Psychiatric Advance Directives

MULTI-COUNTY COLLABORATIVE

Phase 1 Final Evaluation

Fiscal Years 2021-25

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CONCEPTSFORWARD
CONSULTING

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Multi-County Psychiatric Advance Directives (PADs) Innovation Project

Final Summary of the PADs Multi-County Innovation Project Phase One

Introduction

Psychiatric Advance Directives (PADs) are legal tools that allow individuals with a mental health condition or substance use disorder to document their preferences for future behavioral health treatment during periods of wellness, to be used during times when they may be unable to communicate effectively. The Substance Abuse and Mental Health Services Administration (SAMHSA) identifies PADs as best practice in recovery-oriented crisis planning. SAMHSA emphasizes that PADs reduce coercion, improve treatment outcomes, and strengthen person-centered care. However, they caution that widespread adoption requires strong legal frameworks, accessible formats, and cross-system collaboration.

Journal of American Medical Association (JAMA) Psychiatry publications highlight that PADs are associated with increased treatment engagement, fewer crisis episodes, and reduced hospitalization. One study found that participants who completed PADs were significantly more likely to receive preferred medications and avoid unwanted interventions. However, JAMA also flags that provider awareness and training are essential for effectiveness.

Despite federal support—like the Center for Medicare and Medicaid Services' (CMS) 2006 clarification encouraging PADs—California has no specific statute recognizing them as a tool for self-determination during a behavioral health crisis event. This legislative gap has hindered the standardized development and implementation of PADs across counties. There remains little to no information about PADs within the behavioral health, hospital, inpatient, and first responder settings.

To address this, seven California counties—Fresno, Mariposa, Monterey, Orange, Shasta, Contra Costa, and Tri-City Mental Health Authority (herein known as Tri-City)—launched a four-year PADs Innovation Project under the Mental Health Services Act (MHSA). Managed and directed by Concepts Forward Consulting, in partnership with and in collaboration with the counties, the project aimed to develop a standardized, scalable, and multilingual digital web-based PAD platform, along with supportive training materials, policy advocacy, and stakeholder engagement.

As part of their 2020-2023 Strategic Plan, the Commission for Behavioral Health (CBH-formerly the Mental Health Oversight and Accountability Commission) sought to

encourage the use of PADs across California Counties. Initially contracted with the University of Southern California (USC), Saks Institute for Mental Health Law, Policy, and Ethics in 2019. It became clear that specific county expertise was needed to move the project forward. Kiran Sahota, of Concepts Forward Consulting, was contacted and subsequently hired to engage counties in December of 2020.

Ms. Sahota was a seasoned leader in the social services sector with nearly 30 years of experience advancing community behavioral health. She is a former Senior Behavioral Health Manager and former co-chair of the Statewide Mental Health Act Coordinators Committee through the California Behavioral Health Directors Association. She has led efforts in transitional youth housing, law enforcement crisis training, and countywide mental health innovation. Her expertise encompasses strategic planning, program evaluation, CalAIM, Medi-Cal strategies, digital transformation, and system-changing strategic planning, with a focus on innovation and equity. These qualities made her a perfect fit to oversee the large multi-county project.

Project Goals and Vision

The PADs Innovation Project was conceptualized to address long-standing issues in crisis behavioral health response, including overuse of 5150 holds, incarceration, and emergency room visits. Its core objectives include:

- Creating a digital, standardized PAD template.
- Enabling statewide portability and access through a secure web-based platform.
- Providing culturally and linguistically appropriate outreach.
- Developing training curricula and toolkits for individuals and professionals.
- Incorporating personal voices and lived experiences at every development stage.
- Laying legislative groundwork for recognizing PADs under California law.

The overarching philosophy is rooted in autonomy, equity, and early intervention—empowering individuals before a crisis occurs, while creating systemic pathways for responders and providers to access and honor those directives.

Subcontractor partnerships were established early on. Orange County, the primary funder of technology, brought Chorus Innovations, Inc. into the project. They possessed extensive expertise in the iterative process of creating digital behavioral health platforms. Their most prominent work, the CalHOPE website, is still in use within California. Some contractors from the USC attempt were retained for this project, including the Burton Blatt Institute (BBI) for Disability Rights and Syracuse University(SU) in New York. Others were chosen for their behavioral health expertise and specific California county knowledge, including RAND, Idea Engineering (IE), Painted Brain, and Alpha Omega (AO) Translation Services.

Phase One Accomplishments

Standardization and Collaboration

One of the first steps in the Multi-County project was to standardize the fiscal Standard Agreement, which was created to unify contract language across all counties—an achievement described by participating counties as “an innovation in itself.” All subcontractors were also provided a standardized agreement to ensure equity and enforcement throughout the project.

The standard agreement for a fiscal intermediary allowed SU to subcontract on behalf of participating counties, enabling them to collaborate through this shared contract. It was a cost-effective way for counties to work together, with a single process and agreement, rather than individual county procurement processes and indirect or administrative costs. It enabled a single, coordinated project and consultant activities across seven counties through a unified scope of work. This allowed counties to implement and share lessons learned in real-time.

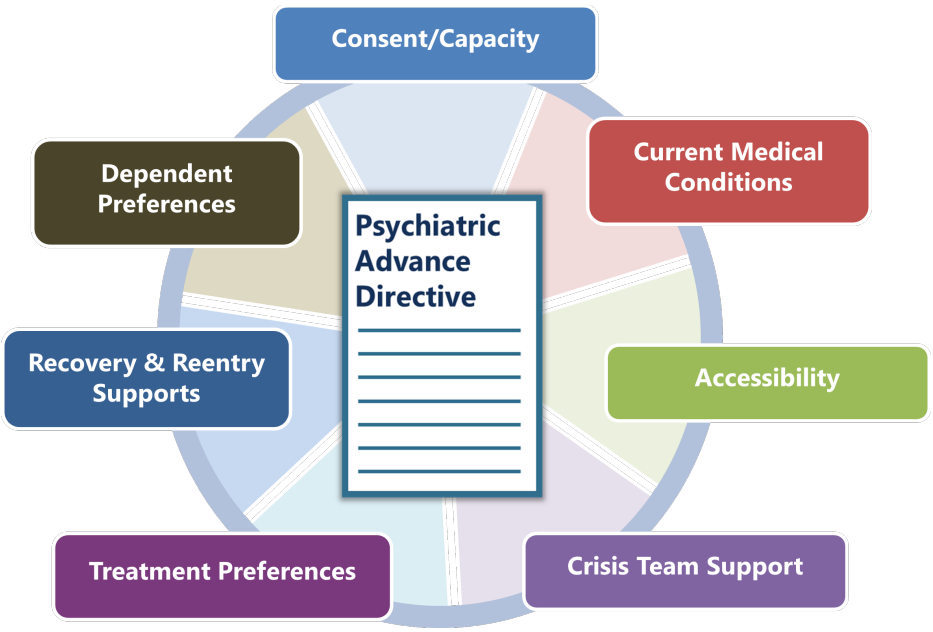
This foundational document facilitated smoother onboarding when the additional counties of Contra Costa and Tri-City joined the project in its second year and could be used to streamline future statewide initiatives.

Individual-Centered Development

Utilizing several examples of PADs from across the country, Painted Brain and its subcontractor, CAMPHRO, conducted extensive listening sessions with project stakeholders that included peer support specialists, individuals with lived behavioral health experiences, family members, caregivers, and first responders to identify the most suitable components and questions to include in the standardization. Their feedback helped improve the PAD components and guided the creation of the facilitator training curriculum. This curriculum, created by Painted Brain, focused on digital literacy, trauma-informed care, and peer-driven facilitation.

Key components of the digital PAD include:

Consent and Capacity
Treatment Preferences
Current Medical Conditions
Accessibility Needs
Recovery and Reentry Supports
Dependent Preferences
Crisis Team Support



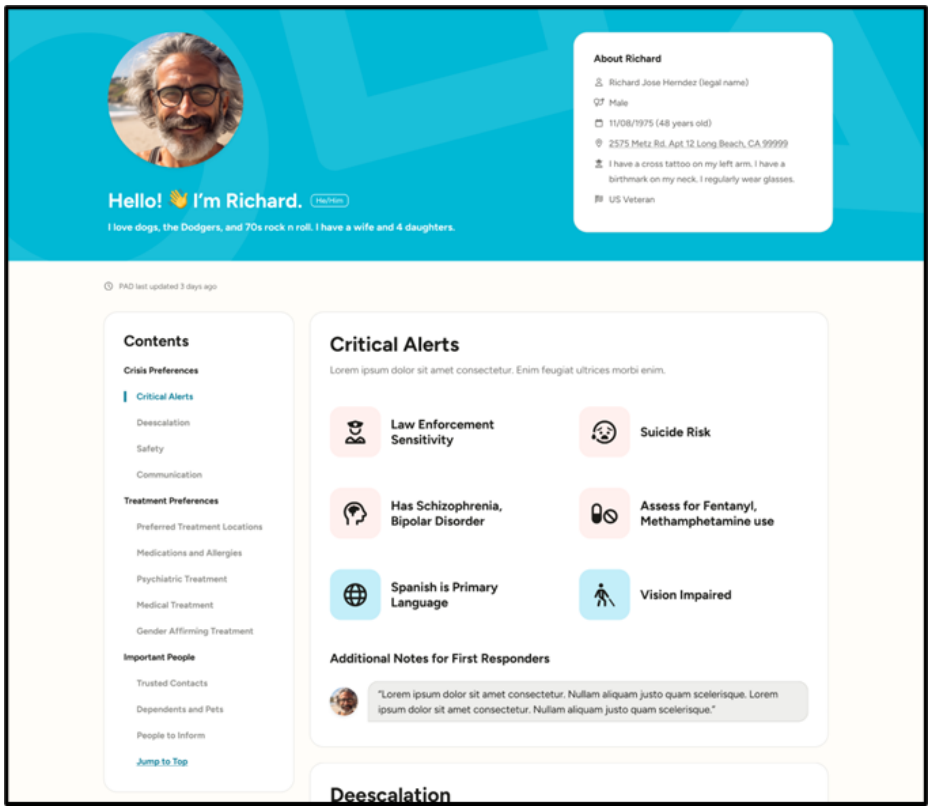
Technology Platform Development

The project progressed with a solid build of the PADs digital platform in an iterative process, performed by technology leader Chorus Innovations in collaboration with statewide peer advocates, stakeholders, and county staff, to develop a digital system that mirrors real-life user experiences and accessibility needs.

"The company who created this, Chorus Innovations, clearly took every suggestion, every thought very seriously and implemented it in the PAD. That process absolutely did not happen, clearly did not happen with the written PAD. With the digital PAD, when they were putting this together, the thoughts, values, beliefs of the people who were on the project were respected and it turned into something that people can buy into and think, oh, yeah, this was created. This was not people making it up as they go, people who went to the horse's mouth and asked for what's really going on." – Interview with PSS

"I've been really impressed with how the workshops and workgroups have shaped this platform. There's very little ego involved—no one is saying, 'This is what we want.' Instead, the group's input is prioritized and implemented. It's been a really positive experience." – Interview with PSS

A mock PAD was created based on a fictional person, "Richard," to show interface logic and flow. The PAD demo was used throughout the project to train facilitators, engage county staff and peer support specialists, and showcase the digital website. The mock PAD account was used as a tool during Beta testing, live demos, and presentations about the platform.



Marketing and Branding

The project aimed to design a professional PAD that was not only easy to use and access, but also easily recognizable with a simple logo. The idea is that the logo would be easily recognizable throughout the state, easily downloadable as an icon on a digital device, and easily recognizable as a visual cue when spoken words may be difficult during a behavioral health crisis. Idea Engineering led the counties through project branding, logo design for PADs recognition, Instagram and Social Media advertising, website design for transparency (www.padsca.org), and videos for training purposes. At each step of the process, peer support specialists and project stakeholders were involved, making all design choices as the project progressed.

Psychiatric
Advance Directive
My Plan • My Voice

Cultural and Linguistic Inclusion

Recognizing California's diverse population, Alpha Omega was contracted to provide translation and interpretation in the participating counties' threshold languages, ensuring accessibility for all ethnic and linguistic communities across the seven counties.

Interpretation services were available in several work groups that were held in Spanish, as well as translation of documents found on the project's public-facing website.

The platform was fully translated to include as a supplement to the Amazon Web Services (AWS) translation used by Chorus Innovations. Phase 2 will use the quick translation available through AWS. Mirroring the efforts found on current government websites, such as the Department of Health Care Services.

Evaluation

RAND finalized a "two-level" evaluation plan to measure PADs training efficacy and user experience. Burton Blatt Institute, which was separately contracted outside the project by Orange County, provided applied qualitative research methods—including interviews and systems analysis—to assess the technology's "build" and PAD's ease of use. The evaluation summary is included in the body of this document.

Project Organization

Concepts Forward Consulting attended the various project work groups and also led the provision of ongoing presentations on the project in California and throughout the nation. The Multi-County Project garnered such positive notoriety that presentations were provided through two SAMSHA nationwide webinars, both held in 2024, New York Peer Alliance 2024, Washington State Co-Occurring Treatments Conference 2024, NAMI CA Annual Conference 2021 and 2024, Southern California Hospital Risk Managers Annual Conference in 2024, and Disability Rights of California, and Patients' Rights Advocates Annual Conference 2025. Additionally, a book published in France included a Chapter on Innovations, referring specifically to the California Multi-County Project, *Le guide des directives anticipées psychiatriques, 2025.*

Locally, presentations have been provided to organizations such as Words to Deeds, Tri-City Probation Department, Shasta County Sheriff's Department and Board of Supervisors, California Health and Human Services CARE Ad Hoc Committee, Orange County Peer "Meeting of the Minds", Judicial Council, CALBHB/C Behavioral Health Boards and Commissions, the California Department of State Hospitals, county leadership and directors, and additional counties interested in the project.

Project organization involved managing project overlaps, scope creep, and advancing all counties and subcontractors toward the common goal, while also considering the nuances of each county's needs and the evolving political climate in the state. There were numerous workgroups provided by all subcontractors, including monthly county-to-county updates, subcontractor coordination, peer, family/caregiver, and friend involvement, first responder collaborations, legislative considerations, and terms of service. and the monthly "Third Thursday" full project meetings. We discussed maternal mental health initiatives overseen by a separate group, as well as landing page development, marketing efforts, beta testing, and technology implementation. Once the project found its "groove," coordination of all activities was seamless, well-received, and attended by all participating counties.

Challenges Encountered

The project, rooted in the idea of innovation, is inherently focused on testing new ideas, theories, or systems for care change. Like any innovative effort, the Multi-County PADs Project Phase 1 faced some challenges along the way. Since project milestones are linked, delays in one area (e.g., peer component design, technology creation, and stakeholder response) caused ripple effects in training, evaluation, and platform development. Converting nuanced PADs components into meaningful, digitized questions and logic trees took more time than expected. Chorus Innovations had to work closely with peers and counties to ensure the platform was user-friendly and met accessibility and security standards.

There were challenges of aligning counties with different processes and their impact on project activities. Some counties faced a delay in Beta testing when the discussion of a Business Associate Agreement was considered; however, it was ultimately decided that the contract holder, SU, would ensure the necessary precautions. Platform Terms of Service (TOS) was also a lengthy discussion, but ultimately, using TOS from existing digital platforms proved to be the most helpful approach, rather than trying to “reinvent the wheel.”

There’s also the challenge of counties working through their internal processes to remain aligned with the collaborative activities and timeline. As much as everyone wanted to Beta test at the same time, it was realized that launch and implementation needed to be a county-specific approach. This delay ultimately impacted and limited the information RAND and BBI would receive to complete their evaluations.

To overcome challenges, solution-focused county-subcontractor meetings and monthly workgroups promoted alignment. Mock platform demos and user testing supported iterative design. Partnerships with law enforcement and correctional health leaders helped expand collaboration, which was crucial for the project's success. Concepts Forward Consulting played a key role in guiding the project, balancing flexibility with accountability.

Standard Agreement

The coordination of initially five unique counties, unique in size, demographics, Board of Supervisors (BOS), stakeholder expectations, and County Council demands, is incredibly challenging. The amazing part is that all five counties dug in for the long haul, figuring out Standard Agreement language that would satisfy the needs of all counties as well as Syracuse University, which was the identified fiscal intermediary. This process took nine months of the project’s first year. Overcoming this challenge enabled the counties to be billed by only one entity instead of seven separate contractors, allowing contractors to contract and invoice with a single entity. This is truly one of the integral parts of the collaborative nature of the project.

County Constraints

Each county faced prolonged contract approval timelines—up to nine months in some cases—due to complex internal reviews by contracting departments, county counsel, auditors, and BOS. This lag hindered the early implementation of the scope of work and hiring. This is something that should be considered when implementing any new project. It took seven counties to come together for a single purpose, yet each process within the counties remains unique to that county.

The project initially started at the height of COVID-19. Numerous counties and subcontractors reported staffing shortages, turnover, or delays in hiring. This particularly impacted the onboarding of peer support specialists and PAD project leads, as well as the ability of small counties with limited behavioral health infrastructure to stay on track. The challenges were overcome in time, and with the understanding that each county must move at its own pace. This is an important factor for outside contractors to understand when working with counties. Every county stayed engaged throughout the four years of Phase 1. The camaraderie among the numerous expectations placed on county staff was often the bond that drove participation in a project that consistently moving forward.

During the project, with the counties collaborating on Phase 2 expansion, Proposition 1 passed, creating an entirely new set of challenges for the counties. Expectations once again were placed on the counties to work toward their Behavioral Health Transformation Plan. The added workflow resulted in a turnover of county staff and the onboarding of new individuals for the project. With the idea of replicability and sustainability always in the forefront, onboarding new staff was a seamless process.

Legislative and Statutory Ambiguity

The Code of Federal Regulation, or better known as 42-CFR, specifically states that Medicare/Medicaid-participating hospitals are to honor advance directives, including PADs, ensuring the right to informed decisions about treatment and proxy designation when incapacitated, further stating that a provider must follow the state mandates as to directives. Currently, in California, a PAD can be considered, in the Probate Code, as a separate, standalone directive. However, most hospitals and medical professionals do not currently ask if an individual has a PAD, and if they do ask, they are not trained on how to respond to an instructional PAD in which a person maintains capacity.

California's lack of a PAD-specific statute creates confusion among providers, first responders, and individuals. Critics argue it still subordinates psychiatric care to physical health decisions. Though Assembly Bill (AB) 1029 allowed for mental health preferences to be added to an Advanced Healthcare Directive, there were no specific behavioral health categories to aid individuals in filling out a document that focused primarily on medical loss of capacity and durable power of attorney. Senate Bill 1338 added the term behavioral health, now including substance use disorder and mental health to advance

health care directives. However, with the creation of the Community Assistance, Recovery, and Empowerment Court (CARE) bill, it did little to encourage an understanding of a PAD or how to facilitate it. In addition, to date, there are very few individuals who 1) qualify for CARE and 2) leave the court without ever filling out a PAD. Probably the most challenging aspect of the PAD is that without legal parity, PADs are often unenforceable or ignored during crisis response.

The project, with the support of Assemblymember Irwin, sponsored AB 2352 to expand the understanding and use of PADs. Though the bill passed the assembly unanimously and had the written support from both CBH and several county directors, the bill had several flaws that it could not overcome. The first being, it came on the heels of several bills, including CARE and Prop 1, that the Peer community was vehemently against, and the PADs bill may have felt like another bill that was directing care for people with lived behavioral health conditions.

During the legislative attempt, the platform product or the PAD registry was still incomplete, leading to uncertainty about its use and access. This included fears about technology, concerns that first responders might access personal preferences, and debate over switching terminology from 'mental health' to 'behavioral health.' Questions also arose about how law enforcement would utilize a PAD. Most notably, there was apprehension about change and difficulty understanding the importance of using an individual’s PAD to identify the best resources and de-escalate behavioral health crises with that person's own words. Much of this fear was reported by communities older than our Transitional Age Youth (TAY), who have experienced traumatic encounters with law enforcement and hospitalization. These populations seemed to overlook the potential of system changes to improve such interactions for younger generations.

A surprising obstacle arose when the idea of integrating a PAD into the California Law Enforcement Telecommunication System (CLETS), which was approved by the Department of Justice (DOJ), was rejected by the Secretary of State (SOS), who currently oversees the federally mandated Registry for directives. The DOJ was unable to connect through a third-party system, specifically the Chorus Innovations Platform, so the request was to connect via the SOS. Unfortunately, this became a barrier for legislation when the SOS indicated they were unwilling to update the rarely used metal file cabinet they currently use to store directives. This issue must be addressed in Phase 2. California lags other states in adopting digital registries. Even smaller states such as Idaho, Kentucky, and North Carolina have digital access.

It is the goal within Phase 2 to readdress the ideas of legislation with a more succinct ask for updated PADs legislation, which may include some of the findings as suggested by Evaluator BBI:

- *Ensure that PADs are viewed, under the law, as having the same legal importance and impact as other advanced health care directives, solidifying the use of the two types of PADs in CA, both instructional or with Proxy.*
- *Set forth the specific elements a PAD must include to be legally sufficient and enforceable.*
- *Alignment with both Probate Code and Welfare & Institutions Code.*
- *Provide that PADs may be created, signed, witnessed, and notarized in writing or digitally.*
- *That a witness or facilitator for an informative PAD may be a clinician, peer facilitator, or trusted individual, and in the individual's words.*
- *Liability protection for crisis teams, first responders, and hospital staff who must attempt to utilize an individual's PAD within their scope of work.*
- *Identify limitations of use by health care professionals and first responders, only in the specific duty when engaged with an individual who gives consent to use their PAD.*
- *And mandatory training for behavioral health professionals, hospital staff, and first responders, to utilize a person's Instructional or Proxy PAD.*
- *Require the SOS to update the registry to an accessible e-registry as currently utilized and maintained in multiple states around the nation.*

Evaluation

Evaluation Methodology

The evaluation of the PADs Innovation Project was collaboratively designed and implemented by a multi-dimensional team comprising the RAND Corporation, Painted Brain, Idea Engineering, Chorus Innovations, and BBI. The primary objective was to assess both the implementation process and the impact of digital Psychiatric Advance Directives (PADs) across seven California counties. A mixed-methods approach ensured a comprehensive understanding of outcomes from various stakeholder perspectives.

Mixed-Methods Approach

The evaluation employed both qualitative and quantitative methods. Qualitative data were collected through semi-structured interviews, focus groups, and narrative reflections from Peer Support Specialists (PSS), individuals with lived experience, county mental health providers, law enforcement personnel, and family advocates. These sessions were designed to capture personal stories, perceived impact, and barriers to PAD engagement.

Quantitative data were collected through several means:

- Pre- and post-training surveys administered by RAND to peer support specialists measured changes in knowledge, confidence, and perceived facilitation competence.
- Chorus Innovations' platform analytics captured user behavior on the digital PAD platform, including PAD completion rates, time spent on sections, and most utilized features.

- Idea Engineering collected metrics from campaign engagement (e.g., social media, print materials, community event attendance).
- PADs were also reviewed anonymously to assess data completeness, usage patterns, and demographic trends.

Technology-Based Data Collection
Chorus Innovations' platform not only served as the digital tool for PAD creation but also as an important evaluation interface. It recorded data such as login frequency, section drop-off rates, and accessibility feature usage. This real-time data helped improve the platform through iterations, guided by WAVE accessibility tests and peer feedback.

Trauma-Informed and Participatory Design
Evaluation tools were co-created with input from peer support specialists and community members to reduce stigma and promote psychological safety during data collection. Surveys and interviews incorporated language designed to be affirming, trauma-informed, and accessible for individuals with varying literacy and cognitive levels.

Community Review and Iterative Learning
Feedback loops were embedded into every phase of the evaluation. Data was continuously reviewed with advisory groups consisting of county behavioral health leaders, peer organizations, and advocacy groups. These stakeholders reviewed emerging findings, validated interpretations, and provided critical context for refining evaluation tools and implementation practices.

Accessibility and Cultural Competence
To ensure inclusivity, all evaluation materials were translated into threshold languages used by the participating counties, including Spanish, Vietnamese, Tagalog, Chinese, Korean, Farsi, and Russian. Focus groups were conducted in multiple languages and included cultural brokers when needed. Cultural competency experts reviewed evaluation surveys to remove language that could be stigmatizing or exclusionary.

Demographic Outcome Variations

The PADs Innovation Project revealed notable variations in outcomes based on participants' demographic backgrounds. These differences underscore the importance of designing behavioral health interventions that are responsive to the diverse communities' cultural, linguistic, economic, and social realities. The project's emphasis on equity and inclusion provided a valuable lens through which these variations could be understood and addressed.

Cultural and Linguistic Responsiveness
Spanish-speaking participants and individuals from Black, Indigenous, and other People of Color (BIPOC) communities highlighted the importance of cultural safety and trauma-informed engagement. They reported that having peer facilitators from similar cultural backgrounds or with shared lived experiences helped build trust and encouraged full

participation in the PAD development process. The availability of translated materials and bilingual staff was crucial in allowing these communities to engage with PADs meaningfully. In counties where early efforts focused on threshold language translation, participation rates among non-English speakers were higher.

Access for People with Disabilities and Older Adults
Participants with disabilities—especially cognitive, visual, and learning disabilities—benefited from accessibility features integrated into the Chorus Innovations platform and by Idea Engineering in the public-facing project website, including screen reader compatibility, large font options, and simplified navigation. For older adults, initial engagement was slower due to hesitations with digital platforms. However, once familiarized with the technology, many reported feeling empowered by the ability to review and revise their PAD independently. Peer facilitators played a pivotal role in bridging the digital divide for this group, offering hands-on support during workshops.

Unhoused and Justice-Involved Individuals
For individuals experiencing homelessness or involved in the criminal justice system, the barriers to engagement were particularly complex. These groups often lacked stable internet access, private space to complete a PAD, or trust in formal mental health systems. In response, the project implemented outreach strategies tailored to these groups, including in-person PAD completion events, direct engagement at shelters or correctional facilities, and trauma-informed messaging. Peer support specialists who shared similar life experiences were especially effective at reducing stigma and encouraging participation.

Transitional-Aged Youth
Transitional-aged youth showed higher engagement with the digital interface, often completing PADs more quickly and independently. Feedback from TAY users suggested they appreciated the flexibility, visual design, and tone of the platform, which felt less clinical and more aligned with their values of autonomy and creativity. However, this group also expressed a desire for additional coaching on the legal aspects of PADs and guidance in translating their values into actionable crisis planning steps.

Activities Contributing to Success

Several core activities and strategic elements contributed significantly to the success of the PADs Innovation Project. These activities were not only integral to engaging participants and stakeholders but also shaped the sustainability and scalability of the project across the seven participating counties.

Peer Facilitation as a Cornerstone
Perhaps the most impactful activity was the implementation of peer-facilitated PAD development. Individuals with lived experience served as Peer Support Specialists (PSS), facilitating PAD creation using trauma-informed, strength-based, and culturally sensitive approaches. Participants consistently cited peer involvement as a key reason

they felt comfortable sharing personal information, trusting the process, and completing their PADs. RAND's evaluation confirmed that peer-led facilitation improved participants' feelings of autonomy, dignity, and psychological safety during the planning process.

Train-the-Trainer Model
Painted Brain's Train-the-Trainer model enabled counties to build local peer facilitation capacity. This cascading training structure allowed experienced peer facilitators to train others within their own systems, building internal sustainability and minimizing reliance on external trainers. The training curriculum emphasized trauma-informed care, legal implications of PADs, communication strategies, and technical navigation of the digital PAD platform. RAND survey data indicated that peer confidence in delivering PAD support services more than doubled following training.

Platform Personalization and User Engagement
Chorus Innovations' design of the digital PAD platform prioritized a welcoming, non-clinical tone and intuitive functionality. Customizable dashboards, celebratory animations upon completing sections, and multilingual interfaces contributed to a user-friendly experience. Iterative feedback sessions and usability testing with individuals with lived experience informed these design choices. As a result, user satisfaction remained high, and section completion rates—particularly for the Crisis Directive—exceeded expectations.

Strategic Outreach and Community Education
Idea Engineering led the project's outreach and education efforts, producing culturally resonant campaigns under the banner "My Plan, My Voice." Materials included printed brochures, social media graphics, informational videos, and digital advertisements. In-person events and peer-led PAD clinics also helped demystify the process and provide immediate access to trained facilitators. Evaluation findings confirmed that counties with higher outreach penetration saw greater PAD initiation and completion rates.

Collaborative Learning Communities
The project, led by Concepts Forward Consulting, promoted inter-county collaboration through advisory committees, cross-county learning communities, and shared implementation toolkits. These forums allowed project managers, peer leaders, and clinical staff to share best practices, address challenges, and align policies across jurisdictions. The sense of shared purpose and collective learning helped foster a culture of innovation and accountability.

Concepts Forward Consulting encouraged all counties to participate in biannual convenings. Six of these convenings took place over the four years of the project. They provided an opportunity for all contractors and counties to meet every six months to discuss progress, challenges, and strategize new ideas for advancing the project. Each county took turns hosting. These convenings significantly contributed to the collaboration and cohesiveness of this large project.

Cultural Competence of the Evaluation

Cultural competence was a foundational principle of the PADs Innovation Project, shaping both implementation and evaluation processes. Given the diversity of California's population, the project team recognized that meaningful engagement and accurate evaluation could only occur through culturally responsive and linguistically accessible practices. This focus on equity and inclusion enhanced participant trust, broadened access, and enriched the quality of data collected across counties.

Translation and Language Access

Alpha Omega worked with Evaluation materials—including surveys, informational flyers, and consent forms—to translate into all threshold languages represented across the seven counties, including Spanish, Vietnamese, Tagalog, Chinese, Korean, Farsi, and Russian. In-person and virtual focus groups were conducted in multiple languages, facilitated by bilingual peer staff or with the support of interpreters. This ensured that participants could fully express themselves without linguistic barriers, improving the depth and reliability of qualitative data collected.

Cultural Brokers and Peer Facilitators

The project employed cultural brokers and peer support specialists who reflected the identities and experiences of the communities they served. These individuals played a vital role in building rapport, clarifying cultural nuances during focus groups and interviews, and advising on adaptations to data collection instruments. Their involvement helped elevate community voices and ensured that cultural worldviews were represented authentically within the findings.

Trauma-Informed and Strengths-Based Framing

Evaluation surveys and interviews were designed with trauma-informed principles in mind. Questions were framed in ways that honored personal agency and avoided clinical or stigmatizing language. Participants were invited to share their experiences as co-creators of change, rather than passive subjects of evaluation. This approach led to more candid feedback and fostered a sense of ownership among stakeholders.

Disability-Inclusive Evaluation Practices

To accommodate participants with disabilities, the evaluation team incorporated universal design principles and used WAVE accessibility tools to ensure digital materials met ADA compliance standards. Surveys and platform interfaces were tested for readability, screen reader compatibility, and cognitive accessibility. Feedback from users with lived experience of disability directly informed interface revisions.

Equity-Centered Analysis

Disaggregated data analysis allowed the evaluation team to identify disparities in outcomes based on race, ethnicity, language, disability status, and housing instability. These insights were used to guide recommendations for targeted outreach, training

enhancements, and future platform adaptations. The emphasis on equity did not stop at data collection—it informed the interpretation and dissemination of findings as well.

Stakeholder Contributions to the Evaluation

Stakeholder engagement was central to the PADs Innovation Project's evaluation framework. Recognizing that sustainable systems change requires input from those directly impacted, the project was designed to ensure that peers, family members, county staff, law enforcement, providers, and community leaders contributed meaningfully throughout all phases of evaluation—from design to interpretation to dissemination.

Inclusive Co-Design Process

Stakeholders were involved early through co-design workshops and advisory group meetings. These forums shaped key aspects of the evaluation, including which outcomes to prioritize, how to frame survey questions, and how best to support vulnerable populations during data collection. Peer support specialists played a critical role in refining the evaluation language to be more strengths-based and affirming. Their feedback led to modifications that made surveys more accessible and culturally resonant.

Advisory Committees and County Workgroups

Each county convened local workgroups that included peers, behavioral health leaders, and community advocates. These teams regularly reviewed implementation progress, surfaced emerging issues, and shared real-time insights with the broader evaluation team. Workgroup discussions directly informed adjustments to peer training materials, outreach strategies, and digital platform content.

Data Validation and Interpretation

Stakeholders contributed to the interpretation of both quantitative and qualitative findings. For instance, peer support specialists helped contextualize survey trends and focus group narratives, offering insights into why certain outcomes varied across populations. These contributions ensured that the evaluation findings were not only statistically valid but also deeply grounded in lived experience and community realities.

Community Storytelling and Media

Idea Engineering collaborated with stakeholders to collect and amplify stories from PAD participants and peer facilitators. These stories were used in public presentations, social media campaigns, and educational materials to demonstrate the project's impact. Participants described how PADs helped them regain a sense of agency and trust in the mental health system—messages that resonated strongly with other potential users and stakeholders.

Collaborative Dissemination

Evaluation findings were shared back with the community through stakeholder webinars,

public forums, and written summaries. These feedback loops allowed for continued reflection and refinement and reinforced a shared commitment to transparency and continuous improvement.

Outcomes of the Innovative Project

The PADs Innovation Project yielded a number of impactful outcomes across individual, programmatic, and systems levels. These outcomes were most notable in three interconnected areas: peer workforce development, digital platform adoption, and improvements in person-centered crisis planning. Together, they demonstrate meaningful progress toward the project's primary purpose—enhancing autonomy, voice, and self-determination for individuals experiencing mental health crises.

Empowering Individuals with Lived Experience

At the core of the PADs project was the aim of helping individuals with a behavioral health condition specify their treatment preferences in advance of a crisis. By developing a digital platform tailored to this population and integrating peer facilitation into every stage of the PAD creation process, the project greatly boosted participant engagement and empowerment. Over 150 people initiated PADs during the beta testing phase, with about half completing the entire Crisis Directive section. These PADs often included detailed notes on preferred medications, hospital choices, calming techniques, and specific cultural or religious considerations that are usually not documented during an emergency psychiatric situation. assessment.

Participants expressed that the process of creating a PAD made them feel heard, respected, and valued. Many reported increased confidence in their ability to advocate for themselves and a sense of relief knowing their wishes would be documented and accessible to healthcare providers and crisis responders. RAND's evaluation documented that participants felt the PAD was "more than a form"—it was a tool for dignity, choice, and control in moments of vulnerability.

Peer Workforce Strengthening

One of the most significant outcomes of the PADs Innovation Project was the development and professionalization of the peer support workforce. Through Painted Brain's Train-the-Trainer model, over 90 Peer Support Specialists (PSS) across the participating counties were trained to facilitate PADs. These peers gained skills in trauma-informed engagement, facilitation techniques, and navigation of digital tools, which significantly increased their confidence and effectiveness.

RAND's retrospective surveys showed that after training, 90% of peer facilitators reported feeling prepared to help someone complete a PAD, compared to just 44% before the training. Similarly, 88% felt confident in explaining the PAD's legal implications, up from 42%. These improvements reflect a successful shift in both skills and self-perception. In addition to the practical skills acquired, peers reported a sense of personal growth and increased professional identity, with some describing the

experience as “transformative” and a key step toward more respected roles within the behavioral health system.

Digital Engagement and Accessibility
The PADs digital platform, modeled by Chorus Innovations, introduced several new practices to the field of mental health crisis planning. Rather than relying on static paper forms, the platform allowed users to interactively create, revise, and securely store their PADs online. Features such as real-time saving, visual dashboards, non-linear section completion, and celebratory animations (e.g., digital confetti after completing a section) were incorporated to enhance user comfort and motivation. Chorus Innovations’ analytics indicated that these design features resulted in strong engagement, especially with the Crisis Directive section, which had the highest rate of completion.

Idea Engineering supported this effort through user-centered branding, such as the “My Plan, My Voice” campaign, which emphasized autonomy, strength, and hope. Participants often described the platform as “friendly,” “welcoming,” and “less clinical,” contrasting it with the intimidating nature of traditional psychiatric documentation.

Accessibility improvements based on user feedback included screen reader compatibility, translated content in multiple languages, and trauma-informed prompts. These enhancements were especially important for communities with disabilities, low literacy, or histories of psychiatric trauma.

Lessons Learned

The PADs Innovation Project provided valuable insights into how digital tools, peer support, and collaborative planning can be integrated to improve mental health crisis care. Through its successes and challenges, the project revealed several key lessons that can guide future implementations in California and beyond.

Implementation Must Be Adaptive
One of the most critical lessons was the need for flexibility. Each county brought different levels of infrastructure, peer workforce readiness, cultural demographics, and system engagement. Counties with pre-existing peer networks and technology platforms were able to implement PADs more swiftly, while others needed more foundational support. A ‘one-size-fits-all’ model proved unfeasible. Tailored training, flexible timelines, and regular coaching allowed counties to proceed at their own pace while maintaining fidelity to the project’s goals.

Peer Leadership is Transformative
The importance of centering peer voices was evident throughout. Peer Support Specialists were not only facilitators but also catalysts for engagement, innovation, and cultural change. Participants often described feeling more understood and respected by peers than by traditional clinicians. The use of peer trainers to teach other peers ensured the training was rooted in lived experience, which enhanced trust and improved

outcomes. This affirmed the value of investing in long-term peer workforce development as part of behavioral health reform.

Digital Equity is Essential
While the digital platform enabled access and efficiency, it also highlighted disparities in digital literacy and internet access. Individuals from rural areas, older adults, and those experiencing homelessness faced barriers to using the platform independently. This reinforced the need to pair technological innovation with human support—such as in-person coaching and printed alternatives—and to advocate for expanded digital access in underserved areas.

Legal and Policy Clarity is Still Needed
Despite the positive reception of PADs, questions still exist about enforceability, whether there is a need for integration with electronic health records, and what is the provider's responsibility. Many counties noted a lack of clarity in state law regarding PAD use during emergencies. Stakeholders called for the development of statewide guidelines to help clinicians, first responders, and legal entities consistently honor PADs. Without formal policy integration, the full potential of PADs might remain unrealized.

Cross-Sector Collaboration is a Success Factor
Partnerships between peers, county behavioral health departments, hospitals, law enforcement, and community organizations were instrumental. Where collaboration was strong, implementation was smoother, and participant engagement was higher. These findings suggest that long-term success requires sustained investment in cross-sector alignment, shared goals, and continuous communication.

Conclusion

The Multi-County PADs Innovation Project marked a pivotal step in reimagining how individuals with a behavioral health condition are supported before and during psychiatric crises. More than a test of technology, the project became a catalyst for cultural transformation—one rooted in autonomy, equity, and compassion. Through the thoughtful integration of peer-led facilitation, user-centered digital tools, culturally competent outreach, and cross-sector collaboration, the project established a person-driven, trauma-informed alternative to traditional crisis planning.

The initiative not only elevated the role of Peer Support Specialists but also empowered participants to reclaim their voice and assert their preferences in care. From the inclusive user experience of the Chorus Innovations platform to the culturally resonant messaging of Idea Engineering to the grounded training by Painted Brain, each component reflected a commitment to inclusion and lived experience as central drivers of change. These strategies collectively advanced a vision of crisis care that is collaborative, healing, and grounded in respect.

Importantly, the project did not treat evaluation as an afterthought, but as a participatory and adaptive process. By embedding real-time feedback loops, digital data integration, and community-informed metrics, the evaluation remained accountable and responsive. Culturally humble, multilingual, trauma-informed, and disability-inclusive methods ensured that the insights gathered were as diverse as the communities served—reinforcing that effective evaluation must reflect the people it aims to support.

Findings from the PADs Innovation Project reinforce that a one-size-fits-all approach is insufficient. True equity in behavioral health requires tailored outreach, meaningful peer engagement, and the removal of digital and institutional barriers. Capacity building, strategic inter-county collaboration, and inclusive design were not just strategies—they were essential conditions for the project's short-term impact and long-term sustainability.

Stakeholders played a vital, co-creative role throughout the project. Their active participation shaped implementation, guided priorities, and built trust across sectors. This deep engagement helped transform the project from a discrete intervention into a movement toward systemic change.

While challenges remain—particularly around digital equity, policy alignment, and sustainable funding- the PADs Innovation Project offers a replicable roadmap for reform. It stands as a testament to what is possible when systems invest in co-creation, culturally responsive care, and person-centered planning. The project's legacy will not be defined solely by the number of PADs completed, but by the cultural shift it sparked: one that values autonomy, centers lived experience, and reimagines crisis care as an opportunity for healing rather than harm.

As California moves forward with behavioral health system transformation, the lessons learned from the PADs Innovation Project will be indispensable. They point the way toward a future where crisis prevention and recovery are guided not by coercion or default protocols, but by dignity, self-determination, and community partnership.

As the seven, and now eight, counties with the addition of Alameda, move into Phase 2, the focus will shift to training law enforcement, courts, crisis teams, first responders, and hospital staff in understanding the use and access of an individual PAD, seeking care coordination for the best personalized care for each individual. The effort also aims to reduce call-for-service time, decrease unnecessary hospitalizations and incarcerations, and build trust among individuals using the PAD. The participating counties are proud of the accomplishments in Phase 1, demonstrating how BHSA funding can be both innovative and collaborative, with a significant impact on the system of care. The project invites you to view the demonstration video at:
https://www.youtube.com/watch?v=iouGdSNhi3I