



November 20, 2013

Richard Van Horn, Chair  
David Pating, Vice Chair  
Mental Health Services Oversight and Accountability Commission  
1300 17th Street, Suite 1000  
Sacramento, CA 95811

**Re: Proposed Prevention and Early Intervention Regulations – Dated November 12, 2013**

Dear Chair Van Horn and Vice Chair Pating:

On behalf of the California Mental Health Directors Association (CMHDA), which represents the 58 county public mental health authorities throughout California, I write to encourage changes in to the above referenced regulations to make outcome measurements more meaningful. CMHDA strongly supports measuring the outcomes of prevention and early intervention efforts related to improving mental health. Improving programs and outcomes, as well as assuring the taxpayers of California that their money is being properly used, is critical to maintaining effective mental health services for Californians.

CMHDA's suggested improvements to the Mental Health Services Oversight and Accountability Commission's (MHSOAC) important role regarding program outcomes can be boiled down to three essential concerns with the regulations as proposed:

1. A clear distinction should be made between Prevention and Early Intervention, as what is measured, and how it is accomplished will be different because Prevention and Early Intervention are not the same.
  - a. For example, Stigma and Discrimination Reduction (SRD) and Suicide Prevention activities (both Prevention activities) should be evaluated on a state-wide basis instead of county-by-county because several initiatives in place are state-wide, involve the California Mental Health Services Authority (CalMHSA), and cannot be separately evaluated from any other programs conducted by a particular county.
2. The evaluation of early intervention programs, to be meaningful, must focus on outcomes related to the target population.
  - a. As written, the proposed regulations instead focus on process (e.g., whether a client follows up on a referral), which may have the impact of rewarding process without informing program success. Further, there is no statistically reliable way to measure interesting information (e.g., the duration of mental illness) that still fails to indicate if there has been any symptom reduction or improved functionality.
3. Evaluation efforts should be leveraged to achieve two compatible goals:

- a. Assurance that Prevention and Early Intervention efforts are effective; and
- b. Support continuous quality improvement so that counties can respond to service gaps and improve outcomes.

Additional details regarding these recommendations are included below.

**1. Clearly distinguish between Prevention and Early Intervention in the regulations.**

Generally, the regulations, as proposed, collapse Prevention and Early Intervention outcomes. The methods to measure outcomes are different for each, but the regulations fail to consistently and clearly make the distinction. The goals and designs of these programs often differ significantly, rendering the same evaluation and reporting requirements inapplicable to both.

**a. Evaluate the impact of stigma and discrimination and suicide prevention activities through a statewide approach.**

- i. *Stigma and Discrimination Reduction (SDR)* - Counties will be asked to measure changes in attitudes and knowledge related to mental illness and changes in attitudes and knowledge related to seeking mental health services. Additionally, the proposed regulations require counties to use a validated measure to do conduct this evaluation. Changes in attitude and knowledge are often not meaningful measures because they do not effectively translate into behavior change. It will be very difficult to tease out the impact of a single SDR activity given the extensive work in this area (multiple statewide activities, local campaigns and efforts, radio shows and media coverage related to mental health) and the time it takes to change attitudes and/or 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 the research literature. The MHSOAC may wish to consult with CalMHSA and RAND for additional support and background on this type of evaluation strategy. Evaluating the impact SDR programs requires a state-wide approach. For example, the MHSOAC might develop a statewide survey that counties can send out to local communities to measure awareness of mental health issues.
- ii. *Suicide Prevention* - Counties with suicide prevention activities will be asked to identify changes in behavior (e.g., decreased attempts) and changes in knowledge about suicide. The information needed to do a meaningful comparison is excessive and requires far more resources than county mental health programs have. Counties are not able to successfully conduct such an evaluation. Evaluating the impact of suicide prevention programs requires a coordinated local and state-wide approach, and CMHDA's members would be happy to work with the MHSOAC to develop a useful way to measure the impact of suicide prevention activities and strategies as a component of a larger, more comprehensive MHSOAC evaluation investment or possibly a WET Regional Partnership project.

**2. Focus on *outcomes* for specific populations for Early Intervention programs.** The proposed regulations heavily favor *process measurement* (emphasis added) instead of

outcomes. While process is important, the utility of evaluating it is meaningless without robust data related to outcomes. It is only after desired outcomes are not achieved that, in an attempt to improve future outcomes, process should be evaluated to determine which parts of the process, if any, negatively impacted outcomes. County data systems do not have the ability to track many of the proposed process measures, even if process were as important as outcomes. Counties with the best data collection and reporting methods, including the largest ones, would be unable to provide detailed referral, diagnostic, and demographic information the proposed regulations require. Assuming that such information would be appropriate to obtain from individuals and would inform MHSOAC about outcomes, a huge financial investment to overhaul local and statewide reporting systems would be required.

Many of the proposed measures require counties to obtain, track, and submit currently unavailable data; some of which is inherently unreliable or subjective. Some successful Early Intervention programs have no referrals (e.g., telephone “warm-lines”). Additionally, Early Intervention programs are diverse; not all of them systematically occur in the assessment, referral, program/treatment process the regulations assume. Because there is not a one-size-fits-all Early Intervention process, the process measures being sought will not accurately capture process data for all Early Intervention efforts, nor will they provide any information about outcomes about improved mental health.

Section 2, Program Evaluation is a good example of process questions that do not measure outcomes:

*(a)(6) For PEI strategy or program to provide Access and Linkage to Treatment referenced in subdivision (f)(1) of Section 1, the County shall measure:*

- (A) Number of referrals to treatment, kind of treatment to which the person was referred, and duration of untreated mental illness.
  - (i) Duration of untreated mental illness shall be measured by the interval from onset of symptoms of mental illness, based on available medical records or if medical records are not available, on self-report or report of a parent or family member, until initiation of treatment.**
- (B) Number of personal who followed through with 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.*

Such process-focused measures may perversely incentivize certain activities – such as making referrals to treatment – instead of achieving desired mental health outcomes. Measuring process, such as referral tracking and timely access to care, should be embedded within county and provider Quality Assessment processes and can be monitored through audits or an External Quality Review Organization (EQRO).

The regulations seem to assume a one-size-fits-all service model that fails to measure outcomes. Neither counties nor their contractors have the ability to accurately categorize the potential risks and personal history of each individual receiving early intervention services, or the ability to meaningfully measure duration of an untreated illness; and such information is not essential to determining whether an Early Intervention initiative is successful (i.e., achieves desired outcomes). Gathering this level of information about

individuals served may require informed consent agreements with clients similar to those utilized in human subject research. In addition to the substantial increased administrative cost burden such an endeavor would require, such an endeavor would likely result in greater numbers of individuals in need of Early Intervention declining services; that would be a bad outcome.

CMHDA recommends that the evaluation of early intervention programs focus on the achievement of outcomes for a specific population of consumers, such as those experiencing a first break psychotic episode.

- 3. Leverage data collection to measure meaningful mental health outcomes that inform continuous program quality improvement.** Initiatives that do not achieve their originally anticipated outcomes can inform continuous program quality improvement. To do this, however, the regulations must not set up a system that measures unexpected outcomes as failures. Instead, the measurement tools should recognize that originally anticipated outcomes may not result, but that valuable information can be an important bi-product of any sincere effort. To that end, language related to efforts and the items that “the program is expected” to achieve should be amended. Additionally, the measurement and evaluation requirements will need to evolve as programs mature, target populations change, and additional knowledge is gained. The regulations are silent as to this important value. By design, quality assurance and quality improvement evaluation must change to address federal health care requirements, changing system needs and new practice.

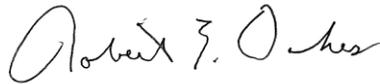
The proposed regulations may impede the ability to respond to changing system needs associated with the Affordable Care Act and other new practice initiatives by codifying overly specific and inflexible state-only requirements. While there are significant evaluation efforts currently underway throughout the state, many of them guided by federal Medicaid and Medicare requirements, they are often not coordinated with state efforts. Many counties have developed their own approaches for local evaluation and quality improvement as a result of federal requirements or local initiatives. 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.

CMHDA strongly supports a coordinated statewide method of measuring the effectiveness of Prevention and Early Intervention programs. Counties continue to invest in data systems to help inform them. However, the proposed regulations do not provide a statewide assessment of Prevention or Early Intervention outcomes. Instead, they focus on program processes, detailed demographic data, and subjective assessments about individuals served – some of which is beyond the current capabilities of counties.

The proposed data collection and reporting regulations are not be feasible for counties and would require significant changes to local and state-level information technology systems, diverting substantial resources away from service delivery to comply with a regulatory scheme that remains void of meaningful outcome measurements. Counties remain willing to work with the MHSOAC to develop outcome measurements that inform the public and policy makers of the utility of Prevention and Early Intervention programs. The proposed regulations do not measure desired outcomes, nor do they provide any meaningful feedback to counties or contractors about what works or where improvements can be made. To the extent that the regulations constitute a state mandate for local government they require Prop 1A review.

CMHDA recognizes the challenges facing the MHSOAC and honors its desire to address the issues confronting mental health service delivery in California. The MHSOAC need not do this challenging work alone. Every county mental health program is working hard to develop outcome measurements. We remain committed to working with the MHSOAC to develop an efficient outcome measurement model that assures taxpayers their funds are being prudently used while also informing counties and contractors about how to continuously improve their programs. We welcome the opportunity to discuss our comments and work collaboratively with the MHSOAC to further strengthen the proposed regulations and ongoing evaluation efforts. CMHDA hopes to continue to work with the MHSOAC, the Department of Health Care Services and other statewide partners to develop a cohesive and efficient statewide approach to evaluation and quality improvement. If you have any additional questions, please do not hesitate to contact me directly at [roakes@cmhda.org](mailto:roakes@cmhda.org) or Molly Brassil at [mbrassil@cmhda.org](mailto:mbrassil@cmhda.org).

Sincerely,



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Cc: Sherri Gauger, Mental Health Services Oversight and Accountability Commission  
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