

Mental Illness Policy Org. Comments and MHSOAC Staff Response: Key Concepts

Presented at November 21, 2013 MHSOAC meeting

Suggestion or Comment	MHSOAC Staff Response	MHSOAC Staff Rationale
PROGRAM REQUIREMENTS		
<p><i>General:</i> Limit all PEI-funded services and programs to individuals with serious mental illness.</p> <p>“The PEI provisions, in every subsection, repeatedly require a diagnosis of at least ‘mental illness’ as a requisite to programmatic services.”</p> <p>“MHSOAC services must be limited to those with serious mental illness, not just those with a mental disorder.”</p> <p>“Prevention and Early Intervention funds may not be used for individuals prior to a diagnosis.”</p> <p>“Prevention and Early Intervention funds may not be used on Universal Prevention Activities. There is a requirement that PEI funds be used effectively and efficiently and targeting groups that are not at risk does not accomplish that.”</p> <p>Example: “5840(b)(3) limits stigma program targeting to those ‘diagnosed with a mental illness or seeking mental health services.’”</p>	<p>Not included</p>	<p>MHSOAC PEI provisions define intended outcomes, not required methods. Draft PEI regulations state that PEI-funded programs that serve individuals must show evidence that they are likely to bring about MHSOAC PEI outcomes for individuals at risk of or with early onset of a potentially serious mental illness, which is defined in W&I Code 5600.3 as “a mental disorder that is severe in degree and persistent in duration and that may cause behavioral disorder or impair functioning so as to interfere substantially with activities of daily living.”</p> <p>Draft regulations differentiate between who receives services and those for whom outcome are intended. In some instances, evidence suggests that best results for individuals at risk of or with a mental disorder occur from providing services to a broader group. In these instances, any benefits that occur to the broader group are an added value, not the purpose.</p>
<p><i>General:</i> Don’t separate prevention from early intervention</p> <p>“The artificial bifurcation of Prevention and Early Intervention Programs into two components (a) prevention and (b) early intervention, as proposed in the draft regulations is contrary to legislation. It complicates, confuses, and will likely end up diverting funds rather than helping to see they are spent appropriately. The legislation is clear that there shall be ‘a’ program designed to prevent mental illnesses from becoming severe and disabling’ ((5840(a)). In addition, 5840 (a), 5840 (b) and 5840 (c) all start by describing ‘The Program’ not multiple programs.”</p> <p>“There is nothing in the legislation that gives MHSOAC the ability to supersede the clear legislative language (ex. in 5840(a)) that counties ‘shall’ have prevention and early intervention programs. Many of the problems with these proposed regs come from the tortured attempt to separate prevention programs from early intervention programs.”</p>	<p>In draft Regulations (new draft)</p>	<p>The “Prevention and Early Intervention” section of the MHSOAC – Part 3.6 – refers to several intended outcomes, all of which, collectively, move mental health from a “fail first” to a “help first” approach that encourages people to seek services; links people to services earlier including, treatment beyond that funded by PEI; and intervenes earlier in the onset of a potential or actual mental illness. Draft PEI regulations include all required MHSOAC PEI outcomes and actions. To avoid confusion based on terminology, the current draft eliminates any reference to “prevention” or “early intervention” programs, except as the overall name for Part 3.6 of the MHSOAC. Draft PEI Regulations describe separately “Programs to Reduce Risk Related to Mental Illness” and “Programs to Intervene Early in the Onset of a Mental Illness” to differentiate the timing of these interventions and to reflect resulting differing approaches to evaluation.</p>
<p><i>General:</i> require or encourage specific program features</p> <p>Example: “Unless otherwise prohibited, prevention and early intervention funds may be used for AB1421 programs and individuals enrolled in those programs in counties that have implemented it.”</p> <p>Example: “The bulk of Prevention and Early Intervention Funds should be spent on children and adults older than 16, since serious mental illness starts in late teens or early twenties and can often be present throughout the rest of</p>	<p>Not included</p>	<p>Consistent with MHSOAC, draft PEI regulations focus on outcomes and the use of effective (previously successful) practices and do not mandate specific programmatic approaches.</p> <p>Examples provided in draft regulations are for clarification, and are likely to be omitted from actual regulations. Encouraging specific practices and approaches is a support (training and technical assistance) activity, not a regulatory activity.</p>

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<p>an individual's life."</p> <p>Example: Laura's Law "has been proven effective at "preventing mental illnesses from becoming severe" and at "reducing the duration of untreated severe mental illness and assisting people in quickly gaining productive lives."</p>		<p>Laura's Law is more applicable for individuals who need ongoing treatment (CSS) than for individuals with early onset or risk of a mental illness, which is the focus of PEI-funded services for individuals.</p>
<p><i>General:</i> PEI-funded programs must address MHSA PEI outcomes.</p> <p>"In 5840(d) and findings and declarations, very specific outcomes are listed (ex. reduced homelessness). Therefore for programs to be evidence based they must (a) serve the target population; and (b) impact the listed outcomes."</p>	<p>Already in draft Regulations (new and previous drafts)</p>	<p>All PEI-funded programs that intend outcomes for specific individuals must address PEI seven negative outcomes as a consequence of untreated mental illness that are applicable to that specific program, including "reduce prolonged suffering," which is defined as risk or symptom reduction. Other PEI-funded programs and strategies must address other specific MHSA PEI outcomes, e.g. increase access to treatment. As discussed above, while the MHSA specifies outcomes, it does not specify methods, only that the program methods be effective and similar to successful programs.</p>
<p><i>Program to Reduce Risk Related to Mental Illness:</i> Require prevention programs.</p> <p>"The legislation specifically says counties "shall establish a program designed to prevent mental illness from becoming severe and disabling." In spite of this clear direction the draft regulations make the prevention program optional."</p>	<p>Not included</p>	<p>The requirement that counties "establish a program to prevent mental illness from becoming severe and disabling" is foundational in the Draft PEI Regulations. There is no MHSA requirement that counties intervene at the point of risk of a mental illness, so draft regulations make it optional but do not require counties to include a Program to Reduce Risk Related to Mental Illness.</p>
<p><i>Program to Reduce Risk Related to Mental Illness:</i> Don't allow PEI funds to be spent to prevent mental illness or to prevent serious mental illness.</p> <p>"Unless otherwise noted, prevention funds may not be spent on 'preventing mental illness' or 'preventing serious mental illness.' 5840(a) defines the program as preventing mental illness from becoming severe and disabling, not preventing mental illness. This is intentional. We do not know how to prevent mental illness. Expending funds to prevent mental illness is contrary to legislation, not evidence-based, and therefore not cost-effective; all of which are required by the legislation."</p>	<p>Not included</p>	<p>One way to prevent mental illness from becoming severe and disabling is to prevent mental illness from developing among individuals with risk factors before the onset of a diagnosed or diagnosable mental illness. There is nothing in the MHSA that precludes this method of preventing mental illness from becoming severe and disabling. There is considerable and increasing evidence that it is possible to prevent a range of serious mental illnesses and/or to prevent the devastating, disabling consequences of mental illness: for example, by providing evidence-based services to individuals with prodromal symptoms of schizophrenia.</p>
<p><i>Program to Reduce Risk Related to Mental Illness:</i> Omit all risk factors except biological.</p> <p>"The issues we have crossed out from the regs may cause poor mental health, but do not cause serious mental illness and are therefore not risk factors. 'Adverse childhood experiences' are almost universal, and do not cause serious mental illness. 'Ongoing stress' is almost universal. 'Poverty' is not a cause of mental illness. 'Family Conflict' is almost universal and does not cause serious mental illness. 'Racism' is not a cause of mental illness. 'Social Inequality' is not a cause of mental illness. The inclusion of these in the list encourages a diversion of funds, rather than the proper expenditure of funds."</p>	<p>Not included</p>	<p>There is ample evidence for a range of risk factors for serious mental illness, including but not limited to biological. A predominant risk factor, which takes a variety of forms, is trauma. Environmental risk factors and biological risk factors interact; they don't exist in isolation. A risk factor does not indicate that a person will definitely develop a serious mental illness, which is among the reasons for inclusion of Programs to Reduce Risk Related to Mental Illness. Even if a mental illness subsequently develops, there is abundant evidence that intervening at the point of risk can have a significant effect on ameliorating the potentially disabling consequences.</p>
<p><i>Program to Intervene Early in the Onset of a Mental Illness:</i> This should be required</p>	<p>Already in draft Regulations</p>	<p>Because of the MHSA PEI requirement to "assist people in quickly regaining productive lives," Draft PEI Regulations require counties to offer a program to</p>

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<p>“The second mandate, specifically referring to individuals with ‘severe’ mental illness who need help ‘regaining productive lives,’ is necessarily about early intervention in, and prevention of relapses.”</p>	<p>(new and previous drafts)</p>	<p>Intervene Early in the Onset of a Mental Illness. While draft regulations don’t mandate specific program features, effective programs to Intervene Early in the Onset of a Mental Illness generally include relapse prevention, draft regulations make explicit that relapse prevention is an allowable activity within a program to Intervene Early in the Onset of a Mental Illness.</p>
<p><i>Program to Intervene Early in the Onset of a Mental Illness:</i> “Add symptom amelioration to definition”</p>	<p>Already in draft Regulations (new and previous drafts)</p>	<p>Counties are required to measure “reduced prolonged suffering,” which is defined operationally as direct mental health recovery outcomes including symptom amelioration for all Programs to Intervene Early in the Onset of a Mental Illness.</p>
<p><i>Program to Intervene Early in the Onset of a Mental Illness:</i> Eliminate 18-month time limit for a Program to Intervene Early in the Onset of a Mental Illness (except for programs to intervene early in a first-onset mental illness or emotional disturbance with psychotic features, which have a four-year time limit).</p> <p>“There is nothing in the legislation that requires funding that works to prevent mental illness from becoming severe and disabling, be withdrawn ever, much less in 18 months or four years. Many services that prevent mental illness from becoming severe and disabling are needed over the consumer’s lifespan. For example, peer support, case management, medication management and other services may be needed long-term to prevent mental illness from becoming severe and disabling.”</p>	<p>Not included</p>	<p>The 18 month limit is intended to differentiate the need for longer-term treatment (beyond early onset) from the need to intervene early using a short-term approach. Individuals who are likely to need services for a longer period should be referred to treatment (including but not limited to CSS), which is a specific requirement of the MHSA PEI section (access and linkage to medically necessary care provided by county mental health programs for children with severe mental illness, as defined in Section 5600.3, and for adults and seniors with severe mental illness, as defined in Section 5600.3, as early in the onset of these conditions as practicable).</p>
<p><i>Outreach for Increasing Recognition of Early Signs of Mental Illness:</i> Limit list of potential responders.</p> <p>“Not everyone is equally likely to come into contact with a person with mental illness. In order for the services to be efficient and effective as required by the legislation, certain groups should be given priority. For example, serious mental illness is most likely to first occur in late teens and early twenties and therefore that suggests targeting High School, Trade School, Military Institutions and college personnel as opposed to kindergarten, pre-school and grade school. Those most likely to develop mental illness are first degree relatives of people with mental illness. That suggests targeting those who work with persons with mental illness so they can determine if relatives might be prone to illness. These facts suggest outreach should not be to the general public as that would not be as efficient a use of funds.”</p>	<p>Not included</p>	<p>Draft regulations require counties to utilize effective methods (methods that have proven to be successful) for all PEI-funded programs, including Outreach for Increasing Recognition of Early Signs and Symptoms of Mental Illness programs. Draft regulations do not dictate specific practices; people in the best position to identify early signs and symptoms will vary across counties. Some of the suggested examples were added.</p> <p>The definition of serious mental illness in regulations is broader than the one that Mental Illness Policy Org. is using, and includes people across the lifespan who are at risk of or who have a serious mental illness or emotional disturbance.</p>
<p><i>Outreach for Increasing Recognition of Early Signs of Mental Illness:</i> Omit language that outreach can include people with early signs of mental illness who can act on their own behalf</p> <p>“The language is superfluous and confuses outreach to gatekeepers with outreach to those who have a mental illness.”</p>	<p>Not included</p>	<p>Based on feedback from individuals with a mental illness, it is essential to include outreach to people with early signs of a mental illness to increase their own recognition and positive response. The MHSA requires the MHSOAC to “ensure that the perspective and participation of diverse community members reflective of California populations and others suffering from severe mental illness and their family members is a significant factor in all of its decisions and recommendations.”</p>

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<p><i>Improving Timely Access to Services for Underserved Populations:</i> "Being a member of an underserved population does not make the individual eligible for MHSA services unless serious mental illness is also present."</p>	<p>Already in draft Regulations (new and previous drafts)</p>	<p>Underserved populations with risk or early onset of a mental illness are eligible for PEI services. The MHSA PEI provision "To Improve Timely Access to Services for Underserved Populations" includes improving access to PEI-funded services and also to treatment beyond early onset.</p>
<p><i>Stigma/Discrimination Reduction Program:</i> "Delete the following from definition of stigma and discrimination reduction: 'and to increase acceptance, dignity, inclusion, and equity for individuals with mental illness, and members of their families.'" "These were not enumerated in the legislation."</p>	<p>Not included</p>	<p>The task of regulations is to interpret, clarify, and implement provisions of legislation. Guided by people with mental illness, as required by the MHSA, we have included in draft PEI regulations positive language associated with the reduction of stigma and discrimination related to mental illness and seeking mental health services. This approach is also consistent with that recommended by the SAMHSA Resource Center to Promote Acceptance, Dignity, and Social Inclusion Associated with Mental Health.</p>
<p><i>Discrimination:</i> "Special attention should be given to reducing stigma against those with psychotic features, as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, criteria for Schizophrenia Spectrum and Other Psychotic Disorders by other mental health clients and mental health programs."</p>	<p>Not included</p>	<p>Goes beyond the MHSA. Designation of priority populations for required MHSA PEI outcomes is a local decision.</p>
<p><i>Discrimination:</i> "Allowable Discrimination activities are defined in 5840(b)(4) separately from anti-stigma activities and therefore should have their own regulations." "Stigma activities are defined 5840 (b)(3) while discrimination activities are described in 5840(b4). Stigma activities must be targeted to people with serious mental illness. Therefore it makes sense to have separate regs for these two separate programs."</p>	<p>Not included</p>	<p>Organization and numbering of draft regulations in document for MHSOAC will change in actual regulations. While it is accurate that the MHSA lists "reduction of discrimination against people with mental illness" separately in 5840(b)(4), it is inaccurate to say that it is defined or described in the MHSA. The task of the PEI regulations is to "interpret, clarify, and implement" terms in legislation. The draft PEI regulations' definition of activities that reduce stigma or discrimination related to mental illness are sufficiently similar that they are included in the same section, and the MHSA language for each is clearly specified.</p>
<p><i>Suicide Prevention Program</i> "should not attempt to reduce all suicide. Suicide Prevention Campaigns should not focus on populations not at risk of suicide due to mental illness." 5840(d)(1) specifically limits suicide campaigns to lowering suicides that "result from untreated mental illness, not lowering all suicides." To suggest campaigns should focus on those not at risk is the exact opposite of what the legislation is attempting to accomplish and would (and has) led to a diversion of funds and waste of funds.</p>	<p>Already in draft Regulations (new and previous drafts)</p>	<p>Draft PEI regulations require that suicide prevention campaigns intend to reduce suicide as a consequence of mental illness. The draft regulations differentiate broad mental illness-related suicide prevention (training, education, coordination, campaigns), in contrast to Programs to Reduce Risk Related to Mental Illness and Programs to Intervene Early in the Onset of a Mental Illness that intend to reduce risk of suicide or suicidal behavior in specific individuals with risk of or early onset of a potentially serious mental illness. Both kinds of efforts are allowed by draft PEI regulations; in all instances, the suicide must be related to mental illness. It is estimated that approximately 90% of people who die by suicide have a mental illness.</p>
<p><i>Family involvement:</i> "Services may be provided to families and others to enable them to provide services and support for the person with serious mental illness. There is nothing in MHSA that suggests these other parties are entitled to services not related to helping someone with mental illness."</p>	<p>Already in draft Regulations (new and previous drafts)</p>	<p>The role of family members in supporting loved ones at risk of or with a potentially serious mental illness is the clear context for all references to family involvement in draft PEI regulations and clarifying language is not needed. The MHSA and existing regulations for all components (MHSA General Standards) require the following: "Family-driven: families of children and youth with serious emotional disturbance have a</p>

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		primary decision-making role in the care of their own children, including the identification of needs, preferences, and strengths, and a shared decision-making role in determining the services and supports that would be most effective and helpful for their children. Family-driven programs/services use the input of families as the main factor for planning, policies, procedures, service delivery, evaluation, and the definition and determination of outcomes." (Title 9, California Code of Regulations, §§3320 and 3200.120)
EVIDENCE OF SUCCESS AND EFFECTIVENESS		
<p>Require evidence-based practices using a specific definition</p> <p>"All programs must be evidenced based... to reduce the duration of untreated serious mental illness or prevent mental illness from becoming severe and disabling. Evidence based means programs supported by scientific peer reviewed independent research, that are effective for people with serious mental illness, and are proven to reduce incarcerations, homelessness, suicide attempts, arrest, violence, and needless hospitalization."</p> <p>"The legislation is quite specific that only interventions that are evidence based are allowed. The fact that there is a 'consensus' around some interventions does not make it evidence based. Evidence based is a function of peer review, not a popularity contest."</p> <p>Example: Suicide Prevention: "There is no evidence that mass media suicide reduction campaigns work. There is some evidence they may increase suicide. Targeting suicide campaigns to the entire population is not an efficient or effective way to reduce suicide due to untreated mental illness, which are the only suicide activities allowed in MHSOAC."</p>	Not Included	<p>The MHSOAC requires PEI programs to be effective and similar to programs that have been proven successful for bringing about stated outcomes. The MHSOAC does not mandate a specific standard of evidence for determining success or effectiveness. At this stage in the evolution of research in the field of prevention and early intervention related to serious mental illness, there are insufficient programs that meet the standard of evidence that Mental Illness Policy Org. suggests. There are numerous well-documented limitations to the required application of the suggested standard for public health programs, including but not limited to impracticality and ethical issues associated with random assignment and numerous issues related to fidelity of application. There are also well-documented issues regarding lack of research and questions of applicability of the suggested standard to communities of color. Most reputable organizations in the field, including the Institute of Medicine, American Psychological Association (APA), SAMHSA, and many others, have adopted broader standards for "evidence-based practice than the definition suggested. APA defines evidence-based practices as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences." For all of these reasons, the expanded range of evidence included in draft PEI regulations is appropriate and necessary.</p>
<p><i>Require evidence of cost-effectiveness for all programs</i></p> <p>"We also suggest that much greater attention be given to Purpose and Intent Section 3, paragraph (e) of MHSOAC legislation which requires 'ensur(ing) that all funds are expended in the most cost effective manner'."</p>	Not included	<p>Draft PEI regulations require counties to use programs that have demonstrated their effectiveness for the intended population, allowing a range of evidence. As California – and the field of prevention and early intervention generally – demonstrate more effective practices and more cost-effective practices, it might be appropriate to add requirements to demonstrate cost-effectiveness. It certainly is appropriate to provide supports to counties to measure the cost-effectiveness of their PEI-funded programs.</p>
EVALUATION		
<p><i>General: Increased and improved use of evaluation data</i></p> <p>"More attention should be paid to 5840(f) which requires the Oversight Commission and regulations 'to reflect what is learned about the most effective prevention and intervention programs.'"</p>	Already in draft Regulations (new and previous drafts)	<p>Staff agrees that it is essential to "reflect what is learned about the most effective prevention and intervention programs," which is one reason that we consider the evaluation components as essential steps toward a comprehensive and integrated performance outcomes and evaluation component for the MHSOAC that includes PEI. There are many uses of evaluation data. One of the most important – reflected in the</p>

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		Commission's logic model – is quality improvement at all levels.
<p><i>General:</i> Require counties to replicate evaluation approaches used to establish research base for evidence-based practices</p> <p>“.. it seems logical and necessary, if counties are modeling on ‘successful’ programs, that they gather data in the same way the earlier program gathered it, so you can draw comparisons between their track record and the successful program they are imitating. Though it would be enormously helpful to give them concrete options, you could also allow them to pick other ‘effective’ and ‘successful’ programs that meet the statutory criteria, in part according to whether the county can follow the earlier data-gathering methodology closely enough to draw meaningful comparisons.”</p>	Not included	It is expected that counties that use evidence-based practices will gather data in the same way as the earlier programs. While this is not an explicit requirement in the Draft Regulations, it is current practice of counties using Evidence-Based Practices and would be a useful focus of training and technical assistance. The California Institute of Mental Health currently provides such assistance to counties regarding their evaluation of a number of evidence-based practices.
<p><i>Programs to Reduce Risk Related to Mental Illness and Programs to Intervene Early in the Onset of a Mental Illness:</i> Focus evaluation requirements on MHSA PEI seven negative outcomes as a consequence of untreated mental illness</p> <p>“While the findings and declarations and 5840(d) specifically mention the purposes of reducing homelessness, incarceration, arrest, suicide and other meaningful outcomes, the draft regs ignore measuring those outcomes and substitute others.”</p> <p>“Primary required measures include reductions in violence, arrest, incarceration, suicide attempts, suicide, homelessness, and needless hospitalization. Others are optional and secondary.”</p>	Already in draft Regulations (new and previous drafts)	Draft regulations require counties to measure direct mental health outcomes (defined as reflecting “reduce prolonged suffering” which is one of the seven MHSA negative outcomes) for all MHSA programs and to measure whichever of the remaining six negative outcomes are applicable to specific programs. Counties are allowed to measure other relevant self-selected outcomes in addition to the seven required by the MHSA PEI section, not as substitutes.
<p><i>Programs to Reduce Risk and Intervene Early:</i> Focus evaluation requirements on MHSA PEI seven negative outcomes as a consequence of untreated mental illness</p> <p>“We are disturbed that clear language of 5840(d) has been ignored and the draft regulations actually encourage expenditures not allowed by the legislation. 5840(d) only allows the expenditure of funds for the listed outcomes if they ‘result from untreated mental illness’. The draft regulations encourage counties to spend the funds reducing the outcomes listed in 5840 (d) (1-7) even when they don’t ‘result from untreated mental illness’. It was never the intent of MHSA to reduce all suicide, incarceration, school drop out, unemployment, prolonged suffering, homelessness, or removal of children from home. The legislation is crystal clear that it is only intended to reduce those outcomes when they result from untreated mental illness.”</p> <p>“Overall, there seems to be a failure by the drafters to understand the difference between cause and effect. The legislation is intended to reduce negative outcomes that are caused by mental illness. The proposed regs seem to suggest the opposite: that it is the negative outcomes (ex. bad grades) that cause the mental illness and therefore</p>	Already in draft Regulations (new and previous drafts)	Draft PEI regulations are explicit that all PEI-funded programs must address MHSA PEI outcomes as a consequence of mental illness, not address general social goals unrelated to risk or onset of mental illness. There is no suggestion that bad grades cause mental illness. There is a clear prohibition from addressing bad grades except as a consequence of untreated mental illness. One reason for the requirement to measure direct mental health outcomes in all instances is to ensure that PEI does not fund programs to address social issues outside of the context of untreated mental illness.

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parts of the regs seem to encourage counties to divert funds to worthy social services under the false construct that they cause mental illness or this is allowable by the legislation. It is the responsibility of MHSOAC to fix this."		
<i>Programs to Reduce Risk and Intervene Early:</i> Don't measure reduced suffering "One last word on the problem of measuring results: it appears obvious that the highly subjective attempt to measure "reduced suffering" which Mr. Jaffee rightly struck at present Section 2(a)(1)(A) won't work, and will waste tremendous amounts of valuable time. With PEI, by definition, you are eliminating symptoms, and/or severe symptoms, before they happen. It is logically impossible to measure suffering that hasn't happened yet. Moreover, even if people with emerging thought and mood disorders would give you straight answers about their suffering—which they absolutely won't—the measures are meaningless because their moods cycle, sometimes rapidly. And you can't possibly create a good control group because you can't deny services. This is intellectual quicksand, and best avoided."	Not included	There is no suggestion in the draft regulations to measure "reduced prolonged suffering" as a subjective experience. Rather, the draft regulations operationally define "reduce prolonged suffering" as reducing symptoms of mental illness for Programs to Intervene Early in the Onset of a Mental Illness, and as reduced risk factors for Programs to Reduce Risk Related to Mental Illness. Draft PEI regulations endeavor to avoid the "intellectual quicksand" of "reduced suffering" by defining the concept operationally in a way to ensure that all PEI-funded programs that intend MHSA PEI outcomes for individuals address and measure risk or onset of potentially serious mental illness.
<i>Programs to Reduce Risk and Intervene Early:</i> "Evaluation designs shall..include the perspective of...those who care for those who experience the 'negative outcomes' listed in 5840(d) which would include police, sheriffs, EMS, shelter workers, mobile crisis services, courts, psychiatric hospitals, emergency rooms and corrections."	Not included	Counties determine the most appropriate design to measure intended MHSA PEI outcomes. Inclusion of various first responders and other service providers listed might, in many instances, be very beneficial and relevant, but would not be required in regulations.
REPORTING		
<i>Report requirements:</i> should differentiate funds spent on individuals with serious mental illness "The state auditor found that there are no procedures in place to ensure funds are spent on the targeted population (those with serious mental illness). The proposed regs should correct that."	Already in draft Regulations (new and previous drafts)	Proposed PEI regulations report number of individuals served and funds spent subdivided by program type, differentiating Programs that Intervene Early in the Onset of a Mental Illness (PEI), Programs to Reduce Risk Related to Mental Illness (PEI), and programs that address other MHSA PEI requirements (for example, Outreach to Increase Recognition of Early Signs of Mental Illness). DHCS regulations for CSS will include requirements to report individuals served who have a serious mental illness beyond early onset. MHSOAC is working with DHCS, in collaboration with partners, to ensure that reporting requirements are integrated. Staff is unable to locate the reference to the auditor's report cited by Mental Illness Policy Org.
REQUIREMENTS IN GENERAL REGULATIONS OR IN CSS (ADULT AND CHILDREN'S SYSTEMS OF CARE)		
<i>Non-supplant requirement.</i> "We are disturbed to see that no provision has been made to ensure that expenditures comply with 5891 (a), the non supplantation provisions."	Not included	This MHSA provision is part of general regulations that apply to all MHSA sections, for which DHCS is responsible. (Title 9, California Code of Regulations, §3410)
<i>Individuals who are incarcerated or on parole:</i> "Funds may be used to pay for people incarcerated in federal prisons, or county jails. Funds may be used for parolees from local jails and federal prisons."	Not included	This provision is part of general regulations that apply to all MHSA sections, for which DHCS is responsible. (Title 9, California Code of Regulations, §3610)
FOCUSED ON PROGRAM REQUIREMENTS RATHER THAN INTENDED OUTCOMES; TRAINING AND TECHNICAL ASSISTANCE		
<i>General:</i> Give counties a list of evidence-based programs from which to select	Not included	Draft regulations require evidence that planned programs are likely to bring about applicable MHSA PEI outcomes for the intended population, but do not limit

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<p>“The best way [to ensure that counties only offer programs that have been proven successful] is to give the counties examples of programs that have already ‘proven effective’ and ‘successful’ in meeting the two separate programmatic mandates in this provision, then giving them the option of demonstrating to you that they have found other programs that have ‘proven effective’ and ‘successful’ if they don’t want to use the options in regulation.”</p>		<p>counties’ choice in what effective programs to choose. Information about effective approaches to meet MHSOAC PEI goals needs to be a key part of support to counties, but is not appropriate for regulations. The MHSOAC requires that decisions about priority needs and populations as the focus for MHSOAC PEI outcomes and the most effective ways to meet those needs be local.</p>
<p><i>General:</i> Support counties to ensure that practices are consistent with the MHSOAC.</p> <p>“The counties will need help getting turned around and actually following the law.”</p>	Not included	<p>Staff agrees that counties will need and deserve support related to these new proposed regulations. Opportunities for counties to support each other and share their useful and important work and accomplishments will also be critical.</p>
MISCELLANEOUS		
<p>“Media reports have documented extensive diversion of PEI funds to such things as hip hop car washes and other unproven uses.”</p> <p>“The new proposed regs should be designed to curb the well documented abuses in the PEI program that were disclosed by the state auditor and our own report: MHSOAC: A 10 year \$10 billion bait and switch.”</p>	N/A	<p>The auditor’s report found no instances of misuse of PEI funds. Reports in the press of the misuse of PEI funds have not been substantiated. Draft PEI regulations take initial steps to address the lack of an integrated MHSOAC evaluation and performance outcomes system that includes PEI by strengthening reporting requirements and initiating evaluation requirements for all PEI programs.</p>
<p>This second mandate [use of effective practices similar to successful programs] has been ignored by regulators and denied funding since the statute’s inception, as has the emphatically repeated requirement to use “successful” and “effective” programs as models.</p>	N/A	<p>Draft PEI regulations require use of effective practices and allow a range of evidence of effectiveness. Also the current PEI Guidelines issued in 2007 state, “PEI projects should include a combination of programs based on a logic model and a high likelihood of effectiveness (evidence-based practices, promising practices, locally proven practices, optimal point of intervention) to achieve PEI outcomes, use a methodology to demonstrate outcomes and advance program improvement and learning.”</p>