojas, urban planner and founder of the Latino Urban Forum, based in Los Angeles, advocates for the use of creative, physical, and play-like activities such as those described above, to better engage community participants in neighborhood planning activities. Rojas states, "I started working with poor and Latino residents of Los Angeles. My goal was to use the power of play to empower people to have a better understanding of their neighborhoods and how they might shape them for the good" (2013).

Web-Based Surveys: The survey is a potent strategy for gathering focused, specific, feedback from stakeholders taking part in community planning processes. Surveys have historically been utilized as a quick, powerful, and efficient way to gather information about people's attitudes and opinions; rank issues in terms of importance and urgency; determine support for initiatives under discussion; and to evaluate current programs and policies, to name a few. Until recently, the only reliable methods for conducting surveys were through the mail, through face-to-face interaction, or on the telephone, and were often expensive and time consuming. The development of web-based surveys have a number of benefits over conventional survey methods: they are more inclusive, allowing further reach; they are less expensive, allowing for a greater number of participants; and data are captured directly in an electronic format, making tabulation immediate, and analysis much simpler (Wyatt, 2000). In addition, platforms for construction of web-based surveys are readily available, in user-friendly formats, making them within reach not just for experts but for many stakeholders. These benefits support the goals of participatory planning processes by reaching a broader constituency, and making survey construction, dissemination, and tabulation available to the people. Stakeholders in the New River Valley (NRV) Region of Virginia are

currently in the final year of a three year long participatory community planning process (2011-2014) designed to develop a vision for the future of the region. The New River Valley Livability Initiative has engaged close to 3,000 citizens so far, who have shared their ideas and thoughts about how they would like the region to remain the same, and how they envision it being different in the future. As part of this process, the Livability Initiative, facilitated by the New River Valley Planning District Commission, has conducted two web-based surveys so far, with one more planned for the future. The first survey sought feedback on a range of possible policies and projects proposed to address challenges faced by the region. Over 700 NRV residents completed this initial survey, with many accessing it from their homes, and others accessing the survey at public libraries and town halls, where it was available to community members without internet access. The results of this survey sought citizen feedback on the preliminary goals developed by the Livability Initiative's seven working groups. The second survey, also web-based, focused on community priorities and was developed from public input during earlier phases of outreach and a set of topic area goals resulting from a year's worth of research and discussion on the part of the Livability Initiative's seven working groups. Close to 700 residents participated in order to provide feedback. The results of this survey were used to inform the direction of the community planning process over the following six months (New River Valley Planning District Commission, 2013).

Principles of the use technology in participatory planning processes

- Understanding the characteristics of meeting types and contexts is important in informing the selection of technologies to enhance participatory processes.
- Many technologies can be understood by the general public; however it is important to be aware that individuals may have differing abilities in the use of technology.
- Decisions about the use of technology in participatory processes should be based on a clear sense of the contribution that the technology can make to the communication and discussion of information.
- Disenfranchised audiences should be identified early in the process. Determining the barriers they may face to technology will help with the creation of user-friendly tools.
- A culturally competent lens should be employed to assess the needs of the populations targeted. Selecting the right medium entails an understanding of the demographics being targeted and their access (or lack of access) to any required tools or technologies.
- Feedback should be solicited from target populations on which technologies are more accessible to them.
- How well the tool reaches populations that don't speak English as a first language should be considered.
- If using software requiring hands-on assistance, accessibility for all abilities and disabilities should be ensured and assistance made available.

- Different curricula and tools may need to be developed to accommodate the unique interests and needs of different populations and the range of technological skills that different populations have.

- Dialogue complements and deepens ideas and knowledge gained from the online experience. Time and space for face-to-face interaction and deliberation of planning ideas and concerns between participants is essential (Chin et al., 2010)

Chapter 3: Application to MHSA Community Program Planning

The theoretical frameworks and practical models used to implement community planning initiatives—as described in Chapter 2—offer guidance to county MHSA staff, professional planners, and CPP stakeholders for the development of planning guidelines, methods and tools. In this chapter we synthesize both common and unique themes that emerged from our research into a set of eight principles that may inform future MHSA CPP processes. Additionally, we describe practical strategies that county mental health administrators and MHSA/CPP staff and contractors can implement to adhere to these principles.

Principles and Practical Applications for MHSA Community Program Planning

The following eight principles derive from an amalgamation of 79 values, principles and codes extracted from our research into public community planning frameworks, as summarized in Chapter 2. Appendix 1 shows how each of the 79 concepts were synthesized to form the principles. Below are practical applications for each of the principles. These practical applications derive from practices described in the case studies as well as from cited research and the expertise and experience of the authors.

- **Be strategic**. Practice thoughtful, deliberate preparation. Establish purpose, priorities and goals before launching the planning process. Use methods and tools based on a clear sense of how they contribute to the process and intended outcomes. Recognize political, social, and market realities to create feasible implementation plans. Engage in systems-thinking by considering the interconnectedness of issues and institutions. Prior to completing planning processes, identify measurable outcomes and indicators of success to support accountability and encourage ongoing programmatic improvement.

    - Practical application: Mental health administrators and MHSA/CPP coordinators can schedule dedicated time on an annual basis to mapping out CPP activities and strategies. Time can be spent evaluating and reflecting on prior year's process. Counties may wish to invite several experienced stakeholders to participate in discussing planning methods (Planning Processes).

    - Practical application: Whenever possible counties can use existing, step-by-step strategic planning frameworks, such as MAPP (See MAPP Framework above) or World Health Organization's Planning Cycle (Von Schirnding, 2002), to guide planning processes. These frameworks should include practical and strategic steps such as visioning, assessment, goal setting, strategizing, prioritization, feasibility analyses, and action planning, implementation planning, monitoring and evaluation.

    - Practical application: MHSA Coordinators can research and use tools from the Community Toolbox. The toolbox, which is maintained by University of Kansas Work Group for Community Health and Development, includes a database on best practices for community health and development and over 300 learning modules on specific skills for

creating and maintaining partnerships; assessing community needs and resources; choosing strategies to promote community health and development; promoting interest in community issues; encouraging involvement in community work; etc. The best practices database is a portal to over 60 websites ranging from the CDC's Community Guide of effective practices for disease prevention, model practices from National Association of County and City Health Officials (MAPP is one such practice), National Registry of Evidence-Based Programs and Practices, and more. The Community Tool Box is a free online at http://ctb.ku.edu/en (Community Toolbox, 2013).

- Practical application: Prior to launching the annual planning process, MHSA/CPP coordinators can informally survey colleagues, mental health board members, and consumer and family advocates to learn about "hot button" issues. Time can be taken early on to research issues and best practices for addressing such challenges (See Healing the Canoe case study).

- Practical application: MHSA/CPP coordinators and mental health administrators can seek to understand the relationships between advocacy organizations, CBOs and agencies and develop strategies for improving dialogue and trust prior to launching the process.

- Practical application: All development of or adjustments to existing plans, policies, programs and initiatives can be coupled with a set of process and outcome measures and a plan for collecting, analyzing and sharing data for systems improvement. Evaluation strategies can be simple and low-cost or more extensive, depending on resources.

- **Focus on strengths and aspirations:** Learn about the community, including their values, hopes, and aspirations through research and participatory visioning processes. Develop plans based on community strengths and assets, and celebrate small and large successes.

  - Practical application: If the county has not done so in a while, staff and/or professional facilitators can lead stakeholders through a visioning process that asks a variety of key questions, such as "What will behavioral health and wellness look like in our county in the future?", "What role would the mental health department play in developing a healthy future?, "What role would your friends, families and neighbors play in promoting wellness, recovery and resiliency?", and "What positive values help us promote healthy communities?"(See Adams Park HIA and San Francisco Healthy Homes case studies).

  - Practical application: MHSA/CPP coordinator can work with a CPP stakeholder steering committee or other stakeholder group to develop a participatory research project related to an important mental health issue in the community (See Reintegrating Drug Users Leaving Jail and Prison case study). Alternatively, the research project could focus on a more general needs assessment or asset mapping project. Plans generated from needs assessments should take advantage of community strengths and assets (See Strong Neighborhoods Initiative case study). The project should seek to understand community strengths and resources, not just challenges and barriers. Agree ahead of time to invest

resources and working collaboratively to develop a strategy to address the issue being studied.

- Practical application: Use a variety of methods to learn about the stakeholder community including interviews with community representatives and organizational leaders; focus groups with various subpopulations, including various underserved, unserved and historically inappropriately served communities; and paper-based and/or electronic surveys. Conduct site visits to community based organizations to better understand the culture of the community and to measure community readiness to implement change (See Adams Park, Centro Diagnóstico, Reintegrating Drug Users and Healing the Canoe case studies).

- Practical application: Every year, counties can celebrate CPP successes by inviting stakeholders to present their achievements and lessons learned. Make it a party. However, don't wait to recognize the contribution of community volunteers, who dedicate their time to the process. Make sure to privately and, when appropriate, publicly acknowledge their contributions.

- **Develop partnerships:** Establish collaborative relationships with all sectors of the community by respecting diversity, encouraging dialogue, valuing and utilizing local knowledge, strengths and expertise, and by seeking points of agreement. Seek commitment. Time and space for face-to-face interaction and deliberation is essential.

  - Practical application: Maintain a database of community leaders and representatives of community based organizations. Keep track of interactions and reach out to groups who are less engaged.

  - Practical application: MHSA/CPP coordinator can reach out to community leaders to have one-on-one conversations about their experience with and expectations for the planning process, and to seek commitment to participate. Coordinators should follow up to encourage ongoing interaction.

  - Practical application: Counties can hire consumers and/or family members to help facilitate needs assessments and planning, thereby lending their knowledge, expertise and experience to the process (See Healing the Canoe case study).

  - Practical application: Seek data from community based organizations, include them in data collection processes, and share findings from mental health department data collection efforts. Engage community organizations in identifying the issues that are most important to their membership. Ask "What are the hopes and concerns of the people most affected by decisions?" and "How is the decision likely to affect the lives of those who are already struggling?" (See Adams Park HIA case study).

- Practical application: Schedule community meetings to introduce stakeholders and community organizations to the planning process. Invite participants to dialogue about their hopes and expectations for the process. Ask participants to complete a survey or sign a pledge card that asks about their level of commitment, what types of issues and activities they are willing to participate in, who else should be at the table, etc. (See Centro Diagnóstico case study).

- **Be accountable**: Model clear, open, and consistent communication. Be accountable and transparent throughout the planning process. Be direct about roles and responsibilities and the degree of decision making authority participants can expect throughout the process. The resulting plans should include specific individuals or institutions that are responsible for implementation, so that accountability continues through the implementation cycle.

  - Practical application: Counties can draft a planning charter that describes the roles and responsibilities of all participants, including planning facilitators. Describe how meeting minutes and other materials will be disseminated, how county will respond to feedback, how decisions will be made.

  - Practical application: MHSA/CPP coordinator and other leaders of the planning process should be careful what to promise and be sure to follow-through on commitments. Respond to all emails; send out agendas and meeting materials on a consistent timeline.

  - Practical application: To all extents possible, include key stakeholders, particularly consumers and family members in all meetings. This will help to ensure and demonstrate transparency, and will help guarantee community participation for the duration of the planning initiative (See Healing of the Canoe case study).

  - Practical applications: Ensure that participants have an opportunity to provide feedback on all planning activities by: 1) providing contact information for MHSA/CPP coordinators, offering drop-in hours, and maintaining an "open-door" philosophy; and 2) handing out and collecting comment cards and /or evaluation forms. Report back to participants on how their feedback was incorporated into ongoing processes (See San Francisco Healthy Homes case study).

  - Practical applications: Commit to collecting data about community characteristics and concerns if and only if the intention is to share the findings and use the data to inform action plans. Vulnerable communities are frequently the target of research, which is not then used to improve social, environmental, economic and health outcomes.

  - Practical applications: Seek verbal and written commitments from mental health administration, service providers, policymakers and elected officials to champion the implementation of plans as part of the planning process. Do not publish plans without demonstrating commitment by those responsible for implementation (See San Francisco Healthy Homes case study above and Action Plan http://www.sfenvironment.org).

- **Build capacity**: Develop individual and organizational knowledge and capacity through co-education and dialogue, and opportunities to participate in research, deliberation and decision making.

    - Practical application: Coordinate interactive trainings for CPP participants about critical mental health issues, but also about best practices in community-building, participatory research, analysis and planning, and social change. Utilize local training resources whenever possible (See San Francisco Healthy Homes case study).

    - Practical application: Sensitize mental health professionals, academics and other "experts" to the expectations of community members so that they do not "talk down" or use alienating concepts or terminology. Encourage external training resources to lead with curiosity and engage in dialogue while at the same time establishing rigorous learning objectives.

    - Practical application: Be prepared to reciprocate. When asking community based organizations to participate in planning efforts, the mental health departments should also be prepared to assist in their own campaigns. Find out about their local initiatives, and offer support, when possible.

    - Practical application: Provide individual CPP participants with incentives that will help them gain knowledge, skill and experience. For example, offer training, jobs and stipends to community-based data collectors and outreach workers; provide scholarships to attend conferences and continuing education credits for health professional stakeholders.

- **Be inclusive:** Recognize the value of meaningful participation by those people whose lives are most affected by the issues at hand. Pay special attention to vulnerable populations and those who might not otherwise be included in decision making. At the same time, be conscientious of stakeholder diversity. Frame issues from multiple perspectives. Recognize the rights of clients but also the needs of service providers. Provide opportunities for people to gather at convenient and comfortable locations at a variety of times and use a variety of approaches and tools that reflect stakeholders' cultures and skills—even if doing so slows the process down.

    - Practical applications: Focus on outreach to unserved, underserved and historically inappropriately served communities, and on consumers and family members, as they are the most affected by MHSA plans. Engage representatives of local CBOs in dialogue about how to reach those who don't typically participate (See Centro Diagnóstico case study.

    - Practical application: Strategies for inclusion include: hiring bilingual outreach workers; translating materials into threshold languages; providing various types of incentives for participation; conducting meetings at various times and in various locations; providing food, language interpretation and childcare at meetings; conducting language-specific meetings; and making sure that meetings are ADA accessible and have comfortable

seating. When using technology, make sure that it is accessible to all participants, or provide equally useful alternatives; hand out glossaries with acronyms and jargon.

- Practical application: Reach out to the greatest number of community members to participate in a variety of planning activities. Large-scale forums and meetings are useful for visioning and goal-setting, data collection about community needs and assets, brainstorming strategies, prioritizing strategies (See Los Angeles County's STD Program). Large gatherings are not necessarily useful for strategy development; strategies are best developed by representative committees (See Capital Elementary School and Strong Neighborhood Initiative case studies).

- Practical application: Consider ways in which technologies can increase meaningful participation, and particularly participation by historically disenfranchised communities. For example, develop a project website (See ImproveSF.com). Additionally, the county or mental health department might invest in simultaneous interpretation equipment. Large counties may invest in technologies to facilitate 21st Century Town Meetings (See http://americaspeaks.org/services/21st-century-town-meeting/).

- Practical application: Uphold the "nothing about us without us" principle by ensuring that consumers and family members are invited to participate in all CPP activities, including planning framework, identifying stakeholders, collecting data, interpreting data, planning strategies and, when possible, participating in decision making (See Healing of the Canoe and Capital Elementary School case study).

- Practical application: Engage all levels of mental health department staff in conversations about their hopes and concerns related to the CPP process. Unless staff members are comfortable with and feel included in the process, they are not likely to support it, and as a result, implementation efforts will likely fail (See Centro Diagnóstico case study). Similarly, prepare elected officials for the process and encourage them to show support.

- Practical application: Offer newcomer orientations on an ongoing basis. Orientations can occur half-hour before meetings; assign a "newcomer buddy" who can help orient newcomers and latecomers.

- **Be prepared to share power and release control.** Build active, meaningful, and inclusive partnerships with stakeholders, not to affirm preconceived assumptions or decisions, but to support community and individual self-determination. Include participants in all phases, from research, to development, and approval of the plan. Teach the skills of research, analysis, advocacy and democracy to enable shared power and leadership.

  - Practical application**:** Submit written assessments, reports and plans to MHSA stakeholder committees for feedback, suggestions, and approval well before they are finalized. Follow MHSA guidelines for posting, public hearings and documentation of final drafts of annual updates, and also provide formal opportunities for public comment and

feedback early on (See Healing the Canoe case study). Be conscious not to merely use the CPP process as a means of "rubber-stamping" county-designed projects.

- Practical application: Provide training to CPP participants in effective advocacy. Advocacy Unlimited, Inc. provides a 14-day advocacy training for persons with mental health and co-occurring disorders in self, systems and legislative advocacy (See http://www.mindlink.org/ed_advocacy_course_overview.html). The World Health Organization provides an advocacy training module as part of its Mental Health Policy and Service guidance package.
  (See http://www.who.int/mental_health/resources/en/Advocacy.pdf)

- Practical application: Encourage planning participants in self-directed outreach and advocacy. For example, invite them and provide them resources to reach out to their peers and colleagues to broaden participation (See Capital Elementary School and Reintegrating Drug Users case studies). Open up portions of meetings for participants to share information on current events, local and statewide initiatives, public hearings, etc. Provide stipends for planning participants to serve as "change agents" whereby they educate a broader base of stakeholders about participatory and community-based initiatives, new services and interventions.

- Practical application: Provide facilitation training to CPP participants and rotate facilitation and note-taking among willing and able participants. Employ co-facilitation techniques by pairing more and less experienced facilitators.

- Practical application: Provide technical support and training to a stakeholder steering committee that meets regularly to research and plan strategies (See Strong Neighborhoods Initiative case study). Make sure the steering committee includes diverse representation from underserved communities, consumers and family members, mental health department staff who have the authority to advance the committee's agenda.

- Practical application: County mental health departments can research the possibility of initiating a Participatory Budgeting initiative, whereby a proportion of the public mental health budget is set aside for a democratic process, and a committee of individuals research a problem, identify a variety of strategies, and vote on how to spend resources (See NYC Participatory Budgeting case study). Since departments do not have the authority to yield budgetary decision making to stakeholders, they may be able to modify the process by allowing stakeholders to make recommendations regarding a portion of MHSA budget.

- Practical application: Appoint a community-based quality improvement committee to collect and review data on the performance of programs implemented as a result of the planning process, and to make recommendations for improvements and funding (See Centro Diagnóstico and Los Angeles County STD case studies).

- **Plan for the long-haul:** While recognizing the CPP processes are organized around a fiscal year calendar, prepare stakeholders for ongoing and long-term committed participation. Recognizing that social transformation takes time and may not follow a linear path, develop strategies for maintaining momentum; engage and reengage over the years, and throughout the planning and implementation process.

    - Practical application: Each year, or upon initiating a community-driven mental health initiative, conduct outreach and invite stakeholders to a community event or several community events to inform them about the planning process (See Centro Diagnóstico case study). Provide ample opportunity for stakeholders to share their vision. At the same time, reach out one-on-one to community leaders to seek their input on the planning process and on critical issues that need to be addressed.

    - Practical application: Form planning and/or advisory committees early on, but realize that while some individuals will participate for many years, others will drop out or participate sporadically. Therefore, continuously reach out to community organizations and leaders, and replenish your committees on regular intervals (See Strong Neighborhoods Initiative case study).

    - Practical application: Identify long-term and short term planning objectives. Each time an objective is met, celebrate successes through email notices, face-to-face celebrations, etc. Send out quarterly newsletters (See San Francisco Healthy Homes case study).

    - Practical application: If a CPP planning committee developed a new initiative or program, continue to engage the committee during the implementation phase to review data on processes and provide recommendations for program improvement (See Strong Neighborhoods Initiative and Centro Diagnóstico case studies).

    - Practical application: At each meeting or gathering, let participants know where they are in the planning process via a visual timeline. Make sure they are aware of the level of commitment expected of them and provide opportunities for different levels of commitment. For example, some individuals may agree to meet on an annual basis to review plans; others on a monthly basis to review data and formulate strategies, or even weekly basis to collect data and conduct outreach.

    - Practical application: Educate participants about the history of social transformation. Let them know that change does not always happen fast, but assure them that the mental health department will be measuring and reporting on progress along the way.

The authors of this report encourage local and statewide stakeholder groups and county mental health departments to consider these applications and to develop other strategies based on the principles described above. During subsequent phases of the Evaluation, we encourage members of the Client Stakeholder Project (CSP), in conjunction with the MHSOAC, to review these principles and applications in addition to practices deemed "promising," which emerge from the evaluation of current CPP processes.

Bibliography

Abelson, J. & Gauvin, F. (2006). *Assessing the Impacts of Public Participation: Concepts, Evidence and Policy Implications*. Canadian Policy Research Networks/Reseaux canadiens de recherché en politiques publiques.

Agger, A. & Lofgren K. (2008). Democratic Assessment of Collaborative Planning Processes. *Planning Theory.* Sage Publications, 7 (2): 145-164.

Al-Kodmany, K. (1999). Combining Artistry and Technology in Participatory Community Planning. *Berkeley Planning Journal*, 13(1):28-36.

Alinksy, S. (1971). *Rules for radicals*. New York: Vintage.

Allee, M. K. (2013). Interview conducted by RDA, October 10, 2013.

Adams, F., with Myles Horton (1975). *Unearthing Seeds of Fire: The Idea of Highlander*. John F. Blair publisher, Winston-Salem, NC.

Avey, H. (2013). Interview conducted by RDA, October 10, 2013.

Bannon, T. & Kozo, J. (2013). Interview conducted by RDA, October 24, 2013.

Bingler, S. B. (2003). *Community-Based School Planning: If Not Now, When?* Edutopia: The George Lucas Educational Foundation. Retrieved on November 9, 2013, from http://www.edutopia.org/community-based-school-planning-if-not-now-when

Burkholder, S., Chupp M. & Star P. (2003). *Principles of Neighborhood Planning for Community Development.* Maxine Goodman Levin College of Urban Affairs, Cleveland State University: Cleveland, Ohio.

Cal. Welfare and Institutions Code §5813.5 (2012).

Centers for Disease Control and Prevention, Agency for Toxic Substances and Disease Registry, Committee on Community Engagement (CDC/ATSDR) (1997). *Principles of Community Engagement*. Centers for Disease Control and Prevention: Atlanta, Georgia.

Centers for Disease Control and Prevention (2013). HIA Stories From the Field: Douglas County Health Department, Reviving Adams Park. Retrieved November, 2013, from: http://www.cdc.gov/healthyplaces/stories/omaha.htm

Chin, J., Dinshaw, A., Likuski, A., McBrayer, M., & Monty, J. (2010) *Interactive Technologies in Participatory Planning: A Guide for Sommerville Community Corporation.* Urban and Environmental Policy and Planning Department, Tufts University, Medford, MA.

Clinical and Translational Science Awards Consortium, Community Engagement Key Function Committee Task Force on the Principles of Community Engagement (2011). *Principles of Community Engagement, 2nd ed*. National Institutes of Health: Washington, District of Columbia.

Community Toolbox (2013) Accessed November 17, 2013 from http://ctb.ku.edu/en/table-of-contents.

Connell, et. al. (1995). New Approaches to Evaluating Community Initiatives. Concepts, Methods, and Contexts. Roundtable on Comprehensive Initiatives for Children and Families. Aspen Institute for Humanistic Studies, New York, NY.

Edwards, R., Jumper-Therman, P., Plested, B., Oetting, E., & Swanson, L. (2000) Community Readiness: Research to Practice. *Journal of Community Psychology*, Vol 28, No. 3 291-307.

EngenderHealth (2002). *Community COPE®: Building Partnership with the Community to Improve Health Services*. New York, NY.

EngenderHealth (2003). *COPE Handbook : A Process for Improving Quality in Health Services, revised edition*. New York, NY

EngenderHealth. COPE® and Community COPE®: Tools for Engaging Communities in Defining and Addressing Quality of Care. PowerPoint accessed December 27, 2013 from http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=5&ved=0CEEQFjAE&url=http%3A%2F%2Fwww.k4health.org%2Fsites%2Fdefault%2Ffiles%2FCOPE%2520and%2520Community%2520COPE%25202.ppt&ei=Dv69UtKMII39oASEp4DwBQ&usg=AFQjCNGD6WMahOWYPjIQiTPa0_Xr_Ewznw&bvm=bv.58187178,d.cGU

Freire, Paolo (1970). *Pedagogy of the Oppressed*. Herder and Herder, New York, NY.

Freire, Paulo (1974). *Education for Critical Consciousness*. London: Sheed & Ward.

Furger, R. (2003). *Rebuilding a school, Revitalizing a Community: School Improvements Enhance a Desire to Learn.* Edutopia: The George Lucas Educational Foundation. Retrieved on November 9, 2013, from http://www.edutopia.org/rebuilding-school-revitalizing-community)

Hart, Angie, Northmore, S. & Gerhardt, C. (2009). Auditing, Benchmarking and Evaluating Public Engagement. National Co-Ordinating Centre for Public Engagement, Bristol, UK.

Healing of the Canoe Project (2013). Retrieved from http://healingofthecanoe.org/phase-i/ November, 2013.

Heller, J. (2013). Interview conducted by RDA, October 17, 2013.

Lacofano, D. (2013). Interview conducted by RDA, October 18, 2013.

ImproveSF, About (2013). Retrieved on November 11, 2013, from http://www.improvesf.com/about-this-site.

ImproveSF, Living Innovation Zones (2013). Retrieved on November 11, 2013, from http://www.improvesf.com/living-innovation-zones.

Israel, B., Schulz, A., Parker, E. & Becker, A. (1998). Community-based Participatory Research: Policy Recommendations for Promoting a Partnership Approach in Health Research. *Education for Health*, 14(2):182-193.

Magee, C., Cavalier, Y. (2012). *Using Active Community Engagement Continuum to Address Health Inequities in an Urban Area.* Poster presented at the National STD Prevention Conference, Minneapolis, MN.

McConville, M. (2013). *Creating Equitable, Healthy, and Sustainable Communities: Strategies for Advancing Smart Growth, Environmental Justice, and Equitable Development.* United States Environmental Protection Agency: Washington, District of Coumbia.

Mental Health Services Act, Cal. Admin. Code tit. 9, §§3100-3856

Michigan Association of School Boards (2006). *MASB Journal: Special Report.* (Summer, 2006). Lansing, MI: Michigan Association of School Boards. Retrieved November, 2013 from http://www.masb.org/Portals/0/pdf/SRcommeng06.pdf.

Minkler, M. et al. (2008). *Promoting Healthy Public Policy through Community-Based Participatory Research: Ten Case Studies.* PolicyLink, School of Public Health, University of California, Berkeley, W.K. Kellogg Foundation.

Minkler, M. (2013). Interview conducted by RDA, October 8, 2013.

Myerson, D. L. (2004). *Involving the Community in Neighborhood Planning.* Urban Land Institute: Denver, CO.

Naryan, D. (2002). *Empowerment and Poverty Reduction: A Sourcebook.* World Bank: Washington, District of Columbia.

National Association of County & City Health Officials. (2013). *MAPP*. Retrieved November 5, 2013, from NACCHO: http://www.naccho.org/topics/infrastructure/mapp/

New River Valley Planning District Commission (2013). *Livability in the New River Valley: Moving from Vision to Action*. Virginia Department of Health: Richmond, VA.

Participatory Budgeting (2013) City of Vallejo, CA. Retrieved November 17, 2013 from http://www.ci.vallejo.ca.us/city_hall/departments___divisions/city_manager/participatory_budgeting/.

Pentz, M. (1999). Effective prevention programs for tobacco use. *Nicotine and Tobacco Research*, *1 (Suppl 1): S99-S107*.

Planning Processes. (n.d.). The Challenge Forum. Retrieved November 17,2013, from http://www.chforum.org/methods/xc412.shtml

Plested, B., Edwards, R. & Jumper-Thurman, P. (2006). *Community Readiness: A Handbook for Successful Change.* Fort Collins, CO: Tri-Ethnic Center for Prevention Research.

PRIME II. (n.d.). *CDQ in Action: Consumer Feedback Improves Clinic Services, Increases Paying Clients*. Retrieved November 11, 2013, from PRIME II: http://www.prime2.org/prime2/pdf/PP_DR-CDQ_hi-res.swf

Resource Development Associates. (2013). *San Francisco Healthy Homes: Project Evaluation.* Oakland, CA.

Rojas, James (2013) Interview conducted by RDA, October 9, 2013.

Russell, N., Igras, S., Johri, N., Kuoh, Hl, Pavin, M., & Wickstrom, J. (2008) The Active Community Engagement Continuum. Retrieved from Acquire Project Website: http://www.acquireproject.org/fileadmin/user_upload/ACQUIRE/Publications/ACE-Working-Paper-final.pdf

Russell, Nancy (2013). Interview conducted by RDA, October 11, 2013.

San Francisco Department of the Environment. (2013). *San Francisco Healthy Homes: Community Action Plan.* San Francisco Department of the Environment: San Francisco, CA.

Sandoval, J. et al. (2011) Process and outcome constructs for evaluating community-based participatory research projects: a matrix of existing measures. *Health Education Research* 27(4): 680-690.

Slotterback, C. S. & Hourdos, J. (2009). *Technology in Planning and Participatory Processes: Identifying New Synergies Through Real World Application*. Hubert Humphrey Institute of Public Affairs, University of Minnesota. Minneapolis, MN.

Stakeholder Participation Working Group of the 2010 HIA of the Americas Workshop. (2012). *Guidance and Best Practices for Stakeholder Participation in Health Impact Assessments, Version 1.0.*

Strong Neighborhoods Initiative. (n.d.). Retrieved November 9, 2013, from San Jose Government: http://www.sanjoseca.gov/index.aspx?NID=1745

Tian, C. (2013). *Open Budget, Open Process: A Short History of Participatory Budgeting in the US*. Sunlight Foundation: Washington, District of Columbia. Retrieved in November, 2013, from http://sunlightfoundation.com/blog/2013/07/15/open-budget-open-process-a-short-history-of-participatory-budgeting-in-the-us/

Uddin K (2004) Public Participation Evaluation: A Conceptual Model for Evaluating Planning Advisory Committee, PIA NSW Division Conference, Wollongong

University of California at Los Angeles, School of Public Health (2003-2006). Retrieved November 6, 2013, from http://www.ph.ucla.edu/hs/health-impact/whatishia.htm#item4.

Voices from the Field: Involving Communities In Quality Services. (2002, November 14). Retrieved November 11, 2013, from IntraHealth International: http://www.intrahealth.org/page/involving-communities-in-quality-services

Von Schirnding, Yasmin (2002). *Health in Sustainable Development Planning: The Role of Indicators*. World Health Organization. Geneva.

Wampler, B. (2012). Participatory Budgeting: Core Principles and Key Impacts. *Journal of Public Deliberation, 8*(2): article 12.

Wickstrom, J. (2013). Interview conducted by RDA, October 22, 2013.

World Health Organization (2013). Retrieved November 6, 2013, from http://www.who.int/hia/about/why/en/index.html).

Wyatt, J. C. (2000). When to Use Web Based Surveys. *Journal of the American Medical Informatics Association,* Jul-Aug 7(4):426-430.

Xie, L. (2013). *The Combination of Mobile Applications and Games as a New Method for Community Engagement.* Georgia Institute of Technology: Atlanta, GA.

Appendix 1: Eight CPP Principles and their Sources

Be strategic	
Principle	Source of Principle
Agree on clear indicators with expected outcomes and on documentation process	Active Community Engagement Continuum
Be clear about purpose before getting started	Active Community Engagement Continuum
Be clear about the purpose and goals of engagement before you begin	Community Engagement
Systems thinking	Mobilizing for Action through Partnership and Planning
Strategic thinking	Mobilizing for Action through Partnership and Planning
Establish clear priorities	Neighborhood Planning
Thoughtful, deliberate preparation	Neighborhood Planning
Recognize market dynamics	Neighborhood Planning
Create feasible implementation plans	Neighborhood Planning
Begin with the right issue	Public Engagement in Education
Understanding the characteristics of meeting types and contexts is important in informing the selection of technologies to enhance participatory processes.	Technology in Community Planning
Decisions about the use of technology in participatory processes should be based on a clear sense of the contribution that the technology can make to the communication and discussion of information.	Technology in Community Planning
Focus on strengths and aspirations	
Principle	Source of Principle
Build on the strengths and resources of the community	Community Based Participatory Research
Identify community assets and strengths	Community Engagement
Learn about the community	Community Engagement
Data	Mobilizing for Action through Partnership and Planning
Celebrate success	Mobilizing for Action through Partnership and Planning
Collect data to inform process	Neighborhood Planning
Development of a vision of what the community can become	Neighborhood Planning
Develop plans based on neighborhood strengths and assets	Neighborhood Planning
ID and development of neighborhood assets	Neighborhood Planning
Participants learn about their community	Participatory Budgeting
Community's values and aspirations for the future will inform discussion and action	Public Engagement in Education

Develop partnerships	
Principle	Source of Principle
Establish partnerships by valuing the strengths and finding points of agreement	Active Community Engagement Continuum
Partner with the community	Community Engagement
Establish relationships with the community	Community Engagement
Dialogue	Mobilizing for Action through Partnership and Planning
Partnerships and collaboration	Mobilizing for Action through Partnership and Planning
Community Partnerships and expertise will be utilized	Public Engagement in Education
Involve all sectors of the community	Public Engagement in Education
Create conversation	Public Engagement in Education
Dialogue compliments and deepens ideas and knowledge…time and space for face-to-face interaction and deliberation of planning ideas and concerns between participants is essential	Technology in Community Planning
Feedback should be solicited from target populations on which technologies are more accessible to them.	Technology in Community Planning
Be accountable	
Principle	Source of Principle
Specific individuals or institutions should be responsible for implementation	Neighborhood Planning
Transparency in the planning process	Neighborhood Planning
Defined and appropriate roles for all participants	Neighborhood Planning
Aligned with oversight and accountability	Participatory Budgeting
Clear, consistent and open communication	Public Engagement in Education
Build capacity	
Principle	Source of Principle
Promote co-learning and empowerment to address social inequality	Community Based Participatory Research
Develop local leadership	Community Development Theory
Educate community about issues	Community Development Theory
Involve organizations rather than independent individuals	Health Impact Assessment
Democratic decision making	Neighborhood Planning
Build capacity of community by helping form effective organization	Participatory Budgeting
Process should have a learning component that helps build community awareness and knowledge about the subject at hand	Public Engagement in Education

Be inclusive	
Principle	Source of Principle
Use approaches that reflect stakeholder culture, even if it slows the process down	Community Based Participatory Research
Recognize the needs of staff and the rights of clients	Community COPE
Democratic decision making by people who's lives are most affected	Community Development Theory
Respect diversity	Community Engagement
Hierarchy of the community: those who are most effected	Community Engagement
No single approach can be prescribed for stakeholder participation	Health Impact Assessment
Ensure diverse participation to understand the community and political realities related to the policy, program, project being studied	Health Impact Assessment
Pay special attention to those representing vulnerable populations	Health Impact Assessment
Include those who might not otherwise be included in decision making	Participatory Budgeting
Opportunities for people to gather at a convenient and comfortable location at a variety of times	Public Engagement in Education
Frame issue from multiple perspectives	Public Engagement in Education
Be aware that individuals may have differing abilities in the use of technology. Different curricula and tools may be needed, etc.	Technology in Community Planning
Be prepared to share power and release control	
Principle	Source of Principle
Understand that flexibility is needed to collaborate and share power	Active Community Engagement Continuum
Involve all participants equally in all phases of research and action	Community Based Participatory Research
Disseminate findings to all participants (in a manner that is easily accessible)	Community Based Participatory Research
Self-determination	Community Engagement
Release control	Community Engagement
Resident involvement in the development and approval of the plan	Neighborhood Planning
meaningful community engagement	Neighborhood Planning
Inform/teach/elected officials and city leadership	Neighborhood Planning
Increase citizen authority	Participatory Budgeting
Voice: participants learn to employ social justice discourse, thus expanding the public debate regarding public spending	Participatory Budgeting
Alter the way that government receives input; enable bureaucrats to engage with citizens	Participatory Budgeting
Active and inclusive partnerships, not to affirm existing leadership but to decrease centralized power	Public Engagement in Education

Plan for the long-haul	
Principle	Source of Principle
Expect to engage and then reengage throughout the life of the project, as communities are dynamic and behavior change is not linear	Active Community Engagement Continuum
Promote long-term commitment by all participants (recognize that policy changes take a long time and commit to staying involved for the long-haul)	Community Based Participatory Research
Long term commitment	Community Engagement
Planning efforts must maintain momentum	Neighborhood Planning
Early and consistent involvement	Neighborhood Planning
Process should allow for sustained involvement by stakeholders	Public Engagement in Education
Enough time to make informed decisions; more than one meeting	Public Engagement in Education
Reconvene stakeholders	Public Engagement in Education
Community will be involved early in the process	Public Engagement in Education