

# Draft Proposed Prevention and Early Intervention Regulations

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## CMHDA Comments to the MHSOAC on Draft Proposed Prevention and Early Intervention Regulations – Version 10-8-13

Submitted to the MHSOAC October 18, 2013

~~**Bold Strikethrough**~~ – Deletion of Language

**Bold Underline** – Addition of Language

*CMHDA Comments in RED*

### *General CMHDA Comments*

*CMHDA strongly supports an emphasis on improving the measurement of outcomes at the consumer and system levels. It is critical that we assess how the Mental Health Services Act (MHSA) has impacted mental health consumers and the system in target areas that should be most changed through the implementation of the MHSA. While there are significant evaluation efforts currently underway throughout the state, they are often not coordinated. Many counties have developed their own approaches for local evaluation and quality improvement. However, because these efforts are not part of a cohesive, coordinated evaluation strategy, California continues to lack for a comprehensive statewide picture of system performance and the effectiveness of services.*

*While CMHDA supports state-level efforts to capture important information from counties to inform coordinated evaluation efforts, we strongly caution the MHSOAC from codifying very specific evaluation and reporting requirements in state regulations. The draft PEI regulations require a significant number of new data elements to be measured and reported by counties. CMHDA is concerned that the intended program evaluation may not be feasible for all counties (and in some cases any counties) and would not result in meaningful data. Evaluation needs and competencies may change significantly in future years depending on federal or state policy changes, new technology, etc. Communities and the state will need the flexibility to alter requirements to effectively respond to those changes. Codifying very specific evaluation and reporting requirements in state regulations may significantly inhibit this flexibility.*

*The draft regulations in their current form put counties in an unfair and inefficient position of being required to comply, subject to audit, with unrealistic and undoable requirements. Requirements may quickly become antiquated as future evaluation needs change and no longer align with the detailed regulatory requirements. Significant changes in data collection and reporting requirements would also require significant changes to local and state-level information technology systems, which would require additional time and resources to achieve. While effective evaluation efforts are critical, significant reporting requirements could necessitate a redirection of funds from services to cover increased administrative responsibilities. These concerns may be exacerbated in small counties. To the*

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*extent that the regulations constitute a state mandate for local government they would require Prop 1A review.*

*CMHDA believes that quality and evaluation specifics are best done through other mechanisms such as contracts or Quality Improvement plans, rather than regulations. By design, quality assurance and quality improvement evaluation must change to address changing system needs and new practice. CMHDA looks forward to working with the MHSOAC, the Department of Health Care Services and other partners to develop a coordinated approach to statewide evaluation.*

*Finally, the MHSOAC may consider addressing Prevention and Early Intervention in separate sections, rather than grouping them together. The goals and designs of these programs often differ significantly, to the extent that the same requirements should not be applicable to both.*

**(Note: Actual section numbers will be assigned later to fit within the current MHSA regulations.)**

## **Section 1. Prevention and Early Intervention**

- (a) "Prevention and Early Intervention" means the component of the Three-Year Program and Expenditure Plan intended to prevent mental illnesses from becoming severe and disabling.
- (b) The county shall use Prevention and Early Intervention funds only to implement programs consistent with these regulations.
- (c) The county shall include in its Prevention and Early Intervention Component:
  - (1) At least one Early Intervention Program.
    - (A) "Early Intervention Program" means treatment and other interventions to address and promote recovery and related functional outcomes for a mental health disorder early in its emergence.
    - (B) Early intervention services shall not exceed eighteen months, unless the individual receiving the service is identified as experiencing first onset of a serious mental illness or emotional disturbance with psychotic features, as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, criteria for Schizophrenia Spectrum and Other Psychotic Disorders, in which case intervention services shall not exceed four years, **or unless there is no capacity to appropriately meet their needs within the larger system of care, in which case there is no limitation.**
    - (C) Early intervention services can include services to parents, caregivers, and other family members of the person with early onset of a mental illness, as applicable.

*CMHDA Comment: While CMHDA recognizes the need to distinguish these programs from more traditional treatment programs, it is also important to provide communities with sufficient flexibility to construct programs according to local needs, which in some cases may require a lengthier timeframe than the proposed limitation of eighteen months. CMHDA proposes amended language to*

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*ensure that individuals who would not otherwise be appropriately served within the larger system of care to continue to be eligible for early intervention services.*

~~(2) Outreach to Gatekeepers:~~

~~(A) “Outreach” is a process of engaging, encouraging, educating, and/or training, and learning from Gatekeepers regarding ways to recognize and respond effectively to early signs of potentially severe and disabling mental illness.~~

~~(i) “Gatekeepers” means families, employers, primary health care providers, school personnel, community service providers, community leaders, cultural brokers, leaders of faith-based organizations, and others in a position to identify early signs of potentially severe and disabling mental illness, provide support, and/or refer individuals who need mental health services.~~

~~(ii) An individual with signs and symptoms of a mental illness can be his or her own “gatekeeper.”~~

~~(B) Outreach to Gatekeepers can be a stand-alone program, an element of a Prevention program or an Early Intervention program, or a combination.~~

(d) Programs should include outreach to families, employers, primary care health care providers, and others to recognize the early signs of potentially severe and disabling mental illnesses. Others may include school personnel, community service providers, community leaders, cultural brokers, and leaders of faith-based organizations.

*CMHDA Comment: CMHDA has significant concerns with the potential unintended implications of this section. Foremost, we are concerned that this section, as written, confuses this statutorily-required outreach requirement with a “program” requirement. While we recognize and support the requirement that counties conduct outreach to families and others to recognize early signs, the proposed regulation in its current form reads as if counties would need to develop standalone “programs” dedicated to outreach. Since this is not how county programs are currently constructed, this would require a dismantling of prevention and early intervention program plans that have already been prioritized through the local planning process. While (B) attempts to address this concern some, the section is still likely to be confusing to counties and their stakeholders. Thus, CMHDA would suggest that this requirement be included as a separate section, rather than as part of (c). Furthermore, stakeholders in some counties have voiced significant concern with the term “gatekeeper” as having negative implications in the mental health community.*

(d) The county may include in its Prevention and Early Intervention Component:

(1) One or more Prevention Programs.

(A) “Prevention Program” means a set of related activities to bring about mental health and when applicable, associated functional outcomes for individuals and members of groups or populations whose risk of developing a serious mental illness is significantly higher than average and, as applicable, their parents, caregivers, and other family members.

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- (i) “Risk factors for mental illness” means conditions or experiences that are associated with a higher than average risk of developing mental health problems, including a serious mental illness. Kinds of risk factors include, but are not limited to, biological including family history and neurological, behavioral, social/economic, and environmental.<sup>1</sup>
  - (ii) Examples of risk factors include, but are not limited to, a serious chronic medical condition, adverse childhood experiences, experience of severe trauma, ongoing stress, exposure to drugs or toxins including in the womb, poverty, family conflict or domestic violence, experiences of racism and social inequality, prolonged isolation, or having a previous mental illness.
- (2) Stigma and Discrimination Reduction Program
- (A) “Stigma and Discrimination Reduction Program” means a county’s direct activities to reduce negative feelings, attitudes, beliefs, perceptions, stereotypes and/or discrimination related to having a mental illness or to seeking mental health services and to increase acceptance, dignity, inclusion, and equity for individuals with mental illness.
  - (B) Examples of Stigma and Discrimination Reduction Programs include, but are not limited to, social marketing campaigns, speakers’ bureaus and other direct-contact approaches, targeted education and training, anti-stigma advocacy, web-based campaigns, efforts to combat multiple stigmas, and efforts to encourage self-acceptance.
- (3) Suicide Prevention Program
- (A) Suicide Prevention Program means organized activities that a county undertakes to prevent suicide that do not focus on or have intended outcomes for specific individuals at risk of or with serious mental illness.
  - (B) Examples of organized activities to combat mental health-related suicide that do not focus on or have intended outcomes for specific individuals include, but are not limited to, public and targeted information campaigns, suicide prevention networks, capacity building programs, culturally specific approaches, screening programs, suicide prevention hotlines or web-based suicide prevention resources, and training and education.
  - (C) Programs that aim to reduce suicidality for specific individuals at risk of or with early onset of a potentially serious mental illness can be either Prevention or Early Intervention Programs.
- (e) All programs listed in subdivisions (c) and (d) shall include all of the following strategies:
- (1) Be designed and implemented to help create Access and Linkage to Treatment.
    - (A) “Access and Linkage to Treatment” means connecting children with severe mental illness, as defined in Section 5600.3, and adults and seniors with severe mental illness, as defined in Section 5600.3, as early in the onset of these conditions as practicable, to medically

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<sup>1</sup> Risk Factors, Mental Illness, Mayo Clinic. Available at <http://www.mayoclinic.com/health/mental-illness/DS01104/DSECTION=risk-factors>.

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- necessary care and treatment, including but not limited to care provided by county mental health programs.
- (i) Access and Linkage to Treatment can be a stand-alone program, an element of a Prevention program or an Early Intervention program, or a combination.
- (2) Be designed, implemented, and promoted in ways that Improve Timely Access to Mental Health Services for Individuals and/or Families from Underserved Populations.
- (A) “Improving Timely Access to Services for Underserved Populations” means to increase the extent to which an individual or family from an underserved population as defined in Title 9 California Code of Regulations Section 3200.300 who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in the onset as practicable, through program features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available, and cost of services.
  - (B) Programs shall provide services in convenient, accessible, ~~acceptable~~, culturally appropriate settings such as primary healthcare, schools, family resource centers, community-based organizations, places of worship, and public settings unless a mental health setting enhances access to quality services and outcomes for underserved populations.
- (3) Be designed, implemented, and promoted using Strategies that are Non-Stigmatizing
- (A) “Strategies that are Non-Stigmatizing” mean promoting, designing, and implementing programs in ways that reduce and circumvent stigma, including self-stigma, and discrimination related to having a mental illness or seeking mental health services, and make services accessible, welcoming, and positive.
  - (B) Non-stigmatizing approaches include, but are not limited to, using positive messages and approaches with a focus on recovery, wellness, and resilience including but not limited to use of culturally appropriate language and concepts; efforts to acknowledge and combat multiple social stigmas, including but not limited to race and sexual preference; co-locating mental health services with other life resources; promoting positive attitudes and understanding of recovery among mental health providers; inclusion and welcoming of family members; and employment of peers in a range of roles.
- (f) The County shall measure and report outcomes for all programs listed in subdivisions (c) and (d) and for strategies listed in subdivision (e) (1) and (2) as required by Section 2 and Section 4.
- (g) **When available, All** programs listed in subdivisions (c) and (d) and all strategies listed in (e) shall use effective methods likely to bring about intended outcomes, based on one of the following standards, or a combination of the standards.
- (1) Evidence-based practice standard: Evidence-based practice means activities for which there is scientific evidence consistently showing improved mental health outcomes for the intended population, including, but not limited to, evidence from randomized clinical trials.
  - (2) Community and or practice-based evidence standard: means activities for which there is clinical, client/family, and community consensus that the practice achieves culturally relevant mental health outcomes for the intended population, especially for underserved communities.

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## **(3) Promising practice standard**

- (h) Changed program: If a county determines a need to make a substantial change to a program or strategy which changes the intended outcome(s) of the program or strategy described in the county's most recent Three-Year Program and Expenditure Plan or annual update, the county shall notify stakeholders and the Mental Health Services Oversight and Accountability Commission using a Prevention and Early Intervention Program Change Report as described Section 3(c).

## **Section 2. Program Evaluation**

- (a) For each PEI program listed in subdivisions (c) and (d) of Section 1 and for strategies listed in subdivision (e)(1) and (e)(2) of Section 1 the County shall define evaluation methods and measure program outcomes at least **annually every three years**, report results as specified in Section 5, and use data from evaluations for quality improvement.
- (1) For Prevention programs and Early Intervention programs that serve individuals, including families.
- (A) The County shall measure the reduction of prolonged suffering that may result from untreated mental illness referenced in Section 5840(d)(5).
- (i) Reduction in prolonged suffering is measured by a reduced risk or severity of mental illness as indicated by reduced risk factors or symptoms and direct measures of recovery, improved mental health status, or increased protective factors. Examples include mental and emotional well being, positive relationships and social connectedness, hopefulness, self-efficacy, perceived peace and harmony, a sense of meaning and life-satisfaction, pro-social behaviors, and choices and actions that promote wellness.
- (ii) **Small counties may seek an exemption from this requirement.**

***CMHDA Comment: Due to small economies of scale, small counties may struggle to achieve this evaluation goal. CMHDA suggests providing flexibility to small counties related to this requirement.***

- (B) The county may select, define, and measure additional indicators, each of which must be logically related to the reduction of any of the other MHS negative outcomes referenced in Section 5840(d) that may result from untreated mental illness.
- (i) Reduction in suicide, incarcerations, school failure or drop out, unemployment, homelessness, or removal of children from their homes as a consequence of untreated mental illness, if applicable to a particular program, is assessed for individuals at risk of or with a serious mental illness using appropriate indicators that the county selects. Examples include, but are not limited to, school success (attendance, grades, or graduation), lack of involvement in the criminal justice system, reduced suicidal ideation or attempts (increased help-seeking), having a place to live, children remaining in their homes (decrease in family risk factors, positive parent-child relationships and communication), or employment (participation in training or job readiness programs).

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~~(2) For Outreach to Gatekeepers referenced in subdivision (c)(2) of Section 1, the County shall measure:~~

~~(A) The number and kind of gatekeepers engaged by setting.~~

- ~~i. Examples of settings include, but are not limited to, family resource centers, senior centers, schools, cultural organizations, churches, faith-based organizations, primary health care, recreation centers, residences, shelters, and clinics.~~

***CMHDA Comment: CMHDA recommends that this item be struck consistent with our recommendation regarding the outreach requirement in Section 1.***

(3) For Stigma and Discrimination Reduction Program referenced in subdivision (d)(2) of Section 1, the County **shall may** measure:

(A) Changes in attitudes, knowledge, and behavior related to mental illness: for example, more accurate information about mental illness and recovery, increased awareness of the effectiveness of prevention and treatment for mental illness, increased comfort and openness to interacting with people with mental illness.

(i) County shall use a validated method to assess changes in attitude, knowledge, and behavior. Example of instruments: the CAMI – Social Restrictiveness Scale and the Brief Implicit Association Test.

(B) Changes in attitudes, knowledge, and behavior related to seeking mental health services

(i) County shall use a validated method to assess changes in attitude, knowledge, and behavior. Example of instruments: Self-Stigma of Seeking Psychological Help Scale, Perception of Stigmatization by Others for Seeking Help Scale, and the Attitudes toward Seeking Professional Psychological Help Scale.

(4) For Suicide Prevention Program referenced in subdivision (d)(3) of Section 1, the County **shall may** measure:

(A) Changes in knowledge about suicide, for example about warning signs, most useful response to someone who is suicidal, available resources and most effective ways to encourage people to utilize them, cultural variations in attitudes about suicide and culturally-specific prevention strategies.

(B) Changes in behavior: for example, decreased suicidal attempts, increased identification of individuals at risk of suicide, increased referrals and support, increased positive self-care and help-seeking by individuals who are feeling suicidal.

***CMHDA Comment: CMHDA recommends that the measurement requirements for these optional programs be permissive enough to allow for necessary flexibility in program design to achieve community goals and to ensure measures are obtainable given local resources. Additionally, changes in attitude and knowledge are often not meaningful measures because they do not effectively translate into behavior change. CMHDA recommends that the evaluation of these programs and strategies be conducted through a statewide longitudinal approach, based on a thorough review of***

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*the research literature. The MHSOAC may consider looking to RAND for additional support and background on this type of evaluation strategy.*

- ~~(5) For PEI strategy to provide Access and Linkage to Treatment referenced in subdivision (e)(1) of Section 1, the County shall measure:~~
- ~~(A) Number of referrals to treatment, kind of treatment to which person was referred, and duration of untreated mental illness.
    - ~~(i) Duration of untreated mental illness means as the interval from self-reported (or parent/family member reported) of onset of symptoms of mental illness until initiation of treatment.~~~~
  - ~~(B) Number of persons who followed through on the referral.~~
  - ~~(C) Number of referrals that resulted in successful engagement in treatment defined as the number of individuals who participated at least once in the program to which the person was referred.~~
  - ~~(D) How long the person received services in the program to which the person was referred~~

*CMHDA Comment: While valuable, this is not information that counties have the ability to track within current data systems. In fact, even the largest counties would not be able to provide referral information to this extent. A significant overhaul of local and statewide reporting systems would be required in order to capture this type of information. As an alternative approach to tracking referrals (which would be undoable for most counties), CMHDA proposes that each county as part of their Three Year Plan and Annual Update describe how their programs have increased access and linkage to treatment.*

- ~~(6) For PEI strategy to Increase Timely Access to Services for Underserved Populations referenced in subdivision (e)(2) of Section 1, the County shall measure:~~
- ~~(A) Number of referrals of members of underserved groups to prevention program, early intervention program, and or treatment including the kind of care, duration of untreated mental illness.
    - ~~(i) Duration of untreated mental illness means as the interval from self-reported (or parent/family member reported) of onset of risk indicators or symptoms of serious mental illness until initiation of treatment.~~~~
  - ~~(B) Number of persons who followed through on the referral.~~
  - ~~(C) Number of referrals that resulted in successful engagement in treatment defined as the number of individuals who participated at least once in the program to which the person was referred.~~
  - ~~(D) How long the person received services in the program to which the person was referred.~~

*CMHDA Comment: While valuable, this is not information that counties have the ability to track within current data systems. In fact, even the largest counties would not be able to provide referral information to this extent. A significant overhaul of local and statewide reporting systems would be*

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*required in order to capture this type of information. Furthermore, counties have no capacity to measure duration of untreated illness and could, at best, do some periodic sampling about follow through with referrals. Engagement into services is a process measure, not an outcome measure. As an alternative approach to tracking referrals (which would be undoable for most counties), CMHDA proposes that each county as part of their Three Year Plan and Annual Update describe how their programs have increased access for underserved populations.*

(b) Evaluation designs shall be culturally appropriate ~~and shall include the perspective of diverse people with lived experience of mental illness, including their family members.~~

*CMHDA Comment: While CMHDA strongly supports inclusion of diverse stakeholders in the program planning and evaluation process, a requirement that counties include all input received through a public input process in the evaluation design is unrealistic. Counties should be required to develop culturally appropriate evaluation designs informed by relevant local and state resources.*

(c) In addition, to the required evaluations listed in this section, a county may also, as relevant and applicable, define and measure the impact of PEI programs on the mental health and related systems, including, but not limited to education, physical healthcare, juvenile justice, social services, and community supports specific to age, racial, ethnic, and cultural groups. Examples of system outcomes include, but are not limited to, increased provision of services by ethnic and cultural community organizations, hours of operation, integration of services including co-location, involvement of clients and families in key decisions, identification and response to co-occurring substance-use disorders, staff knowledge and application of recovery principles, collaboration with diverse community partners, or funds leveraged.

## Section 3. Prevention and Early Intervention Program Plan

(a) As part of the Three-Year Program and Expenditure Plan or annual update, the county shall include in the Prevention and Early Intervention Program Plan the following information:

~~(1) A description of how the county ensured that staff and stakeholders involved in the Community Program Planning process required by Title 9 CCR section 3300, were informed about and understood the purpose and requirements of the MHSa Prevention and Early Intervention component.~~

(2) A description of the county's plan to involve community stakeholders **meaningfully in all phases of the MHSa Prevention and Early Intervention component program plan development**, including program planning and implementation, monitoring, quality improvement, evaluation, and budget allocations.

~~(3) A brief description, with specific examples of how each Prevention and Early Intervention funded program will reflect and be consistent with all relevant (potentially applicable) MHSa General Standards set forth in Title 9 CCR section 3320.~~

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*CMHDA Comment: The three year program and expenditure plan and annual update requirements are clearly specified in statute, and further explained in Title 9, CCR section 3500. Including additional requirements in this section may lead to unnecessary confusion.*

~~(4) For each new Early Intervention program as defined in Section 1(c)(1), the county shall include a description of the program including but not limited to:~~

~~(A) Identification of the target population for the intended mental health outcomes.~~

- ~~i. Specify demographics including, but not limited to, age, race/ethnicity, gender and if relevant, primary language spoken, military status, and LGBTQ identification.~~
- ~~ii. Specify the mental illness or illnesses for which there is early onset.~~
- ~~iii. Specify how each participant's early onset of a potentially serious mental illness will be determined.~~

*CMHDA Comment: While valuable, this is not information that counties have the ability to track within current data systems. In fact, even the largest counties would not be able to provide demographic and diagnostic information to this extent. A significant overhaul of local and statewide reporting systems would be required in order to capture this type of information. Furthermore, it may not be appropriate to ask of participants for this type of information in some instances. To gather this level of information regarding program participants may require counties to pursue additional confidentiality agreements with clients, similar to those utilized in human subject research initiatives – which would not be a realistic endeavor for more counties.*

~~(B) Specify any MHSa negative outcomes referenced in Section 5840(d) that the program is expected to affect, including the reduction of prolonged suffering as a consequence of untreated serious mental illness.~~

- ~~i. List the indicators that the county will use to measure reduction of prolonged suffering as referenced in Section 2(a)(1)(A).~~
- ~~ii. If the county decides to additionally measure the reduction of any other specified MHSa negative outcome as a consequence of untreated mental illness, as referenced in Section 2(a)(1)(B), list the indicators that the county will use to measure the intended reductions.~~
- ~~iii. Explain the evaluation methodology, including, how and when outcomes will be measured, how data will be collected and analyzed, and how the evaluation will reflect cultural competence.~~

*CMHDA Comment: In order to mitigate confusion and support local flexibility, CMHDA recommends removing (i) through (iii) from this requirement which is unnecessarily specific.*

~~(C) Specify the type of problem(s) and need(s) for which the program will be directed and the activities to be included in the program that are intended to bring about mental health and~~

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related functional outcomes for individuals with early onset of potentially serious mental illness.

- (D) Specify how the early intervention program is likely to reduce prolonged suffering as referenced in Section 5840(d) and as defined in Section 2 (a)(1)(A) and (B), by using one of the two standards (or a combination) specified in subdivision (g) of Section 1 as follow:
- ~~i. If evidence based standard, provide a brief description of or reference to the relevant evidence applicable to the specific intended outcome, explain how the practice's effectiveness has been demonstrated for the intended population, and explain how the county will ensure fidelity to the evidence based practice in implementing the program.~~
  - ~~ii. If community and/or practice based standard, describe the evidence that the approach is likely to bring about MHSA outcomes for the intended population.~~

*CMHDA Comment: In order to mitigate confusion and support local flexibility, CMHDA recommends removing (i) and (ii) from this requirement which is unnecessarily specific.*

- (E) For the reduction of any addition MHSA negative outcome as referenced in Section 2(a)(1)(B), specify how the early intervention approach is likely to reduce the specified MHSA negative outcome referenced in Section 5840(d) by using one of the two standards (or a combination) specified in subdivision (g) of Section 1 as follows:
- ~~i. If evidence based standard, provide a brief description of or reference to the relevant evidence applicable to the specific intended outcome, explain how the practice's effectiveness has been demonstrated for the intended population, and explain how the county will ensure fidelity to the evidence based practice in implementing the program.~~
  - ~~ii. If community and/or practice based standard, describe the evidence that the approach is likely to bring about MHSA outcomes for the intended population.~~

*CMHDA Comment: In order to mitigate confusion and support local flexibility, CMHDA recommends removing (i) and (ii) from this requirement which is unnecessarily specific.*

- (5) For each new Prevention program as defined in Section 1(d)((1), the county shall include a description of the program including but not limited to:
- (A) Identification of the target population for intended mental health outcomes.
    - ~~(i) Specify participants' risk of a potentially serious mental illness, either based on individual risk or membership in a group or population with greater than average risk of a serious mental illness.~~
    - ~~(ii) Specify how each participant's risk of a potentially serious mental illness will be defined and determined.~~

*CMHDA Comment: Identifying individual risk for serious mental illness is practically impossible.*

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(B) Specify reduction of MHSA negative outcomes referenced in Section 5840(d), in addition to reduction of prolonged suffering, that the program is expected to affect.

- ~~(i) List the indicators that the county will use to measure reduction of prolonged suffering as referenced in Section 2(a)(1)(A).~~
- ~~(ii) If the county decides to measure the reduction of any other specified MHSA negative outcome as referenced in Section 2(a)(1)(B), list the indicators that the county will use to measure the intended reductions.~~
- ~~(iii) Explain the evaluation methodology, including, how and when outcomes will be measured, how data will be collected and analyzed, and how the evaluation will reflect cultural competence.~~

*CMHSA Comment: In order to mitigate confusion and support local flexibility, CMHDA recommends removing (i) through (iii) from this requirement which is unnecessarily specific.*

(C) Specify the type of problem(s) and need(s) for which the Prevention program will be directed and the activities to be included in the program that are intended to ~~bring about mental health and related functional outcomes for individuals with higher than average risk of potentially serious mental illness~~ reduce the negative outcomes that may result from untreated mental illness, as specified in W&I 5840(d).

*CMHDA Comment: It is extremely difficult, if not impossible, to link most prevention initiatives to individual outcomes. CMHDA recommends the amended language to instead link the program goals and activities to the intended outcomes outlined in the MHSA.*

(D) Specify how the prevention approach is likely to bring about reduction of specified MHSA negative outcomes referenced in Section 5840(d) for the intended population, including reduction of prolonged suffering as defined in Section 2 (a)(1)(A) and (B), by using one of the two standards (or a combination) specified in subdivision (g) of Section 1, ~~as follows:~~

- ~~(i) If evidence-based standard, provide a brief description of or reference to the relevant evidence applicable to the specific intended outcome, explain how the practice's effectiveness has been demonstrated for the intended population, and explain how the county will ensure fidelity to the evidence-based practice in implementing the program.~~
- ~~(ii) If community and or practice-based standard, describe the evidence that the approach is likely to bring about MHSA outcomes for the intended population.~~

~~(6) For each new Outreach to Gatekeepers program, the county shall include a description of the program including but not limited to:~~

~~(A) Identify the kinds of gatekeepers the program intends to reach.~~

- ~~(i) Describe briefly the gatekeeper's setting and opportunity to identify diverse individuals with early signs and symptoms of potentially serious mental illness.~~

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- ~~(B) Specify the methods to be used to engage gatekeepers and for gatekeepers and public mental health service providers to learn together about how to identify and respond supportively to signs and symptoms of potentially serious mental illness, including timeframes for measurement.~~
- ~~(C) Specify how the proposed method is likely to bring about intended outcomes using one of the two standards (or a combination) specified in Section 1(g) as follows:~~
- ~~(i) If evidence-based standard, provide a brief description of or reference to the relevant evidence applicable to intended outcome, explain how the practice's effectiveness has been demonstrated and explain how the county will ensure fidelity to the evidence-based practice in implementing the program.~~
  - ~~(ii) If community and or practice based standard, describe the evidence that the approach is likely to bring about MHSA outcomes.~~
- ~~(D) Indicate if the county intends to measure other outcomes than those required in Section 2 (a) (2)(A) (B), and (C) and, if so, what outcomes and how will they be measured.~~

(6) The county shall include a description of the plan to outreach to families, employers, primary care health care providers, and others to recognize the early signs of potentially severe and disabling mental illnesses.

*CMHDA Comment: CMHDA recommends the above proposed change consistent with the proposed change to the outreach requirement articulated in Section 1.*

- (7) For each new Stigma and Discrimination Reduction Program, the county shall include a description of the program including but not limited:
- (A) Identify whom the campaign intends to influence.
  - (B) Specify the methods and activities to be used to change attitudes, knowledge, and/or behavior regarding mental illness and seeking mental health services, consistent with requirements in Section 2 (a)(3)(A) and (B), including timeframes for measurement.
  - (C) Specify how the proposed method is likely to bring about the selected outcomes using one of the two standards (or a combination) specified in Section 1(g) **as follows:**
    - ~~(i) If evidence-based standard, provide a brief description of or reference to the relevant evidence applicable to the intended outcome, explain how the practice's effectiveness has been demonstrated and explain how the county will ensure fidelity to the evidence-based practice in implementing the campaign.~~
    - ~~(ii) If community and or practice based standard, describe the evidence that the approach is likely to bring about MHSA outcomes.~~

*CMHDA Comment: In order to mitigate confusion and support local flexibility, CMHDA recommends removing (i) and (ii) from this requirement which may be unnecessarily specific.*

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- (8) For each new Suicide Prevention Program, the county shall include a description of the program including but not limited to:
- (A) Identify whom the campaign intends to influence.
  - (B) Specify the methods and activities to be used to change attitudes and behavior to prevent suicide.
  - (C) Indicate how the county will measure changes in attitude, knowledge, and behavior related to suicide risk, consistent with requirements in Section 2(a)(4)(A) and (B), including timeframes for measurement.
  - (D) Specify how the proposed method is likely to bring about selected outcomes using one of the two standards (or a combination) specified in Section 1(g) ~~as follows:~~
    - ~~(i) If evidence based standard, provide a brief description of or reference to the relevant evidence applicable to the intended outcome, explain how the practice's effectiveness has been demonstrated and explain how the county will ensure fidelity to the evidence based practice in implementing the campaign.~~
    - ~~(ii) If community and or practice based standard, describe the evidence that the approach is likely to bring about MHSA outcomes.~~

*CMHDA Comment: In order to mitigate confusion and support local flexibility, CMHDA recommends removing (i) and (ii) from this requirement which may be unnecessarily specific.*

- (9) ~~For all new programs referenced in subdivisions (4) through (8) above, When applicable,~~ explain how the program will be implemented to help create Access and Linkage to treatment for individuals with serious mental illness as referenced in Section 1(e).
- (A) Explain how individuals will be identified as needing assessment or treatment for a serious mental illness or serious emotional disturbance that is beyond the scope of an early intervention program.
  - (B) Explain how individuals, and, as applicable, their parents, caregivers, or other family members, will be linked to county mental health services, a primary care provider, or other mental health treatment.
  - ~~(C) Explain how the program will follow up with the referral to support engagement in treatment.~~
  - (D) Indicate if the county intends to measure outcomes other than those required in Section 2(a)(5)(A).

*CMHDA Comment: Most counties do not have a mechanism to follow-up on referrals to support in engagement in treatment. Furthermore, engagement in treatment is a process measure, not an outcome measure.*

- (10) For all new programs referenced in subdivisions (4) through (8) above, indicate how the program will use strategies to Increase Access to Services for Underserved Populations, as required in Section 1(e).

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~~(A) For each new program, the county shall indicate the intended setting(s) and why the setting enhances access for specific, designated underserved populations. If the county intends to locate the program in a mental health setting, explain why this choice enhances access to quality services and outcomes for the specific underserved populations.~~

*CMHDA Comment: This requirement unnecessarily complicates planning and reporting efforts. Additionally, appropriate settings for prevention and early intervention may differ significantly.*

(B) Indicate if the county intends to measure outcomes other than those required in Section 2 (a) (6) (A) and, if so, what outcome and how will it be measured, including timeframes for measurement.

(11) For all new programs referenced in subdivisions (4) through (8) above, indicate how the program will use Strategies that are Non-stigmatizing, ~~including a description of the specific strategies to be employed and the reasons the County believes they will be successful and meet intended outcomes.~~

(12) For all programs for the following fiscal year, the county shall include the following information based on a locally-defined methodology

(A) Estimated number of children, adults, and seniors to be served in each Prevention and each Early Intervention program that provide direct service to individuals.

(B) The county may also include estimates of the number of individuals who will be reached by Outreach to Gatekeeper, Suicide Prevention Programs, and Stigma and Discrimination Reduction Programs.

(13) Fiscal projections: The county shall include projected expenditures for each Prevention and Early Intervention program by fiscal year and by the following sources of funding:

(A) Estimated total mental health expenditures, MHSA Prevention and Early Intervention funding, Medi-Cal FFP, 1991 Realignment, Behavioral Subaccount, and other funding.

(B) The county shall identify each PEI-funded program as Prevention, Early Intervention, ~~Gatekeeper Outreach~~, Stigma and Discrimination Reduction Program, or Suicide Prevention Program and estimated expected expenditures for each program. If a program includes more than one element, the County shall estimate the percentage of funds dedicated to each element.

(i) The county shall estimate the amount of funding for PEI Administration.

*CMHDA Comment: CMHDA recommends the above proposed change consistent with the proposed change to the outreach requirement articulated in Section 1.*

(b) The county shall estimate the amount of funding for PEI Assigned Funds. PEI Assigned Funds represent funds voluntarily assigned by the County to CalMHSA or any other organization in which counties are acting jointly.

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- (c) Prevention and Early Intervention Program Change Report: If a county determines a need to make a substantial change to a program or strategy as described in subdivision (h) of Section 1, the county shall in the next Three-Year Program and Expenditure Plan or annual update, whichever is closest in time to the planned change, include the following information:
- (1) A brief summary of the program as initially set forth in the original Three-Year Program and Expenditure Plan or annual update
  - (2) A description of the change
  - (3) Explanation for the change including, stakeholder involvement in the decision and, if any, evaluation data supporting the change

## Section 4. Annual Prevention and Early Intervention Report

- (a) The county shall report the following program information annually as part of the annual update or Three-Year Program and Expenditure Plan. The report shall include the following information for the reporting period:
- (1) For each Prevention program and Early Intervention program that provides direct services to individuals, including families, list:
    - (A) ~~Unduplicated~~ numbers of individuals served annually
      - (i) ~~If a program serves both individuals at risk of (Prevention) and individuals with early onset of (Early Intervention) potentially serious mental illness, the county shall report numbers served separately for each category.~~
      - (ii) Programs that serve families shall report information for each individual family member served.
    - ~~(2) For each Outreach to Gatekeepers program, provide the number of gatekeepers by kind of settings as defined in Section 1(c) successfully engaged.~~
    - ~~(3) Access and Linkage to Treatment Strategy:
      - (A) ~~Number of individuals with serious mental illness referred to treatment, kind of treatment to which person was referred, and duration of untreated mental illness as defined in Section 2(a)(5)(A)(i).~~
      - ~~(B) Number of individuals who followed through on the referral.~~
      - ~~(C) Number of individuals who participated at least once in the program to which they were referred.~~
      - ~~(D) How long the person received services in the program to which the person was referred.~~~~

*CMHDA Comment: While valuable, this is not information that counties have the ability to track within current data systems. In fact, even the largest counties would not be able to provide referral information to this extent. A significant overall of local and statewide reporting systems would be required in order to capture this type of information.*

- (4) Increase Timely Access to Services for Underserved Populations Strategy:
  - (A) Identify the specific underserved populations for whom outreach was conducted.

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- ~~(B) Number of referrals of members of underserved groups to prevention programs, early intervention programs, and/or treatment including kind of care, that resulted from the outreach.~~
- ~~(C) Number of individuals who followed through on the referral.~~
- ~~(D) Number of referrals that resulted in successful engagement in treatment defined as the number of individuals who participated at least once in the program to which they were referred.~~
- ~~(E) How long the person received services in the program to which the person was referred.~~
- ~~(F) Interval between onset of risk indicators or mental illness as self-reported (or parent/family member reported) and entry into treatment.~~
- ~~(G) Interval between referral and engagement in services, including treatment.~~

*CMHDA Comment: While valuable, this is not information that counties have the ability to track within current data systems. In fact, even the largest counties would not be able to provide referral information to this extent. A significant overhaul of local and statewide reporting systems would be required in order to capture this type of information.*

- (5) For the information reported under subdivisions ~~(1) through (4) above~~, ~~disaggregate~~ numbers served, ~~number of gatekeepers engaged, and number of referrals for treatment and other services~~ by:
  - (A) Age group by the following ages: 0-15 (children/youth); 16-25 (transition age youth); 26-59 (adult); and ages 60+ (older adults)
  - ~~(B) Race/ethnicity by the following categories:~~
    - ~~(i) American Indian or Alaska Native~~
    - ~~(ii) Asian Indian~~
    - ~~(iii) Asian, other~~
    - ~~(iv) Black or African American~~
    - ~~(v) Cambodian~~
    - ~~(vi) Chinese~~
    - ~~(vii) Filipino~~
    - ~~(viii) Guamanian~~
    - ~~(ix) Hispanic/Latino~~
    - ~~(x) Multi-racial~~
    - ~~(xi) Hmong~~
    - ~~(xii) Japanese~~
    - ~~(xiii) Korean~~
    - ~~(xiv) Laotian~~
    - ~~(xv) Mien~~
    - ~~(xvi) Native Hawaiian~~
    - ~~(xvii) Pacific Islander~~

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- ~~(xviii) Samoan~~
- ~~(xix) Vietnamese~~
- ~~(xx) Unknown/not reported~~
- ~~(xxi) White or Caucasian~~
  
- ~~(C) Primary language spoken listed by threshold languages~~
- ~~(E) Sexual orientation, if known,~~
- ~~(F) Disability, if any,~~
- ~~(G) Veteran status,~~
- (H) Gender
- (I) Any other data the County considers relevant

***CMHDA Comment: This is not information tracked by most counties within current data systems for prevention and early intervention programs. Prevention programs, in particular, by design do not capture this level of demographic information about individual participants.***

- (6) For Stigma and Discrimination Reduction Programs and Suicide Prevention Programs, counties may report available numbers of individuals reached, including demographic breakdowns. An example would be the number of individuals who received training and education or who clicked on a web site.
- (7) For all programs and strategies, counties may report implementation challenges, successful approaches, lessons learned, and relevant examples.

## **Section 5. Evaluation Report**

- ~~(a) The County shall submit the Evaluation Report to the MHSOAC every three years as part of the Three Year Program and Expenditure Plan. The Evaluation Report answers questions about the impacts of PEI programs on individuals with risk or early onset of serious mental illness and on the mental health and related systems.~~
- ~~(b) The Evaluation Report shall describe the evaluation methodology, including methods used to select outcomes and indicators, collect data, and analyze results, including timelines.~~
- ~~(c) The Evaluation Report shall provide results and interpretation of results for all required evaluations set forth in Section 2.~~
- ~~(d) The county may also include in the Evaluation Report any other evaluation data on selected outcomes and indicators, including evaluation results of the impact of PEI programs on mental health and related systems.~~
- ~~(e) The county may report any other available evaluation results in Annual Updates.~~

***CMHDA Comment: All counties may not have the necessary infrastructure to produce this type evaluation report and many, especially smaller counties, this would be completely unrealistic. It may require significant resources to develop the infrastructure necessary to comply with this requirement***

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*as outlined. Furthermore, ongoing quality improvement activities at the state and local levels would see minimal benefit from this type of report.*

## **Section 6. Prevention and Early Intervention Annual Revenue and Expenditure Report**

~~(a) The county shall report as part of the MHSAs Annual Revenue and Expenditure Report the following:~~

~~(1) The total funding source dollar amounts expended during the reporting period on each PEI program broken by the following funding source: MHSAs PEI funds, Medi-Cal FFP, 1991 Realignment, Behavioral Health Subaccount, and other funds.~~

~~(A) The county shall identify PEI programs as either those focused on Prevention, Early Intervention, Gatekeeper Outreach, Stigma and Discrimination Reduction Program, or Suicide Prevention Program. If a program includes more than one element, the county shall estimate the percentage of funds dedicated to each element.~~

~~(2) The amount of funding expended for PEI Administration broken by the following funding source: MHSAs PEI funds, Medi-Cal FFP, 1991 Realignment, Behavioral Health Subaccount, and other funds.~~

~~(3) The amount of funding expended for PEI evaluation broken by the following funding source: MHSAs PEI funds, Medi-Cal FFP, 1991 Realignment, Behavioral Health Subaccount, and other funds.~~

~~(4) The amount of funding for PEI Assigned Funds.~~

~~(A) PEI Assigned Funds represent funds voluntarily assigned by the County to CalMHSA or any other organization in which counties are acting jointly.~~

*CMHDA Comment: Welfare and Institutions Code (W&I) 5899 specifies that the Department of Health Care Services, in consultation with the MHSOAC and CMHDA, shall develop and administer instructions for the annual MHSAs Revenue and Expenditure Report. According to W&I 5899, the report is intended to provide information that allows for the evaluation of prevention and early intervention strategies, among other MHSAs program elements. In order to mitigate confusion and the potential for conflicting requirements and instructions, CMHDA recommends that this section be removed from the PEI regulations, and that counties should look to the aforementioned DHCS instructions for guidance on the annual revenue and expenditure report.*