

**TITLE 9, CALIFORNIA CODE OF REGULATIONS**  
**Innovative Projects of the Mental Health Services Act**  
**Notice published: July 11, 2014**

**NOTICE OF PROPOSED RULEMAKING**

NOTICE IS HEREBY GIVEN that the Mental Health Services Oversight and Accountability Commission (Commission) is proposing to take the action described in the Informative Digest after considering all comments, objections, and recommendations regarding the proposed action.

**PUBLIC HEARING**

The Commission will hold a public hearing starting at 2:00 p.m. on August 28, 2014, at the Mental Health Services Oversight and Accountability Commission located at 1325 J St, Suite 1700 on the 17th Floor in Sacramento, California. The conference room is wheelchair accessible. At the hearing, any person may present statements or arguments orally or in writing relevant to the proposed action described in the Informative Digest. The Commission requests, but does not require, that persons who make oral comments at the hearing also submit a written copy of their testimony at the hearing. The hearing will end when all comments have been received or at 3:00pm, whichever comes first.

**WRITTEN COMMENT PERIOD**

Any interested person, or his or her authorized representative, may submit written comments relevant to the proposed regulatory action to the Commission. Comments may also be submitted by facsimile (FAX) at 916-445-4927 or by e-mail to [Lauren.Quintero@mhsoac.ca.gov](mailto:Lauren.Quintero@mhsoac.ca.gov). The written comment period closes at **5:00 p.m.** on **August 28, 2014**. The Commission will consider only comments received at the Commission office or at the public hearing, by that time.

Submit comments to:

Lauren Quintero  
Mental Health Services Oversight and Accountability Commission  
1325 J St., Suite 1700  
Sacramento, CA 95814  
(916) 445-8696

**AUTHORITY AND REFERENCE**

Pursuant to the authority vested by Section 5846 of the Welfare and Institutions Code, the Mental Health Services Oversight and Accountability Commission (Commission) is seeking changes to:

Division 1 of Title 9 of the California Code of Regulations as follows: Adopt Article 2, Sections 3200.182, 3200.183, and 3200.184; Adopt Article 5, Sections 3510.020, 3580, 3580.010, and 3580.020; and Adopt Article 9, Sections 3900, 3905, 3910, 3910.010, 3910.015, 3910.020, 3915, 3920, 3925, 3930, and 3935. This proposed action implements, interprets, and makes specific Sections 5830, 5845, 5846, 5847, 5848, 5892, and 5897, Welfare and Institutions Code; and uncodified Sections 2 and 3 of the Mental Health Services Act.

## **INFORMATIVE DIGEST**

On June 26, 2013 Governor Brown signed into law Assembly Bill 82 which went into effect immediately. Assembly Bill 82 gave the Mental Health Services Oversight and Accountability Commission (Commission) the mandate to adopt regulations necessary for the administration of the Innovation Component of the Mental Health Services Act (MHSA).

The California voters approved Proposition 63 during the November 2004 General Election. Proposition 63 became effective on January 1, 2005 as the MHSA. The MHSA expands mental health services to children/youth, adults and older adults who are at risk of or have serious mental illness or serious emotional disturbance and whose service needs are not being met through other funding sources. Through imposition of a 1% tax on personal income in excess of \$1 million, the MHSA provides the opportunity to offer increased funding, personnel and resources to support county mental health programs and monitor progress toward statewide goals for children/youth, adults, older adults and families.

Welfare and Institutions Code Section 5847 directs each county mental health program to prepare and submit to the Commission a Three-Year Program and Expenditure Plan (Plan) and annual updates. The Plan is comprised of five components of activities and/or services for which the funding established under the MHSA can be spent. The components are Community Services and Supports; Capital Facilities and Technological Needs; Workforce Education and Training; Prevention and Early Intervention; and Innovative Programs.

Prior to its elimination on June 30, 2012, the California Department of Mental Health (DMH) had the authority to adopt regulations for all of the MHSA components. Given the scale of each component DMH implemented each component on a sequential and/or phased-in approach. Accordingly, DMH drafted regulations through a concurrent process as the MHSA components were being developed. Regulations for the Innovation Component had not been adopted prior to June 30, 2012. In July 2012 the Department of Health Care Services (DHCS) was given authority, in consultation with the MHSAOAC, to develop regulations as necessary to implement the MHSA. Then in June 2013, the MHSAOAC was mandated to adopt regulations for the Innovation Component.

The goal of the Innovation Component is to create, pilot, test, adopt, and disseminate new and changed mental health practices to support the following MHSA-specified purposes: (1) Increase access to underserved groups, (2) Increase the quality of services, including measurable outcomes, (3) Promote interagency and community collaboration, and (4) Increase access to services (Welfare and Institutions Code Section 5830, subdivision (a)). Section 5830 also requires counties to choose one of these as its primary purpose.

Welfare and Institutions Code Section 5830 requires the County to support innovative approaches by doing one of the following: (A) Introducing new mental health practices or approaches, including, but not limited to, prevention and early intervention, (B) Making a change to an existing mental health practice or approach, including, but not limited to, adaptation for a new setting or community, or (C) Introducing a new application to the mental health system of a promising community-driven practice or an approach that has been successful in nonmental health contexts or settings.

Pursuant to Section 5830, the Innovation Component consists of “innovative projects that may affect virtually any aspect of mental health practices or assess a new or changed application of

a promising approach to solving persistent, seemingly intractable mental health challenges, including, but not limited to, any of the following:

1. Administrative, governance, and organizational practices, processes, or procedures.
2. Advocacy
3. Education and training for service providers, including nontraditional mental health practitioners
4. Outreach, capacity building, and community development
5. System development
6. Public education efforts
7. Research
8. Services and interventions, including prevention, early intervention, and treatment.”

This regulatory proposal would establish, for the first time, regulations for the administration of the Innovation Component of the MHSA.

This Informative Digest accompanies the proposed regulations to adopt 18 regulations, located in the California Code of Regulations Title 9, Division 1, Chapter 14, Article 2, Definitions, Article 5, Reporting Requirements and Article 9, Innovation.

#### **POLICY STATEMENT OVERVIEW AND ANTICIPATED BENEFITS OF PROPOSAL**

This regulatory proposal in its entirety helps to ensure that all projects funded with Innovation Funds reflect the intended outcomes articulated in the MHSA and promotes statewide consistency and conformity in the administration and reporting of evaluation results of Innovative Projects. Consistent and high quality evaluation data will enable the MHSOAC to conduct more effective oversight and evaluation. Sound evaluations that produced reliable data will also support local and statewide quality improvement efforts, which, for the Innovation Component, will lead to a higher probability that successful Innovative Projects will be adopted by the originating County as well as other counties. Overall, the quality of mental health services programs will increase, which will benefit California residents with and at risk of serious mental illness and their families, as well as the population as a whole, who is affected in various ways by untreated and inadequately treated mental illness.

#### **CONSISTENCY AND COMPATIBILITY WITH EXISTING STATE REGULATIONS**

During the process of developing these regulations, the Mental Health Services Oversight and Accountability Commission conducted a search of any similar regulations on this topic and found that these are the only regulations dealing in this subject area (Mental Health Services Act Innovation). Also, the Commission researched the general Mental Health Services Act regulations and met with the Department of Health Care Services to ensure that the Commission’s proposed regulations were not duplicate, inconsistent, or incompatible with any other regulations in development by the Department of Health Care Services. Therefore the Commission concluded that this regulatory proposal is consistent with existing Mental Health Services Act regulations.

## **MATERIAL UPON WHICH THE COMMISSION RELIES IN PROPOSING THE RULEMAKING ACTION**

1. African American Health Institute of San Bernardino county. (2012). Population report of the California reducing disparities project: African American strategic planning workgroup: Reducing mental health disparities in black Californians using community-defined practices: "We ain't crazy."
2. Aguilar-Gaxiola S, et al. (2012). Community-defined solutions for Latino mental health care disparities. California reducing disparities project. Latino strategic planning workgroup population report.
3. American Academy of Child & Adolescent Psychiatry. (2010). A guide to building collaborative mental health care partnerships in pediatric primary care. AACAP Council.
4. American Evaluation Association. (2011). "Public Statement of Cultural Competence in Evaluation." Adopted April 2011.
5. California Bridge to Reform Waiver. (2013). California mental health and substance use system needs assessment and service plan: Volume 2, Service Plan, September 30, 2013. California Department of Health Care Services.
6. California Department of Mental Health. (2009). Information Notice 09-02. Proposed Guidelines for the Mental Health Services Act Innovation Component of the Three-Year Program and Expenditure Plan.
7. California Healthcare Foundation. (2013). Mental Health Care in California: Painting a Picture. California Health Care Almanac.
8. California State Auditor. (2013). Mental Health Services Act: The State's Oversight Has Provided Little Assurance of the Act's Effectiveness, and Some Counties Can Improve Measurement of Their Program Performance.
9. Campbell PB & Jolly EJ. (n.d.). Beyond rigor: Appropriate Analysis. Campbell-Kibler Associates, Inc. and Science Museum of Minnesota. Retrieved June 25, 2014, from [http://beyondrigor.org/PDF/BeyondRigor\\_AppropriateAnalysis.pdf](http://beyondrigor.org/PDF/BeyondRigor_AppropriateAnalysis.pdf).
10. Centers for Disease Control and Prevention. (1999). Framework for Program Evaluation in Public Health. MMWR 48(No. RR-11).
11. Cheng R. (2012). California Reducing Disparities Project: Asian-Pacific Islander population report. Prepared for Office of Health Equity, California Department of Public Health.
12. Collins PY. (2012). Using Collaborative Care to Reduce Racial and Ethnic Disparities in Mental Health Care. NAMHC Concept Clearance. National Institute of Mental Health. Retrieved June 25, 2014, from <http://www.nimh.nih.gov/funding/grant-writing-and-application-process/concept-clearances/2012/using-collaborative-care-to-reduce-racial-and-ethnic-disparities-in-mental-health-care.shtml>.

13. Council of National Psychological Associations for the Advancement of Ethnic Minority Interests. (2003). Psychological treatment of ethnic minority populations. Association of Black Psychologists, Washington, DC.
14. Davidson L, et al. (2006). Recovery From Severe Mental Illness: Research Evidence and Implications for Practice. Center for Psychiatric Rehabilitation, Trustees of Boston University.
15. Disability Rights Education and Defense Fund. (n.d.). Mental Health Services for Children with Disabilities: the Story in California. Washington, DC. Retrieved June 25, 2014, from <http://dredf.org/news/publications/california-endowment/>.
16. Garbarino S and Holland J. (2009). Quantitative and Qualitative Methods in Impact Evaluation and Measuring Results: Issues Paper. UK Department for International Development. Social Development Direct.
17. IOM (Institute of Medicine). (2001). Crossing the quality chasm: A new health system for the 21st century. Washington, DC: National Academy Press.
18. Kavita K, et al. (2006). What Is Necessary To Transform The Quality Of Mental Health Care, Health Affairs 25(3). 681-693.
19. Kazdin AE & Rabbitt SM. (2013). Novel Models for Delivering Mental Health Services and Reducing the Burdens of Mental Illness. Clinical Psychological Science 1(2), 170-191.
20. Lopez MH. (2014). In 2014, Latinos will surpass whites as largest racial/ethnic group in California. Factank: News in the Numbers. Pew Research Center. Retrieved June 25, 2014, from <http://www.pewresearch.org/fact-tank/2014/01/24/in-2014-latinos-will-surpass-whites-as-largest-raciaethnic-group-in-california/>.
21. Lopez SR, et al. (2012). From Documenting to Eliminating Disparities in Mental Health Care for Latinos. American Psychologist 67(7), 511-523.
22. McGuire TG & Miranda J. (2008). New evidence regarding racial and ethnic disparities in mental health: Policy implications. Health Affairs 27(2), 393-403.
23. McLaughlin JA and Jordan GB. (2010). Using Logic Models. In Wholey JS, et al (Eds.), Handbook of Practical Program Evaluation, 55-81.
24. Medicaid Health Plans of America Center for Best Practices. (2012). Best Practices Compendium for Serious Mental Illness.
25. Mikalson P, et al. (2012). First do no harm: Reducing disparities for lesbian, gay, bisexual, transgender; queer and questioning populations in California. The California LGBTQ reducing mental health disparities population report.
26. Miller BF, et al. (2011). A National Agenda for Research in Collaborative Care: Papers From the Collaborative Care Research Network Research Development Conference. AHRQ Publication No. 11-0067.

27. National Institute of Mental Health. (2005). Treatment research in mental illness: Improving the nation's public mental health care through NIMH funded interventions research. Report of the National Advisory Mental Health Council's Workgroup on Clinical Trials. U.S. Department of Health and Human Services.
28. National Institute of Mental Health. (2008). The National Institute of Mental Health Strategic Plan.
29. Native American Health Center. (2012). Native vision: A focus on improving behavioral health wellness for California Native Americans. California Reducing Disparities Project: Native American Strategic Planning Workgroup Report.
30. Office of the Surgeon General. (2001). Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General. Center for Mental Health Services (US); National Institute of Mental Health (US). Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2001 Aug.
31. Parks J & Pollack D (Eds.). Integrating Behavioral Health and Primary Care Services: Opportunities and Challenges for State Mental Health Authorities. (2005). National Association of State Mental Health Program Directors Medical Directors Council.
32. Perlman SB & Dougherty RH. (2006). State behavioral health innovations: Disseminating promising practices. The Commonwealth Fund.
33. Sanchez K et al. (2012). Eliminating disparities through the Integration of Behavioral Health and Primary Care Services for Racial and Ethnic Minorities, Including populations with Limited English Proficiency: A Review of the Literature. U.S. Department of Health and Human Services, Office of Minority Health and the Hogg Foundation for Mental Health.
34. Snowdon L. (2012). Health and mental health policies' role in better understanding and closing African American-White American disparities in treatment, access, and quality of care. *American Psychologist* 67(7), 524-531.
35. Sonpal-Valias N. (2009). Measuring The Difference: An Outcome Evaluation Resource for the Disability Sector. Alberta Council of Disability Services.
36. State of Illinois Department of Human Services. (n.d.). The Expectation is Recovery: Evidence-Based Practices: State-of-the-Art Strategies to Help Recover from Mental Illnesses.
37. Substance Abuse & Mental Health Services Administration. (2002). Report to Congress on the prevention and treatment of co-occurring substance abuse disorders and mental disorders. U.S. Department of Health and Human Services.
38. Sue S, et al. (2012). Asian American mental health: A call to action. *American Psychologist* 67(7), 532-544.
39. Taylor-Powell E and Steele S. (1996). Collecting Evaluation Data: Direct Observation. University of Wisconsin-Extension Cooperative Extension.

40. U.S. Department of Health and Human Services. (2011). HHS Action plan to reduce racial and ethnic health disparities: A nation free of disparities in health and health care.
41. University of Wisconsin-Extension. (2003). Welcome to Enhancing Program Performance with Logic Models.
42. Wenzel et al. (2006). A Collaboration Between Researchers and Practitioners to Improve Care for Co-Occurring Mental Health Disorders in Outpatient Substance Abuse Treatment. RAND Health.

## **DISCLOSURES REGARDING THE PROPOSED ACTION**

The Commission has made the following initial determinations:

Mandate on local agencies and school districts: None.

Proposition 63 created the Mental Health Services Fund, which is directly distributed to the County to fund the MHSA programs. The County, through a community program planning process, determines, based on available unspent funds, what services to fund with the Mental Health Services Fund.

Costs or savings to any state agency: None.

Cost to any local agency or school district which must be reimbursed in accordance with Government Code sections 17500 through 17630: None.

Other nondiscretionary cost or savings imposed on local agencies: None.

Significant effect on housing costs: None.

Fiscal impact on public agencies including costs or savings to state agencies or costs/savings in federal funding to the state: None.

Significant, statewide adverse economic impact directly affecting business including the ability of California businesses to compete with businesses in other states: None.

Results of the economic impact assessment/analysis: The Commission concludes that the regulations would not:

- Have a significant, statewide adverse economic impact directly affecting business, including the ability of California businesses to compete with businesses in other states.
- Have a significant impact on the creation of jobs or new businesses or the elimination of jobs or existing businesses or affect the expansion of businesses currently doing business in the State of California.

The Commission has determined that this regulatory proposal will have the following benefits to the health and welfare of California residents, worker safety, and the state's environment:

Benefits of the Proposed Action: There are expected benefits to the health, safety, and welfare of California residents and to the state's quality of life by developing, piloting, evaluating, and implementing Innovative Projects that increase access to mental health services especially for underserved populations, improve the quality and outcome of mental health services, and

improve inter-agency and community collaboration. Developing and adopting new or changed practices with demonstrated effectiveness to address intractable mental health challenges can be expected to benefit the health, safety, and welfare of California residents, including those with unidentified serious mental illness; the larger number with unaddressed risk of or early onset of a potentially serious mental illness; and the still larger number of friends, colleagues, loved ones, and the many service sectors that are adversely affected by unrecognized, unaddressed, and untreated mental illness.

These regulations specify basic standards for evaluating Innovative Projects, including measuring and reporting on both outcomes and the program elements most responsible for contributing to those outcomes. The regulations also make it explicit that the timeframe and funding for the Innovative Project includes dissemination of successful mental health approaches, as well as lessons learned, to other counties, thereby disseminating the potential benefits.

Cost impacts on a representative private person or businesses: The Commission is not aware of any cost impacts that a representative private person or business would necessarily incur in reasonable compliance with the proposed action.

Small Business Determination: The proposed regulations would not affect small businesses as these regulations only affect County mental health departments.

## **CONSIDERATION OF ALTERNATIVES**

In accordance with Government Code section 11346.5, subdivision (a)(13), the Commission must determine that no reasonable alternative considered by the Commission or that has otherwise been identified and brought to its attention would be more effective in carrying out the purpose for which this action is proposed, would be as effective and less burdensome to affected private persons than the proposed action described in this Notice, or would be more cost-effective to affected private persons and equally effective at implementing the statutory policy or other provision of law.

The Commission invites interested persons to present statements or arguments with respect to alternatives to the proposed regulations at the scheduled hearing or during the written comment period.

## **CONTACT PERSONS**

Inquiries concerning the proposed administrative action may be directed to:

Lauren Quintero  
Mental Health Services Oversight and Accountability Commission  
1325 J St., Suite 1700  
Sacramento, CA 95814  
(916) 445-8696

The backup contact person for these inquiries is:

Cody Scott  
Mental Health Services Oversight and Accountability Commission  
1325 J St., Suite 1700  
Sacramento, CA 95814  
(916) 445-8696

Please direct requests for copies of the proposed text (the “express terms”) of the regulations, the Initial Statement of Reasons, or other information upon which the rulemaking is based to Ms. Quintero at the above address.

**AVAILABILITY OF INITIAL STATEMENT OF REASONS, TEXT OF PROPOSED REGULATIONS, AND RULEMAKING FILE**

The Commission will have the entire rulemaking file available for inspection and copying throughout the rulemaking process at the Commission office at 1325 J St., Suite 1700, Sacramento, CA 95814. As of the date this notice was published in the Notice Register, the rulemaking file consists of copies of the exact language of the proposed regulations, the Initial Statement of Reasons, and all of the information upon which the proposal is based.

Following the public comment period the Commission may thereafter adopt the proposals substantially as described below or may modify the proposals if the modifications are sufficiently related to the original text. With the exception of technical or grammatical changes, the full text of any modified proposal will be available for 15 days prior to its adoption from the person designated in this Notice as contact person and will be mailed to those persons who submit written comments related to this proposal, or who provide oral testimony if a public hearing is held, or who have requested notification of any changes to the proposal.

**AVAILABILITY OF THE FINAL STATEMENT OF REASONS**

Upon its completion, copies of the Final Statement of Reasons may be viewed and downloaded from the Commission’s website at [www.mhsoac.ca.gov](http://www.mhsoac.ca.gov) or by contacting Ms. Quintero at the above address.

**AVAILABILITY OF DOCUMENTS ON THE INTERNET**

Copies of the Notice of Proposed Action, the Initial Statement of Reasons, and the text of the regulations in underline and strikeout can be accessed through the Commission’s website at [www.mhsoac.ca.gov](http://www.mhsoac.ca.gov).

\*\*\*\*\*END\*\*\*\*\*