

## Draft Proposed Prevention and Early Intervention Regulations

(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.

Unless otherwise noted, prevention funds may not be spent on 'preventing mental illness' or 'preventing serious mental illness'.<sup>1</sup>

Unless otherwise noted, PEI funds may only be spent on people with serious mental illness or people with mental illness (if those later expenditures are to prevent the mental illness from becoming severe and disabling).<sup>2</sup>

Unless otherwise noted, PEI funds may not be spent to reduce suicide, incarceration, school failure or dropout, unemployment, prolonged suffering, or homelessness, among individuals who have not already been diagnosed with mental illness.<sup>3</sup>

(a)(b) The county shall use Prevention and Early Intervention funds only to implement programs consistent with these regulations.

(b)(c) The county shall include in its Prevention and Early Intervention Component:

(1) At least one Early Intervention Program.

(A) "Early Intervention Program" means early intervention services that have demonstrated their effectiveness<sup>4</sup> and provide treatment and other

---

<sup>1</sup> 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.

<sup>2</sup> The findings and declarations, purpose and intent, and 5840(a) and 5840(c) clearly establish MHSA and PEI in particular as intended to help those with mental illness or serious mental illness, not those without. Exceptions are noted.

<sup>3</sup> 5840(d) clearly limits expenditures to reducing these outcomes in people with 'untreated mental illness'. We have found numerous examples of counties using the funds to reduce these outcomes in people who do not have a mental illness. MHSOAC has an obligation to issue regs to insure that practice stops.

<sup>4</sup> Section 2 (e), Findings and Declarations allows funding of only 'effective treatment and support'. Section 2 (f) Findings and Declarations calls for expanding programs that have 'demonstrated their effectiveness.' 5840(c) limits spending to those "similar to those provided under other programs effective in preventing mental illness from becoming severe." 5840(c) also limits spending to those that "have been successful". Media reports and our own investigation found numerous PEI programs that were being funded that had not 'demonstrated their effectiveness' (ex. Hip Hop Carwash). Therefore regs should highlight the need for programs to be effective.

## Draft Proposed Prevention and Early Intervention Regulations

~~interventions to~~ address and promote symptom amelioration<sup>5</sup>, recovery and related functional outcomes for a mental illness<sup>6</sup> 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 early intervention services shall not exceed four years.~~<sup>7</sup>

(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 long as such services are designed to prevent the individual with mental illness from having the mental illness become severe and disabling or to reduce the duration of untreated severe mental illness.

(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~~

---

<sup>5</sup> Not everyone recovers. There is nothing in the legislation that allows the funding to be limited to those who recover. Ameliorating symptoms is an important component of 'preventing mental illness from becoming severe and disabling'.

<sup>6</sup> The legislation is very clear that it is not intended to help those with a "mental health disorder". Using 'mental health' instead of 'severe mental illness' will encourage the diversion of funds to a population voters did not intend to serve. Proposition 63 Findings and Declarations Section 2 (a) differentiated between mental illnesses and serious mental illnesses. "Mental illnesses are extremely common; they affect almost every family in California. They affect people from every background and occur at any age." However, the legislation goes on to establish that it is not intended to help this large population. "In any year, between 5% and 7% of adults have a serious mental illness as do a similar percentage of children — between 5% and 9%. Therefore, more than two million children, adults and seniors in California are affected by a potentially disabling mental illness every year." Rather than being for the mental illnesses that affect every family, MHSA is for this smaller group. Purpose and intent: To "define serious mental illness among children, adults and seniors as a condition deserving priority attention...to reduce the long-term adverse impact on individuals, families and state and local budgets resulting from untreated serious mental illness...To expand...programs have already demonstrated their effectiveness in providing ...medically necessary psychiatric services, and other services, to individuals most severely affected by or at risk of serious mental illness." Therefore MHSA services must be limited to those with serious mental illness.

<sup>7</sup> 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.

## Draft Proposed Prevention and Early Intervention Regulations

mental illness. People who are most likely to be<sup>8</sup> in a position to identify, support, and refer individuals who need mental illness services.

- (i) "Gatekeepers" means doctors, nurses, psychiatric social workers, police, sheriffs, correction officials, EMS, mobile crisis teams, psychologists, homeless services, shelter workers,<sup>9</sup> families, employers,<sup>10</sup> primary health care providers, school personnel, community service providers, community leaders, cultural brokers, people who support Individuals who are homeless, leaders of faith-based organizations, and others most likely to come into contact with people likely to be mentally ill and are<sup>11</sup> 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 thereof.

~~(e)(d)~~ The county may shall<sup>12</sup> include in its Prevention and Early Intervention Component:

- (1) One or more Prevention Programs.

---

<sup>8</sup> The language is superfluous and confuses outreach to gatekeepers with outreach to those who have a mental illness.

<sup>9</sup> 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.

<sup>10</sup> Employers or 'leaders' as a group are no more or less likely than the general public to come into contact with people who need outreach. Expending funds on populations like employers that are less likely than others (say H.S. teachers) to come into contact with people with mental illness is not an efficient use of funds.

<sup>11</sup> Again, the funds should be spent most efficiently, not the least efficiently. This means reaching gatekeepers who are more likely than the general population to come into contact with those who need help.

<sup>12</sup> 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.

## Draft Proposed Prevention and Early Intervention Regulations

- (A) "Prevention Program" means ~~a set of related activities and interventions that have demonstrated their effectiveness at preventing people with mental illnesses from having those illnesses become severe and disabling<sup>13</sup> or at reducing the duration of untreated severe mental illness.<sup>14</sup> Prevention programs should target to bring about mental health<sup>15</sup> and when applicable, associated functional outcomes for individuals and members of groups or populations whose who have a mental illness<sup>16</sup> or whose~~ risk of developing a serious mental illness is significantly higher than average (as defined in (i) below) and, as applicable, their parents, caregivers, and other family members if services to these other populations are narrowly targeted at helping the person with mental illness.<sup>17</sup>
- (i) "Risk factors for mental illness" ~~are primarily, not exclusively, 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 genetic and neurological family history and neurological, behavioral, social/economic, and environmental.~~<sup>18</sup>
- (ii) Examples of risk factors for serious mental illness include having a first degree relative with mental illness or serious mental illness, having a first degree relative who has previously attempted or committed suicide, has previously attempted suicide,<sup>19</sup> ~~but are not limited to, a serious chronic medical condition, adverse childhood~~

<sup>13</sup> Per 5840(a). See also previous discussion on need to be effective and evidence-based to reduce very specific outcomes in a very narrowly targeted population (5-9% of total population per Findings and Declarations Section (2)(a).)

<sup>14</sup> Per 5840 (c).

<sup>15</sup> The language is quite clear that PEI (and all MHSA programs) are for people with serious mental illness, not mere 'mental health' issues. See Purpose and Intent and Findings and Declarations.

<sup>16</sup> 5840 (a) establishes that the program is only for people who have a mental illness and need services to prevent it from becoming severe and disabling. Given the history of this requirement being ignored, it is important that regs specifically note it.

<sup>17</sup> 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.

<sup>18</sup> We would be glad to provide the research showing that the risk factors for developing serious mental illness are largely genetic and biological. There is no behavior known to 'cause' serious mental illness. Being poor, coming from a broken home, getting bad grades etc. are not known to 'cause' serious mental illness. There are people with schizophrenia, bipolar, major depression who come from wealthy homes, poor homes, homes with two parents and no parents.

<sup>19</sup> We would be glad to provide MHSA the research showing that these are the primary risk factors associated with developing serious mental illness.

## Draft Proposed Prevention and Early Intervention Regulations

~~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,<sup>20</sup> having a previous mental illness, a previous suicide attempt, or having a family member with a or having a previous serious mental illness.~~

(a) Prevention services include relapse prevention for individuals in recovery from a serious mental illness.

(2) The county may include in its Prevention and Early Intervention Program a Stigma and/or Discrimination Reduction Program Campaigns<sup>21</sup>

(A) "Stigma ~~and Discrimination~~ Reduction Program Campaign" means a county's direct activities to people either diagnosed with a mental illness or seeking mental health services<sup>22</sup> to reduce negative feelings, attitudes, beliefs, perceptions, stereotypes ~~and/or discrimination<sup>23</sup>~~ related to being diagnosed with a mental illness, having a mental illness, or to either being diagnosed with a mental illness or seeking mental health services ~~and to increase acceptance, dignity, inclusion, and equity for individuals with mental illness, and members of their families.<sup>24</sup>~~

(B) Examples of Stigma and Discrimination Reduction Programs Campaigns include, but are not limited to, campaigns in psychiatric hospitals, wellness centers, community mental health centers, jails, prisons, peer

<sup>20</sup> These issues may cause 'poor mental health', 'bad grades', unemployment, homelessness, etc. they do not cause mental illness or serious mental illness. The findings and declarations, purpose and intent, and specific language in all of MHSA make it clear that program is meant to 'define serious mental illness as a condition deserving priority attention'. 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 a 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. We encourage the drafters to review Findings and Declarations Section 2(a) and draft regs that ensure focus is on the 5-9% defined in the legislation and prevent diversion elsewhere.

<sup>21</sup> Allowable Discrimination activities are defined in 5840(b)(4) separately from anti-stigma activities and therefore should have their own regulations.

<sup>22</sup> 5840(b)(3) limits stigma program targeting to those 'diagnosed with a mental illness or seeking mental health services'. There has been extensive past abuse of this category of spending as counties have spent stigma funds on programs not designed to reach those with mental illness, in need of services, or seeking services. MHSAAC has an obligation to reign in this misspending.

<sup>23</sup> 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.

<sup>24</sup> These were not enumerated in the legislation.

## Draft Proposed Prevention and Early Intervention Regulations

programs, shelters and other locations where people with serious mental illness are likely to be disproportionately represented.<sup>25</sup> It may also include other activities narrowly targeted at “those diagnosed with a mental illness or seeking mental health services” including 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,<sup>26</sup> and efforts to encourage self-acceptance that are targeted to those diagnosed with a mental illness or seeking mental health services.<sup>27</sup>

Stigma campaigns may not be targeted to the general public.<sup>28</sup>

Stigma campaigns must be narrowly tailored to the 5-9% of Californians with serious mental illness, not the ‘1 in 4’ with any mental health problem.<sup>29</sup>

~~(B)~~(C) Discrimination Reduction Campaign means reduction in discrimination against people with serious mental illness.<sup>30</sup> Examples of Discrimination Reduction Campaigns include those targeted to police, sheriffs, psychiatrists, psychologists, hospital workers, psychiatric social workers, providers, those who work with the homeless, probation and parole officers, mental health care workers and peers.<sup>31</sup> 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.

---

<sup>25</sup> 5840(b)(3)) limits anti-stigma spending to those “diagnosed with a mental illness or seeking mental health services”. Therefore, the examples given should be places where people with mental illness or seeking services are disproportionately represented. This also helps ensure the funds are spent efficiently and effectively as required by other sections of the legislation. Failure to include this language will lead to the continued misspending of stigma funds to reach the general public rather than those defined in the legislation.

<sup>26</sup> MHSA stigma campaigns must clearly be limited to mental illness not other so-called stigmas.

<sup>27</sup> Per 5840(b)(3).

<sup>28</sup> Per 5840(b)(3).

<sup>29</sup> Findings and declaration (a) clearly states that it is the intent of the legislation to focus on the 5-9% with serious mental illness. In the past PEI stigma funds have been used to address the “1 in 4” with a mental health issue. This is contrary to legislation. Also see Section 3 (a), Purpose and Intent. “To define serious mental illness ....as a condition deserving priority attention.”

<sup>30</sup> Per 5840(b)(4).

<sup>31</sup> In order to meet the previously discussed requirements that all MHSA funded efforts be efficient and effective, discrimination reduction campaigns should also be targeted at those with a higher than average likelihood of interacting with the 5-9% of the population with serious mental illness. Otherwise most of the efforts will be wasted.

## Draft Proposed Prevention and Early Intervention Regulations

(3) The county may include in its Prevention and Early Intervention Program a Suicide Prevention Program

(A) ~~Suicide Prevention Program means organized activities that a county undertakes to prevent suicide as a consequence of untreated mental illness. This category of programs does efforts specifically designed to prevent suicides that result from untreated mental illness. Suicide Prevention Campaigns should not attempt to reduce all suicide. Suicide Prevention Campaigns should not focus on populations not at risk of suicide due to not focus on or have intended outcomes for specific individuals at risk of or with serious mental illness.~~<sup>32</sup>

(i) Suicide prevention activities that aim to reduce suicidality for specific individuals at risk of or with early onset of a potentially serious mental illness can be a focus of a Prevention program as defined in subdivision (d)(1) or a focus of an Early Intervention Program as defined in subdivision (c)(1).

~~(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.~~<sup>33</sup>

(Renumber) 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. For purposes of Section 5840, enrollment in AB 1421 programs shall not be considered discrimination.

(e) All programs listed in subdivisions (c) and (d) shall include all of the following strategies:

(Renumber) Be evidenced based. Be evidence 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.<sup>34</sup>

<sup>32</sup> 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.

<sup>33</sup> 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 MHSA. We would be glad to share the evidence with you on this.

<sup>34</sup> See Section 2(c), findings and declarations. MHSA is designed to ‘define serious mental illness as a condition deserving priority attention’. So programs must be evidence based to help those with serious mental illness. Further, in 5840(d) and findings and declarations, very specific outcomes are listed (ex.

## Draft Proposed Prevention and Early Intervention Regulations

~~(4)~~(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, and~~ adults and seniors with severe mental ~~illness, illnesses, as~~ defined in Section 5600.3, as early in the onset of these conditions as practicable, to medically necessary care and treatment, including but not limited to mobile crisis intervention services, mental illness clinics, hospitalization, respite care, and care provided by county or state mental health programs. Include processes and procedures to engage individuals with anosognosia and other individuals with serious mental illness who need but refuse treatment.
- (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 thereof.

~~(5)~~(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 with serious mental illness<sup>35</sup> 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<sup>36</sup>~~ receives appropriate services as early in the onset as practicable after diagnosis<sup>37</sup>, through program proven effective at reducing the duration of untreated mental illness and/or prevents mental illness from becoming severe and disabling.<sup>38</sup> ~~features-Features may also include connection to inpatient care when needed, such as~~ accessibility, cultural and language appropriateness, transportation, family focus, hours available, and cost of services.

---

reduced homelessness). Therefore for programs to be evidence based they must (a) serve the target population; and (b) impact the listed outcomes.

<sup>35</sup> All MHSA and PEI programs must be limited to people with serious mental illness. Being a member of an underserved population does not make the individual eligible for MHSA services unless serious mental illness is also present.

<sup>36</sup> MHSA is for serious mental illness, not mental health. It requires the presence of mental illness. There are not yet any known risk factors that can be eliminated that would lead to the prevention of mental illness.

<sup>37</sup> There is no way to predict who will and won't develop serious mental illnesses. While there may be prodromal indications, the research is not developed enough to say they are predictive.

<sup>38</sup> See 5840(a) and 5840 (c).

## Draft Proposed Prevention and Early Intervention Regulations

(B) PEI Programs shall provide services to people with serious mental illness<sup>39</sup> in the most effective and efficient culturally appropriate settings including 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 settings that enhances provide access to quality services and outcomes for underserved populations.

~~(6)~~(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 being diagnosed with a mental illness, having a mental illness or seeking mental health services, and make services accessible, welcoming, and positive both for individuals who have achieved a high level of recovery and those who have not.<sup>40</sup> For purposes of this section, AB-1421 programs, 5150 admissions, inpatient hospitalization are not stigmatizing.<sup>41</sup>

(B) Non-stigmatizing approaches include, but are not limited to, using positive messages and approaches with a focus on system amelioration, recovery, wellness, and resilience; communicating the appropriate use of hospitalization; medications, the ~~including but not limited to~~ use of culturally appropriate language and concepts; efforts to acknowledge and combat multiple social stigmas to the extent they impact on serious mental illness such as those, ~~including but not limited to relating 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; understanding not everyone recovers, inclusion and welcoming of family members; highly symptomatic consumers, and employment of peers in a range of roles if supported by independent evidence.<sup>42</sup>

<sup>39</sup> All MHSA and PEI programs must be limited to people with serious mental illness.

<sup>40</sup> Many people with SMI, do not recover. 90% do not work. Messages that communicate that everyone recovers or can become a productive member of society are stigmatizing to those who as a result of their illness remain highly symptomatic.

<sup>41</sup> MHSA is intended to help the most seriously ill. Some of these may on occasion need hospitalization, guardianship or assisted interventions. It would be a misuse of MHSA funds to encourage stigma or discrimination against these individuals or work to make the services they need less likely to be provided. This is especially true since these types of services were specifically authorized by the legislature.

<sup>42</sup> We refer drafters to “Consumer-providers of care for adult clients of statutory mental health services” by the Cochrane Collaborative, considered one of the highest quality authorities on research. That research, as well as that by others, examines the evidence base for peer support and strongly suggests that MHSOAC and counties are using MHSA funds for peer activities not supported by evidence. Available at <http://www.ncbi.nlm.nih.gov/pubmed/23543537>.

## Draft Proposed Prevention and Early Intervention Regulations

Special attention should be given to reducing stigma and discrimination against people 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 mental health programs.<sup>43</sup> For purposes of this section, communicating the relationship between untreated serious mental illness and violence, use of AB-1421 programs, guardianships, and inpatient hospitalization are non-stigmatizing.

~~(d)~~(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.

~~(e)~~(g) 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 following 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~~people with serious mental illness<sup>44</sup>, including, but not limited to, scientific peer-reviewed research using randomized clinical trials. Evidence-based programs must improve one or more of the outcomes intended to be improved by the legislation, specifically reduction in homelessness, arrest, incarceration, suicide and hospitalization among people with mental illness.<sup>45</sup>

(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.

(h) Changed program: If a county determines a need to make a substantial change to a program or strategy or target population of the program or strategy described in the county's most recent Three-Year Program and Expenditure Plan or annual update that was adopted by the local county board of supervisors as referenced in 5847, the county shall comply with the requirements described in Section 3(c) regarding a Prevention and Early Intervention Program Change.

---

<sup>43</sup> These are defined in the 5840(b)2. Stigma activities, like all others must be designed to help people with serious mental illness. Unfortunately, much of what passes for anti-stigma activities is stigmatizing to those with serious mental illness. It suggests that they can recover, when they don't. Ex. According to Bazelon, 90% of SMi do not work. In spite of this, anti-stigma campaigns often claim everyone can become productive members of society, thereby stigmatizing those who can't.

<sup>44</sup> Programs that help people without serious mental illness, ex a 'mental health issue' are not evidence based to help those MHA and PEI are intended to serve.

<sup>45</sup> See findings and declarations and Purpose and Intent and 5040(a) previously discussed for a list of outcomes MHA and PEI in particular is intended to improve. Programs that do not improve these outcomes or improve softer measures are not evidence based to accomplish the objectives of the legislation.

## Draft Proposed Prevention and Early Intervention Regulations

(Renumber) PEI funds may not be used for public relations; to stigmatize or cause a reduction in services to those with serious mental illness in inpatient units, guardianship, 5150 or AB-1421 programs; communicate falsehoods about serious mental illness; lobbying; or influencing legislation. Funds must serve individuals with serious mental illness, except that funds may be used to prevent those with mental illness from having it become severe and disabling. No funds may be used to prevent serious mental illness without a waiver from MHSOAC as there is currently no evidence that serious mental illness can be prevented.

### 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, and report results every three years as specified in Section 5, and use data from evaluations for quality Improvement.
- (1) For Prevention programs as defined in Section 1(d)(1) and Early Intervention programs as defined in Section 1(c)(1) that serve individuals, including families.
- (A) The County shall measure the reduction of prolonged suffering that may result from untreated mental illness as referenced in Section 5840(d)(5) and report on diagnosis.
- (i) Reduction in prolonged suffering is measured by a reduced risk or severity of mental illness as indicated by reduced ~~risk factors or symptoms~~<sup>46</sup> and direct measures of recovery, improved mental health status, ~~or increased protective factors. Examples~~ Primary required measures 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.~~<sup>47</sup> reductions in violence, arrest, incarceration, suicide attempts, suicide, homelessness, and needless hospitalization.<sup>48</sup>
- (B) The county may select, define, and measure additional indicators that are logically related to the reduction of any of the other MHSA negative outcomes referenced in Section 5840(d) and Findings and Declarations, Section 2 paragraphs (c) and (d) that may result from among people with untreated mental illness.

---

<sup>46</sup> The risk factors associated with serious mental illness are biological and genetic and we do not know how to reduce.

<sup>47</sup> These are not described anywhere in the legislation. The regulations should see that the intent of the legislation (reduced homelessness, suicide, incarceration, hospitalization) are achieved and not substitute the legislative intent with other measures.

<sup>48</sup> These are defined as the important measures in Section 2, findings and declarations, paragraphs (c) and (d) and 5840(d).

## Draft Proposed Prevention and Early Intervention Regulations

- (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 ideations~~ suicide 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) among people with mental illness.
  - (C) The county must report statistical information on the diagnosis of individuals served and the processes used to ensure that MHSA PEI funds are restricted to people diagnosed with mental illness and serious mental illness. The county must report steps to monitor and ensure programs are serving only eligible populations.<sup>49</sup> The county must report on steps taken to monitor and ensure MHSA funds are not supplanting other funds and are being used to expand existing systems of care.
- (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 type of setting.
    - (i) Examples of settings include, but are not limited to, jails, police departments, sheriff departments, hospitals, mental health centers, homeless services, inpatient units, libraries, public transit facilities.<sup>50</sup> family resource centers, senior centers, schools, cultural organizations, churches, faith-based organizations, primary health care, ~~recreation centers,~~<sup>51</sup> residences, shelters, and clinics.
- (3) For Stigma ~~and Discrimination~~ Reduction Program Campaigns referenced In subdivision (d)(2) of Section 1, the County shall measure:

<sup>49</sup> The auditor found there was no assurance that funds were reaching intended recipients. MHSOAC regulations should ensure that funds are reaching those defined in PEI section which is individuals with serious mental illness and individuals with mental illness who need services to prevent the illness from becoming severe and disabling.

<sup>50</sup> In order for programs to meet MHSA requirements to be effective and efficient they must target gatekeepers most likely to come into contact with people with serious mental illness.

<sup>51</sup> Recreation centers are not more likely than other settings to see people with serious mental illness. An argument can be made that people with serious mental illness are less likely than the general population to use recreation centers.

## Draft Proposed Prevention and Early Intervention Regulations

- (A) Changes in attitudes, knowledge, and behavior related to mental illness among people with mental illness or who are seeking services for mental illness: for example, more accurate information about mental illness, symptom amelioration, prognosis and recovery, increased awareness of the effectiveness of prevention and medication and other treatments for mental illness, increased comfort and openness to interacting with other 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 ensure that the campaigns were targeted at people with mental illness or seeking mental illness treatment and not the general public.<sup>52</sup> Counties shall measure:
- (A) ~~Changes in knowledge about suicide, for example about relationship to untreated mental illness, 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. Suicide rates and attempted suicide rates.~~<sup>53</sup>
- (B) Changes in behavior, for example, decreased suicidal attempts, increased identification of individuals with mental illness at risk of suicide, increased successful referrals and support, increased positive self-care and help-seeking by individuals who are feeling suicidal.

For Discrimination Reduction Campaigns referenced in 5840(b)(4) counties may measure understanding of serious mental illness, the difference between serious mental illness and improving mental health and an understanding of the types of services needed to improve

<sup>52</sup> 5840(b)(3) limits stigma activities to those "diagnosed with a mental illness or seeking mental health treatment".

<sup>53</sup> 5840(d)(1) limits suicide reduction activity to reducing suicide among those with untreated mental illness. The best measure is a reduction of suicide or suicide attempts. The other measures proposed are needlessly divorced from and ineffective ways to measure reduced suicide and suicide attempts. The other measures are likely to lead to a diversion of funds as counties try to improve those measures, even as suicide and suicide attempts rise.

## Draft Proposed Prevention and Early Intervention Regulations

outcomes for people with serious mental illness including adequate inpatient facilities, mobile crisis intervention teams, CIT teams, Mental Health Courts, respite centers, medications, and other services that help people with serious mental illness.

- (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 by diagnosis, kind of treatment to which person was referred, and duration of untreated mental illness
    - (i) Duration of untreated mental illness means the interval from onset of symptoms of mental illness, based on available medical records or when not available<sup>54</sup> on self-report or report of a parent or family member, 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
- (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) Diagnoses. Number of referrals of persons with mental illness or serious mental illness ~~members of underserved groups to various kinds of care~~ (prevention program, early intervention program, and/or treatment) by diagnosis including the kind of care, duration of untreated mental illness.
    - (i) Duration of untreated mental illness means the interval from onset of risk indicators or symptoms of serious mental illness, based on available medical records, professional records or on self-report or report of a family member, 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.

---

<sup>54</sup> Self-reports are notoriously unreliable. This is especially true for those with anosognosia. Self-reports should only be used when documentation is unavailable.

## Draft Proposed Prevention and Early Intervention Regulations

- (b) Evaluation designs shall be culturally appropriate and shall include the perspective of (a) diverse people with ~~lived experience of~~ mental illness, ~~including (b)~~ their family members (c) 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. For example, an assessment of increased integration of systems should reflect the extent to which individuals and families, criminal justice, homeless programs, EMS and courts perceive an integrated service experience. Intended outcomes should be meaningful and relevant to participants. Evaluations should corroborate self-reported findings.<sup>55</sup>
- (c) In addition to the required evaluations listed in this section, a county ~~may~~ shall 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 jails, prisons, criminal justice, sheriff’s departments, police departments, EMS, corrections, psychiatric hospital and units, mobile crisis units, homeless shelters<sup>56</sup>, education, physical health care, justice, social services, homeless shelters, and community supports specific to age, racial, ethnic, and cultural groups. ~~Primary E~~examples of system outcomes include, but are not limited to, reduced homelessness<sup>57</sup>, arrest, incarceration, hospitalization and homelessness. Secondary outcomes include increased provision of mental health services to people with serious mental illness by ethnic and cultural community organizations, hours of operation, integration of services including co-location, involvement of ~~clients~~ persons with mental illness and families in key decisions, identification and response to co-occurring substance-use disorders, staff knowledge and application of recovery and symptom amelioration principles, collaboration with diverse community partners, or funds leveraged.

County plans must document the diagnoses of the persons being served, proof that programs are evidenced based to help the target population: those who have serious mental illness (vs. a ‘mental health disorder’); documentation that the program cause progress by actually reducing homelessness, suicide, incarceration, hospitalization, arrest or other issues defined in the legislation’s purpose and intent or findings and declarations. Plans must document steps taken to ensure that ineligible individuals are not recipients of MHSA funding and that MHSA funds are used to expand existing systems of care and are not supplanting other funds.

### **Section 3. Prevention and Early Intervention Program Plan**

---

<sup>55</sup> How the system looks to those in the mental health system is often radically different from how it looks to courts, corrections, police, sheriffs, EMS, shelters, etc. Those in the mental health system see those who have not been offloaded to prisons, jails and shelters. Since the legislation is designed to reduce incarceration, homelessness, arrest, and suicide, it is important that those who are called when those outcomes occur be involved in the evaluation to provide their perspective.

<sup>56</sup> Again: the purpose of MHSA is to reduce these outcomes, therefore evaluation of success or failure can only be achieved by involving those who are called to address the legislatively defined outcomes.

<sup>57</sup> MHSOAC must ensure that counties measure the outcomes of MHSA investment in terms of reduced hospitalization, suicide, arrest, incarceration, and homelessness as primary measures. Other secondary, softer process measures may be monitored, but in no way should process measures substitute for progress measures.

## Draft Proposed Prevention and Early Intervention Regulations

- (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 and the process for evaluating stakeholder input and rejecting input that diverts funds from helping to improve important outcomes in people with serious mental illness.
  - (2) A description of the county's plan to involve community stakeholders, including police, sheriffs, hospital administrators, courts, corrections, and EMS meaningfully in all phases of the MHSA Prevention and Early Intervention component, 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 MHSA General Standards set forth in Title 9 CCR section 3320 and the requirement to limit services and programs to those with mental illness or serious mental illness.
  - (4) For each 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, primary mental illness diagnosis,<sup>58</sup> and if relevant, primary language spoken, military status, and LGBTQ identification.
      - (ii) Specify the mental illness or illnesses for which there is early onset and the mental illness whose duration is being reduced.
      - (iii) Specify Affirmation that each person has a mental illness, the primary diagnosis, and specify how each participant's early onset of a potentially serious mental illness will be determined.
    - (B) 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 related functional outcomes for individuals with early onset of potentially serious mental illness.
    - (C) Specify any MHSA negative outcomes as a consequence of untreated mental illness referenced in Section 5840(d) that the program is expected

---

<sup>58</sup> Serving people with serious mental illness is at the core of MHSA. Any evaluation that does not ensure those receiving services are part of the targeted population, are by definition, useless.

## Draft Proposed Prevention and Early Intervention Regulations

to affect, including the reduction of prolonged suffering as a consequence of untreated 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 in persons with mental illness or serious mental illness.
  - (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.
- (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 the combination of standards~~ the criteria specified in subdivision (g) of Section 1 as follows:
- (i) For 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) For community and/or practice-based standard, describe the evidence that the approach is likely to bring about MHSA outcomes for the intended population.<sup>59</sup>~~
- (E) For the reduction of any addition MHSA negative outcome as a consequence of untreated mental illness 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 the combination of standards~~ criteria specified in subdivision (g) of Section 1 as follows:
- (i) For evidence-based standard, provide a brief description of or reference to the peer-reviewed, independent 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.

---

<sup>59</sup> See previous discussion on evidence based programs. Programs are evidence based if proven in scientifically rigorous studies to improve major outcomes in people with serious mental illness. "Consensus" does not trump the need for evidence.

## Draft Proposed Prevention and Early Intervention Regulations

~~(ii) For community and/or practice-based standard, describe the evidence that the approach is likely to bring about MHSA outcomes for the intended population.~~

- (5) For each 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 by diagnosis.
    - (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.
  - (B) 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.
  - (C) Specify reduction of MHSA negative outcomes as a consequence of untreated mental illness as 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 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.
  - (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 the combination of standards criteria~~ specified in subdivision (g) of Section 1 as follows:
    - (i) For evidence-based standard, provide a brief description of or reference to the relevant peer reviewed, independent evidence applicable to the specific intended outcome, explain how the

## Draft Proposed Prevention and Early Intervention Regulations

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) For 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 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 why they have a greater than average exposure opportunity to identify diverse to individuals with mental illness who are likely to develop early signs and symptoms of potentially serious mental illness.
  - (B) Specify the methods to be used to engage gatekeepers and 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 evidence-based standards or a the combination of standards specified in Section 1(g) as follows:~~
    - (i) For 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 proven and explain how the county will ensure fidelity to the evidence-based evidence based practice in implementing the program.
    - ~~(ii) For 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.
- (7) For each Stigma ~~and Discrimination~~-Reduction Program, the county shall include a description of the program including but not limited to:
- (A) Identify whom the campaign intends to influence and the evidence that the group is at higher than average risk of having a serious mental illness.
  - (B) Specify the methods and activities to be used to change-improve attitudes, knowledge, and/or behavior regarding being diagnosed with

## Draft Proposed Prevention and Early Intervention Regulations

- mental illness, having mental illness and increase the likelihood of seeking mental health services for mental illness, consistent with requirements in Section 2(a)(3)(A) and (B), including timeframes for measurement.
- (C) Specify how the proposed method is cost-effective and likely to bring about the selected outcomes using one of the two standards or a the combination of evidence-based standards specified in Section 1(g) as follows:
- (i) For 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 evidence based practice in implementing the campaign.
- ~~(ii) — For community and or practice-based standard, describe the evidence that the approach is likely to bring about MHSA outcomes.~~
- (8) For each Suicide Prevention Program, the county shall include a description of the program including but not limited:
- (A) Specify the methods and activities to be used to change attitudes and behavior to prevent mental illness-related suicide.
- (B) Indicate how the county will measure changes in attitude, knowledge, and behavior related to reducing suicide as a consequence of untreated reduced suicide and suicide attempts due to mental illness, consistent with requirements in Section 2(a)(4)(A) and (B), including timeframes for measurement.
- (C) Specify how the proposed method is likely to bring about selected outcomes using one of the two standards or a the combination of standards criteria specified in Section 1(g) as follows:
- (i) For 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) — For community and or practice-based standard, describe the evidence that the approach is likely to bring about MHSA outcomes.~~
- (9) For all programs referenced in subdivisions (4) through (8) above, 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).

## Draft Proposed Prevention and Early Intervention Regulations

- (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 and the steps taken to ensure the referral is completed.
  - (D) Indicate if the county intends to measure outcomes other than ~~those required in Section 2 (a)(5)(A),~~ reduced homelessness, suicide, incarceration, arrest, and hospitalization among people with serious mental illness.
- (10) For all programs referenced in subdivisions (4) through (8) above, indicate how the program will use strategies to Increase Access to Services for Underserved Populations with serious mental illness or a mental illness that is likely to become severe and disabling, as required in Section 1(e).
- (A) For each program, the county shall indicate the intended setting(s) and why the setting enhances access for specific, designated underserved populations with serious mental illness or a mental illness that is likely to become severe and disabling. If the county intends to locate the program in a non-mental health setting, explain why this choice enhances access to quality services and outcomes for the specific underserved population and what steps are being taken to ensure the funds are only used for those with serious mental illness or a mental illness that is likely to become severe and disabling.
  - ~~(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 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 in persons with serious mental illness.
- (12) For all programs for the following fiscal year, the county shall include the following information
- (A) Estimated number of children, adults, and seniors to be served in each Prevention and each Early Intervention program that provides direct service to individuals, by diagnosis.
  - (B) The county may also include estimates of the number of individuals with serious mental illness or mental illness that will likely become severe and

## Draft Proposed Prevention and Early Intervention Regulations

disabling 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.
- (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.
- (c) Prevention and Early Intervention Program Change Report: If a county determines a need to make a substantial change to a program, strategy, or target population 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 originally adopted 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 the numbers served and the number with serious mental illness by diagnosis. For those without serious mental illness, indicate the serious mental illness that is being prevented:

## Draft Proposed Prevention and Early Intervention Regulations

- (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 and the diagnosis of the family member that made the family eligible for MHSA funded support.
- (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 successfully referred to treatment, kind of treatment to which individual 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 individual received services in the program to which the individual was referred.
- (4) Increase Timely Access to Services for Underserved Populations Strategy:
  - (A) Identify the specific underserved populations for whom county intends to increase timely access to services by diagnosis.
  - (B) Number of successful 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 individual received services in the program to which the individual 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.

## Draft Proposed Prevention and Early Intervention Regulations

- (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 and diagnosis by the following categories as follows:
    - (i) American Indian or Alaska Native
    - (ii) Asian
    - (iii) Native Hawaiian or other Pacific Islander
    - (iv) Black or African American
    - (v) White
  - (C) Ethnicity as follows:
    - (i) Hispanic or Latino
    - (ii) Non-Hispanic or Latino
  - (D) Primary language spoken listed by threshold languages
  - (E) Sexual orientation, if known,
  - (F) Disability, if any,
  - (G) Veteran status,
  - (H) Gender identity
  - (I) Any other data the County considers relevant
- (6) For Stigma and/or Discrimination Reduction Programs Campaigns and Suicide Prevention Programs Campaigns, counties shall report number of suicides and suicide attempts. Counties may report available numbers of individuals with serious mental illness reached, including demographic and diagnostic breakdowns. An example would be the number of individuals with mental illness who received training and education or who clicked on a web site.
- (7) For all programs and strategies, counties may report implementation challenges, successful and unsuccessful 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

## Draft Proposed Prevention and Early Intervention Regulations

questions about the impacts of PEI programs on individuals with ~~risk or early onset~~ mental illness or of serious mental illness and on the mental health and related jail, homeless, corrections, criminal justice and hospital 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.

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

- (a) The county shall report as part of the MHSA 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: MHSA 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: MHSA 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: MHSA 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.