

PEI Regulations: Matrix (September 20, 2013 Workgroup Meeting)

Term Requiring Interpretation/ Specification or Implementation	MHSA Statute and Suggested Regulation Concepts Presented at August Workgroup Meeting And Workgroup Feedback with Staff Response
1. Serious mental illness	<p>MHSA Statute Section 3(a): The people of the State of California hereby declare their purpose and intent in enacting this act to be as follows: To define serious mental illness among children, adults and seniors as a condition deserving priority attention, including prevention and early intervention services...</p> <p>Staff Suggestions Presented at August Workgroup Meeting (Concepts not exact words for regulations) Serious Mental Illness¹: 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>Rationale</p> <ul style="list-style-type: none"> • This definition is consistent with W&I Code 5600.3 <p>Workgroup Feedback – None</p>
2. Prevention services	<p>MHSA Statute Section 3(a): The people of the State of California hereby declare their purpose and intent in enacting this act to be as follows: To define serious mental illness among children, adults and seniors as a condition deserving priority attention, including prevention and early intervention services...</p> <p>5840(c): The program shall include mental health services similar to those provided under other programs effective in preventing mental health illnesses from becoming severe</p> <p>Section 3(c): The people of the State of California hereby declare their purpose and intent in enacting this act to be as follows: To expand the kinds of successful, innovative service programs for children, adults and seniors begun in California, including culturally and linguistically competent approaches for underserved populations. These programs have already demonstrated their effectiveness in providing outreach and integrated services, including medically necessary psychiatric services, and other services, to individuals most severely affected by or at risk of serious mental illness.</p> <p>Staff Suggestions Presented at August Workgroup Meeting (Concepts not exact words for regulations) Prevention Services: programs and interventions intended to bring about mental health and related functional outcomes for individuals and members of groups or populations whose risk of developing a serious mental illness is significantly higher than average, and as applicable, their families</p> <p>At risk of serious mental illness: individuals with identified risk factors or members of a group with demonstrated</p>

¹ There are varying definitions in the field of mental health of “serious mental illness.”

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2. Prevention services (Continued)	<p>greater than average vulnerability to mental illness.</p> <p>Because there must be the intended outcome of reducing risk of serious mental illness, MHSA-funded Prevention Services do not include services for the purpose of enhancing general or community wellness.</p> <p><u>Outcomes:</u> Counties measure and report on self-selected indicators that relate to one or more of the MHSA seven negative outcomes. See #11 below.</p> <p>[Note: Examples of “functional outcomes” are reduction in incarcerations, school failure or drop out, homelessness etc. as a consequence of untreated mental illness. See #11 below.]</p> <p>Rationale</p> <ul style="list-style-type: none"> • This definition is consistent with SAMHSA definition of prevention in mental health² • Prevention services are appropriately directed to reduce the likelihood of serious mental illness and its negative consequences for individuals and communities at elevated risk. See below for specific examples of elevated risk. • This is consistent with SAMHSA definition of a risk factor for serious mental illness:” a characteristic at the biological, psychological, family, community, or cultural level that precedes and is associated with a higher likelihood of problem outcomes” [from mental illness and substance abuse].³ • Examples of risk factors for serious mental illness: include a serious chronic medical condition, experience of severe trauma, ongoing stress, exposure to drugs or toxins including in the womb, prolonged isolation, or having a previous mental illness.⁴ <p>Workgroup Feedback – None</p>
3. Early intervention services	<p>MHSA Statute</p> <p>Section 3(a): The people of the State of California hereby declare their purpose and intent in enacting this act to be as follows: To define serious mental illness among children, adults and seniors as a condition deserving priority attention, including prevention and early intervention services...</p>

² “Creating communities where individuals, families, schools, faith-based organizations, and workplaces take action to promote emotional health and reduce the likelihood of mental illness, substance abuse including tobacco, and suicide.” Substance Abuse and Mental Health Services Administration, *Leading Change: A Plan for SAMHSA’s Roles and Actions 2011-2014*. HHS Publication No. (SMA) 11-4629. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2011. P. 3.

³ SAMHSA (2013). *Levels of risk, levels of intervention: What are risk and protective factors?* Substance Abuse and Mental Health Services Administration, Training and Technical Assistance. Available at <http://captus.samhsa.gov/prevention-practice/prevention-and-behavioral-health/levels-risk-levels-intervention/1>.

⁴ Mayo Clinic (2012), Risk Factors: Mental Illness, Available at <http://www.mayoclinic.com/health/mental-illness/DS01104/DSECTION=risk-factors>.

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<p>3. Early intervention services (Continued))</p>	<p>5840(c): The program shall include mental health services similar to those provided under other programs effective in preventing mental health illnesses from becoming severe, and shall also include components similar to programs that have been successful in reducing the duration of untreated severe mental illnesses and assisting people in quickly regaining productive lives.</p> <p>Staff Suggestions Presented at August Workgroup Meeting (Concepts not exact words for regulations) Early Intervention Services: Treatment and other interventions intended to address a mental health disorder early in its emergence. Early Intervention services do not exceed one year, unless the individual receiving the service is identified as experiencing first onset of serious mental illness with psychotic features, as defined in the Diagnostic and Statistical Manual of Mental Disorders criteria for a psychotic disorder, in which case, an Early Intervention does not exceed five years.</p> <p><u>Outcomes:</u> Counties define, measure, and report outcomes of their Early Intervention Programs, including improved functionality as a consequence of recovery from mental illness. Counties report on self-selected indicators that relate to one or more of the MHSA seven negative outcomes. See #11, Negative Outcomes, below.</p> <p>Rationale</p> <ul style="list-style-type: none"> • This definition differentiates early intervention services from treatment for ongoing serious mental illness within the adult or children’s systems of care (CSS). <p>Workgroup Feedback</p> <table border="0" data-bbox="478 889 1976 1365"> <tr> <td data-bbox="478 889 1213 1365"> <p><u>Suggestion</u></p> <p>Add qualifier to the one year requirement. For example, “Early Intervention services do not <i>generally</i> exceed one year...”</p> <p>Take out the five-year clause.</p> <p>Include aging adults.</p> </td> <td data-bbox="1234 889 1976 1365"> <p><u>MHSOAC Staff Response</u></p> <p>It is difficult to add qualifiers to the regulations. Changed to the one year to 18 months. (See draft Section 1(c).)</p> <p>Changed to not exceed 4 years. There are instances where it does not make sense to remove an individual from a PEI program after 18 months because of continuity. A maximum time-limit is necessary to ensure individuals aren’t kept in a PEI program indefinitely. (See draft Section 1(c).)</p> <p>Individuals of all ages are included. The “aging adults” aspect is not applicable to regulations, but could be a TA focus.</p> </td> </tr> </table>	<p><u>Suggestion</u></p> <p>Add qualifier to the one year requirement. For example, “Early Intervention services do not <i>generally</i> exceed one year...”</p> <p>Take out the five-year clause.</p> <p>Include aging adults.</p>	<p><u>MHSOAC Staff Response</u></p> <p>It is difficult to add qualifiers to the regulations. Changed to the one year to 18 months. (See draft Section 1(c).)</p> <p>Changed to not exceed 4 years. There are instances where it does not make sense to remove an individual from a PEI program after 18 months because of continuity. A maximum time-limit is necessary to ensure individuals aren’t kept in a PEI program indefinitely. (See draft Section 1(c).)</p> <p>Individuals of all ages are included. The “aging adults” aspect is not applicable to regulations, but could be a TA focus.</p>
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4. Prevent mental illness from becoming severe	<p>MHSA Statute 5840(a): The State Department of Health Care Services, in coordination with counties, shall establish a program designed to prevent mental illnesses from becoming severe and disabling.</p> <p>Staff Suggestions Presented at August Workgroup Meeting (Concepts not exact words for regulations) Severe: Same definition as “serious” which is already defined. See #1: Serious Mental Illness</p> <p><u>Measure</u>: For Prevention and Early Intervention Services (serving individual clients), counties will measure prevention and reduction of severity by reduced risk (prevention) and signs and symptoms (early intervention) of serious mental illness and increased recovery, wellness, and resilience for individuals with risk or early onset of serious mental illness. See #12, Negative Outcomes and #13, Performance Outcomes.</p> <p>Rationale</p> <ul style="list-style-type: none"> • Consistent with W&I Code 5600.3 • Consistent with outcomes-based approach • [Definition of early intervention is similar to standard used in PEI Guidelines] <p>Workgroup Feedback – None</p>				
5.Prevent mental illness from becoming disabling	<p>MHSA Statute 5840(a): The State Department of Health Care Services, in coordination with counties, shall establish a program designed to prevent mental illnesses from becoming severe and disabling.</p> <p>Staff Suggestions Presented at August Workgroup Meeting (Concepts not exact words for regulations) Disabling: impair functioning so as to interfere substantially with activities of daily living</p> <p><u>Measure</u>: Counties will measure prevention or reduction of disability as a consequence of serious mental illness using indicators consistent with MHSA negative outcomes. See #12, Negative Outcomes and #13, Performance Outcomes.</p> <p>Rationale</p> <ul style="list-style-type: none"> • Definition is consistent with W&I Code 5600.3. • Consistent with outcomes-based approach. <p>Workgroup Feedback</p> <table border="0" data-bbox="478 1328 1959 1445"> <tr> <td data-bbox="478 1328 1060 1364"><u>Suggestion</u></td> <td data-bbox="1157 1328 1497 1364"><u>MHSOAC Staff Response</u></td> </tr> <tr> <td data-bbox="478 1377 1060 1412">Make “severe” and “disabling” one definition.</td> <td data-bbox="1157 1377 1959 1445">The regs do not define these terms because they are covered by the current legal definition of serious mental illness.</td> </tr> </table>	<u>Suggestion</u>	<u>MHSOAC Staff Response</u>	Make “severe” and “disabling” one definition.	The regs do not define these terms because they are covered by the current legal definition of serious mental illness.
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6. Effective practices	<p>MHSA Statute 5840(c): PEI programs shall include mental health services similar to those provided under other programs effective in preventing mental illnesses from becoming severe.</p> <hr/> <p>Staff Suggestions Presented at August Workgroup Meeting (Concepts not exact words for regulations) Effective Practices: Requirement for use of effective practices applies to all PEI programs and to required strategies for all programs. Counties must have evidence that the practice is likely to bring about mental health or related functional outcomes, successful outreach to and engagement of potential responders, successful links to treatment for individuals with serious mental illness, and/or reduction of mental health-related stigma/discrimination.</p> <p><u>Evidence of effectiveness</u>: Evidence can range from: (1) evidence-based practice, which includes randomized controlled clinical trials (the research gold standard) or clinically relevant, methodologically sound research with a less thoroughly documented base of evidence; or (2) community and practice-based evidence which includes clinical and client/family expertise and community consensus that the practice achieves mental health outcomes, especially for underserved communities, and is consistent with client and, as applicable, parent preferences. This also includes a process to develop specific criteria by which effectiveness can be documented with the capacity eventually to give the approach equal standing with evidence-based practices validated by research. Measurement of outcomes will confirm or disconfirm the effectiveness of the practice.</p> <p>Rationale</p> <ul style="list-style-type: none"> • MHSA requires use of effective practices. Per Uncodified Section 3(c) one of the purposes of the MHSA is to expand the kinds of successful, innovative service programs for children, adults and seniors including culturally and linguistically competent approaches for underserved populations. • Cultural competency requires range of acceptable evidence. Client- and family-focused general standards require practices that are acceptable to clients and, as applicable, to parents and other family members. • [Evidence of effectiveness is similar to standard used in PEI Guidelines] <p>Workgroup Feedback</p> <table border="0" data-bbox="462 1185 1995 1437"> <thead> <tr> <th data-bbox="462 1185 1155 1226"><u>Suggestion</u></th> <th data-bbox="1155 1185 1995 1226"><u>MHSOAC Staff Response</u></th> </tr> </thead> <tbody> <tr> <td data-bbox="462 1234 1155 1282">Call out cultural issues, cultural congruency.</td> <td data-bbox="1155 1234 1995 1347">“For the intended population” was added to both definitions. This will have a big impact on the use of evidence-based practices. (See draft Section 1(g).)</td> </tr> <tr> <td data-bbox="462 1364 1155 1437">Clarify counties will not require or prioritize evidence-based practices.</td> <td data-bbox="1155 1364 1995 1437">Did not add this prohibition. State-level is to allow a range of evidence and to require that evidence applies to the intended</td> </tr> </tbody> </table>	<u>Suggestion</u>	<u>MHSOAC Staff Response</u>	Call out cultural issues, cultural congruency.	“For the intended population” was added to both definitions. This will have a big impact on the use of evidence-based practices. (See draft Section 1(g).)	Clarify counties will not require or prioritize evidence-based practices.	Did not add this prohibition. State-level is to allow a range of evidence and to require that evidence applies to the intended
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6. Effective practices (Continued)	Include range or combination when talking about evidence of effectiveness.	people to be served. Local-level (stakeholder input) is to decide what evidence to require. "Or a combination" was added to address this point. (See draft Section 1(g).)						
7. Improving timely access to services for underserved populations	<p>MHSA Statute 5840(a): ...The program shall emphasize improving timely access to services for underserved populations.</p> <p>Staff Suggestions Presented at August Workgroup Meeting (Concepts not exact words for regulations) Improving Timely Access to Services for Underserved Populations: "Underserved population" is defined in Regulations. (9 CCR 3200.300) "Access" means the extent to which an individual who needs mental health services is able to receive them, based on conditions such as availability, cultural and language appropriateness, transportation needs, and cost of services. PEI programs serve individuals and populations in non-traditional mental health settings such as primary healthcare clinics, schools, and family resource centers; unless a traditional mental health setting enhances access to quality services and outcomes for underserved populations. <u>Outcomes:</u> Counties report number of individuals served by age group, gender, race/ethnicity/culture and language spoken. These will be flexible enough to account for individual county demographics. Counties measure and report data related to access to services for underserved populations, compared to populations that are not currently underserved using a few common indicators. See #12 Performance Outcomes.</p> <p>Rationale</p> <ul style="list-style-type: none"> • Definition of "access" is similar to SAMHA definition and consistent with Prevention and Early Intervention Glossary of Acronyms, Terms, and definition included in PEI Guidelines. • Consistent with outcomes-based approach. <p>Workgroup Feedback</p> <table border="0" data-bbox="453 1185 2003 1458"> <thead> <tr> <th data-bbox="453 1185 1163 1234"><u>Suggestion</u></th> <th data-bbox="1163 1185 2003 1234"><u>MHSOAC Staff Response</u></th> </tr> </thead> <tbody> <tr> <td data-bbox="453 1234 1163 1347">Flip order of access to start with traditional first.</td> <td data-bbox="1163 1234 2003 1347">Definition changed to address this concern; word "traditional" is omitted, since the definition depends on context. (See draft Section 1(e)(2)(A) and (B).)</td> </tr> <tr> <td data-bbox="453 1347 1163 1458">Talk about increasing access to an array of appropriate services.</td> <td data-bbox="1163 1347 2003 1458">This was added. (See draft Section 1(e)(2)(A) and (B).)</td> </tr> </tbody> </table>		<u>Suggestion</u>	<u>MHSOAC Staff Response</u>	Flip order of access to start with traditional first.	Definition changed to address this concern; word "traditional" is omitted, since the definition depends on context. (See draft Section 1(e)(2)(A) and (B).)	Talk about increasing access to an array of appropriate services.	This was added. (See draft Section 1(e)(2)(A) and (B).)
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7. Improving timely access to services for underserved populations (Continued)	<p>Outcomes- Quality too (not just money spent).</p> <p>Outcomes -race, ethnicity, etc.-capture cultural heritage.</p> <p>PEI programs should serve people in the best place (where they are).</p> <p>Define traditional (if used).</p> <p>Include the homeless population.</p> <p>Talk about community-valued modalities and what is appropriate for different communities.</p>	<p>Evaluation of outcomes includes both client-family outcomes and program-system outcomes which will address this issue. (See draft Section 2.)</p> <p>The draft regulation uses the racial/ethnic categories from CSI for the required reports. This will be further discussed at the September 20th meeting. (See draft Section 4(a)(5).)</p> <p>Agree. Definition reflects this concept. (See draft Section 1(e)(2)(A) and (B).)</p> <p>Definition changed to address this concern; “tradition” is not part of current definition. (See draft Section 1(e)(2)(A) and (B).)</p> <p>Particular program focuses are not being required. To reduce homelessness as a consequence of untreated mental illness is one of the seven MHSA negative outcomes counties may address in prevention and early intervention programs. This could be a TA emphasis.</p> <p>Definition was changed to address this concern. (See draft Section 1(e)(2)(A) and (B).)</p>
8. Outreach	<p>MHSA Statute 5840(b)(1): PEI programs shall include the following components: outreach to families, employers, primary care health care providers, and others to recognize the early signs of potentially severe and disabling mental illnesses.</p> <p>Staff Suggestions Presented at August Workgroup Meeting (Concepts not exact words for regulations) <i>Outreach to Potential Responders: a respectful process of building relationships, which meets people where they are with the goal of engaging potential responders who would not otherwise identify and refer people who need mental health services.</i></p> <p>Outreach in this context includes training to increase skills and to change behavior of “responders” to recognize and respond to signs of potentially serious mental illness.</p> <p><u>Outcomes:</u> Counties measure and report data and outcomes for their outreach to potential responders using a few common indicators.</p>	

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8. Outreach (Continued)	<p>Rationale</p> <ul style="list-style-type: none"> This definition is consistent with SAMHSA definition of evidence-based outreach practices.⁵ Training is included in “outreach” to be consistent with overall MHSA intention for conducting outreach to potential responders. Consistent with outcomes-based approach. <p>Workgroup Feedback</p> <table border="0"> <thead> <tr> <th data-bbox="478 521 632 548"><u>Suggestion</u></th> <th data-bbox="1178 521 1520 548"><u>MHSOAC Staff Response</u></th> </tr> </thead> <tbody> <tr> <td data-bbox="478 570 1136 630">Use the words “gateways” and/or “gatekeepers” to replace responders.</td> <td data-bbox="1178 570 1877 630">Changed to reflect this language. (See draft Section 1(c)(2))</td> </tr> <tr> <td data-bbox="478 695 1136 755">Include potential clients as people to do outreach to priority populations at risk.</td> <td data-bbox="1178 695 1808 722">This was added. (See draft Section 1(c)(2)(C).)</td> </tr> <tr> <td data-bbox="478 776 764 803">Training and learning.</td> <td data-bbox="1178 776 1808 803">This was added. (See draft Section 1(c)(2)(D).)</td> </tr> <tr> <td data-bbox="478 824 1079 885">Use individuals and family members with lived experience, include those without diagnosis.</td> <td data-bbox="1178 824 1969 885">Particular types of gatekeepers are not required. This should be addressed through T/TA.</td> </tr> <tr> <td data-bbox="478 906 905 933">Outreach – include social media.</td> <td data-bbox="1178 906 1955 1036">Particular types of outreach are not listed in the regs. This should be addressed through TA. Added as an example medium for stigma and discrimination reduction campaigns. (See draft Section 1(d)(2)(B).)</td> </tr> </tbody> </table>	<u>Suggestion</u>	<u>MHSOAC Staff Response</u>	Use the words “gateways” and/or “gatekeepers” to replace responders.	Changed to reflect this language. (See draft Section 1(c)(2))	Include potential clients as people to do outreach to priority populations at risk.	This was added. (See draft Section 1(c)(2)(C).)	Training and learning.	This was added. (See draft Section 1(c)(2)(D).)	Use individuals and family members with lived experience, include those without diagnosis.	Particular types of gatekeepers are not required. This should be addressed through T/TA.	Outreach – include social media.	Particular types of outreach are not listed in the regs. This should be addressed through TA. Added as an example medium for stigma and discrimination reduction campaigns. (See draft Section 1(d)(2)(B).)
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9. Access and linkage	<p>MHSA Statute 5840(b)(2): PEI programs shall include the following components: ... 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>Staff Suggestions (Presented at August Workgroup Meeting (Concepts not exact words for regulations)) “Access” is defined in #7.</p> <p>All PEI programs must use effective methods to provide children, adults, and seniors with serious mental illness</p>												

⁵ Olivet et al. (2009). Assessing the evidence: What we know about outreach and engagement. SAMHSA. Available at <http://homeless.samhsa.gov/resource/assessing-the-evidence-what-we-know-about-outreach-and-engagement-37555.aspx>.

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<p>9. Access and linkage (Continued)</p>	<p>access and linkage to treatment as early in the onset as practicable.</p> <p>Linkage: No specified method suggested other than the requirement that it be “effective.”</p> <p><u>Outcomes:</u> Counties measure, and report outcomes of the access and linkage elements of their PEI programs Using a few common indicators.</p> <p>Rationale</p> <ul style="list-style-type: none"> • All PEI programs present opportunities to fulfill the MHSA PEI requirement to link individuals with serious mental illness to treatment. • Suggested approach balances requirement for effective linkage to treatment be included in all PEI programs with flexibility for counties and stakeholders to prioritize specific practices. • Suggested approach is consistent with PEI Guidelines <p>Workgroup Feedback – None</p>
<p>10. Reduction in stigma and discrimination</p>	<p>MHSA Statute</p> <p>5840(b)(3): PEI programs shall include the following components: ... reduction in stigma associated with either being diagnosed with a mental illness or seeking mental health services.</p> <p>5840(b)(4): PEI programs shall include the following components: reduction in discrimination against people with mental illness.</p> <p>Staff Suggestions Presented at August Workgroup Meeting (Concepts not exact words for regulations)</p> <p>Stigma and discrimination reduction encompasses: (a) direct efforts to combat mental health-related stigma and discrimination, and (b) Indirect efforts to design, implement, and describe programs in ways that circumvent stigma, including self-stigma, and make services accessible and acceptable.</p> <p>All MHSA-funded PEI programs include the indirect element of addressing mental health stigma using effective practices.</p> <p>Counties may also fund direct efforts to combat mental health related stigma and discrimination.</p> <p><u>Outcome:</u> For both PEI indirect Stigma and Discrimination Reduction strategies and direct Stigma and Discrimination Reduction Programs, counties measure, and report on intended outcomes and use resulting data for purposes of quality improvement using a few common indicators.</p> <p>Rationale</p> <ul style="list-style-type: none"> • This approach provides a way for counties to fulfill the MHSA mandate to work to reduce stigma and discrimination related to mental illness or seeking mental health services through indirect approaches without a

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10. Reduction in stigma and discrimination (Continued)	<p>requirement to offer a specific stigma and discrimination reduction program.</p> <ul style="list-style-type: none"> • Consistent with outcomes-based approach. <p>Workgroup Feedback</p> <p><u>Suggestion</u></p> <p>Use language from the act about mental illness or seeking mental health services</p> <p>Sensitivity to words that other cultures use around mental health.</p> <p>Acknowledge in stigma section that issue applies within field of mental health and among mental health service providers.</p> <p>Multiple stigmas</p> <p><u>MHSOAC Staff Response</u></p> <p>This was done. (See draft Section 1(c)(2)(A).)</p> <p>Language in definitions and example of outcomes include positive language and a range of conceptions of mental health indicators to reflect this idea. (See draft Section 2(a)(1)(A).)</p> <p>This is a TA priority.</p> <p>This was added to examples. (See draft Section 1(d)(2)(B).)</p>
11. Negative Outcomes	<p>MHSA Statute</p> <p>5840(d): The program shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness: suicide, incarcerations, school failure or drop out, unemployment, prolonged suffering, homelessness, and removal of children from their homes.</p> <p>Staff Suggestions Presented at August Workgroup Meeting (Concepts not exact words for regulations)</p> <p>Negative Outcomes: Reduction of suffering and suicide are considered direct mental health outcomes. Reductions in incarcerations, school failure or drop out, unemployment, homelessness, or removal of children from their homes as a consequence of untreated mental illness are considered functional outcomes.</p> <p><u>Outcomes:</u> For Prevention and Early Intervention programs that serve specific clients (including families), counties select, define, measure, and report indicators that relate to one or more of the MHSA seven negative outcomes.</p> <p>Rationale</p> <ul style="list-style-type: none"> • Defining and measuring outcomes tied to the seven negative outcomes provides a basis for assessing the cumulative focus and outcomes of MHSA-funded PEI programs.

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11. Negative Outcomes (Continued)	<p>Workgroup Feedback</p> <p><u>Suggestion</u></p> <p>Keep the door open on negative outcomes that are not included in the MHSA.</p> <p>Include risk factors that precede outcomes: for example, danger signs that a child in danger of being removed from the home because of issues related to untreated mental illness.</p> <p><u>MHSOAC Staff Response</u></p> <p>Regulations make it clear that counties are free to define and measure additional outcomes, beyond the seven negative outcomes in the MHSA. (See draft Section 2(a)(1)(B), and (c); Section 5(e).)</p> <p>Added examples of interim risk factors. (See draft Section 1(d)(1)(A).)</p>
12. Performance Outcomes	<p>MHSA Statute</p> <p>5848(c): The plans shall include reports on the achievement of performance outcomes for services pursuant to ... Part 3.6 (commencing with Section 5840)... of this division funded by the Mental Health Services Fund and established jointly by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, in collaboration with the California Mental Health Directors Association.</p> <p>Staff Suggestions Presented at August Workgroup Meeting (Concepts not exact words for regulations)</p> <p>Performance Outcomes: All PEI-funded programs will measure and report outcomes and use outcome data to improve the quality of their PEI efforts.</p> <p><u>Outcomes:</u> Counties will measure and report on a few common indicators established by the state for the following: Improve Timely Access Services for Underserved Populations (See #7); Outreach to Potential Responders (See #8); Linking individuals with Serious Mental Illness to Treatment (See #9); Stigma/ Discrimination Reduction (See #10).</p> <p><u>Outcomes:</u> Counties will measure and report on self-selected indicators that relate to one or more of the MHSA seven negative outcomes for the following PEI programs: Prevention (See #2) and Early Intervention (See #3).</p> <p>Rationale</p> <ul style="list-style-type: none"> • Defining common indicators of outcomes provides a basis to measure and communicate statewide progress and impact of the MHSA PEI component. • Selecting, defining and measuring outcomes tied to the seven negative outcomes for Prevention and Early Intervention Programs provides a basis for assessing the cumulative focus and outcomes of MHSA-funded PEI programs.

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12. Performance Outcomes (Continued)	<p>Workgroup Feedback</p> <table border="0"> <tr> <td data-bbox="464 293 1171 407"> <u>Suggestion</u> Outcomes need to be established by Commission or DHCS. </td> <td data-bbox="1171 293 2003 532"> <u>MHSOAC Staff Response</u> Outcomes specified in regulation are steps toward the performance outcome framework being developed. MHSOAC is working with DHCS to provide input regarding general regulations, which also addresses the beginning development of an evaluation framework. (See draft Section 2.) </td> </tr> </table>		<u>Suggestion</u> Outcomes need to be established by Commission or DHCS.	<u>MHSOAC Staff Response</u> Outcomes specified in regulation are steps toward the performance outcome framework being developed. MHSOAC is working with DHCS to provide input regarding general regulations, which also addresses the beginning development of an evaluation framework. (See draft Section 2.)		
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13. Number Served	<p>MHSA Statute 5847(e): Each expenditure update shall indicate the number of children, adults, and seniors to be served pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850), and the cost per person.</p> <hr/> <p>Staff Suggestions Presented at August Workgroup Meeting (Concepts not exact words for regulations) Number Served: Counties report both estimated and actual numbers of individual clients (and, as applicable, members of their families) for programs that serve individual clients.</p> <p>Rationale</p> <ul style="list-style-type: none"> • Per 5845(d)(6) MHSOAC has authority to request data and information to use in its oversight, review, training and technical assistance, accountability, and evaluation capacity. • It is important that public and policy makers are informed about use of MHSA funds. • There was consensus from counties and stakeholders to include this reporting requirement in the 3 year Plan Instructions for PEI. <p>Workgroup Feedback</p> <table border="0"> <tr> <td data-bbox="464 1097 1171 1179"> <u>Suggestion</u> Use actual numbers, not estimates. </td> <td data-bbox="1171 1097 2003 1448"> <u>MHSOAC Staff Response</u> Both estimates and actual numbers are required for Prevention and Early Intervention programs that serve individuals. Estimates of the number of people to be served provide helpful information to the local decision makers in reviewing the plan. The annual report asks for actual numbers. (See draft Section 3(a)(12); and Section 4.) </td> </tr> <tr> <td data-bbox="464 1393 1171 1448"> Can we measure how disparities are being reduced? </td> <td data-bbox="1171 1393 2003 1448"> MHSOAC requires programs that increase access to services </td> </tr> </table>		<u>Suggestion</u> Use actual numbers, not estimates.	<u>MHSOAC Staff Response</u> Both estimates and actual numbers are required for Prevention and Early Intervention programs that serve individuals. Estimates of the number of people to be served provide helpful information to the local decision makers in reviewing the plan. The annual report asks for actual numbers. (See draft Section 3(a)(12); and Section 4.)	Can we measure how disparities are being reduced?	MHSOAC requires programs that increase access to services
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13. Number Served (Continued)	<p>Look at private and public sector penetration rates.</p> <p>When measuring individuals served we should include those individuals that were screened at schools.</p> <p>Keep estimates in.</p> <p>Touch base with CalMHSA.</p>	<p>for underserved populations and requires all MHSA-funded programs to be culturally appropriate. Current draft regs include outcomes for PEI-specific requirement to increase access. Reduction of other disparities, such as mental health outcomes, might need to go into a Policy parking lot for future consideration and recommendations.</p> <p>Not currently in draft regulations but on priority discussion list.</p> <p>This is included in the evaluation requirement under the strategy to provide Access and Linkage to Treatment. (See draft Section 2(a)(5).)</p> <p>Estimated number to be served and estimated number actually served for programs that don't serve specific individuals have been retained. (See draft Section 3(a)(12); and Section 4.)</p> <p>MHSOAC staff intention with regard to PEI regulations is to include two key elements of CalMHSA/RAND PEI Evaluation Framework: classify all PEI programs (where is the money going?) and use population measures (statewide and regional) for an element of statewide PEI evaluation. Both of these goals require further development. The proposed regulations classify programs into five broad categories and by intended MHSA outcomes, but classification requires more refinement. MHSOAC intends to collaborate with DHCS to collect county data for, among other goals, eventual use with population measures. The topic of reporting data is on the priority discussion list.</p>
14. Expenditure Plan	<p>MHSA Statute 5847(b): The three-year program and expenditure plan shall be based on available unspent funds and estimated revenue allocations provided by the state and in accordance with established stakeholder engagement and planning requirements as required in Section 5848. The three-year program and expenditure plan and annual updates shall include all of the following: A program for prevention and early intervention in accordance with Part 3.6 (commencing with Section 5840).</p>	

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14. Expenditure Plan (Continued)	<p>5847(e): Each county mental health program shall prepare expenditure plans pursuant to...Part 3.6 (commencing with Section 5840) for prevention and early intervention programs..., and updates to the plans developed pursuant to this section. The expenditure update shall include utilization of unspent funds allocated in the previous year and the proposed expenditure for the same purpose.</p> <p>5892(a)(3): Twenty percent of funds distributed to the counties pursuant to subdivision (c) of Section 5891 shall be used for prevention and early intervention programs in accordance with Part 3.6 (commencing with Section 5840) of this division.</p> <hr/> <p>Staff Suggestions Presented at August Workgroup Meeting (Concepts not exact words for regulations) Counties report: (1) estimated total mental health expenditures for each PEI program, and identify each applicable program as either focusing on prevention or early intervention (Outreach to Potential Responders and Stigma and Discrimination Reduction Programs generally cannot be categorized as either prevention or early intervention, since they combine both elements); (2) estimated PEI, Medi-Cal FFP, 1991 realignment, behavioral health subaccount, and other funding used for each PEI program, and identify each applicable program as either focusing on prevention or early intervention (see previous note); (3) estimated PEI funding for PEI administration; and (4) actual and estimated PEI funds voluntarily assigned by the county to CalMHSA or any other organization in which counties are acting jointly.</p> <p>Counties report actual expenditures (need to insert information from the ARER and Annual Update and Three-Year Plan Reports on Actual Expenditures)</p> <p>Rationale</p> <ul style="list-style-type: none"> • Sufficient expenditure information is necessary to allow for informed local approval and local and MHSOAC oversight of use of PEI funds. • Sufficient information about actual expenditures is necessary for local and state oversight and accountability and to report to the public and decision-makers about the use of MHSA funds. • The reporting requirements were included in the FY 2014-2015 through FY 2016-2017 MHSA Program and Expenditure Plan Instructions (3- year Plan Instructions). • See attached fiscal forms from 3-year Plan Instructions and Annual Revenue and Expenditure Report for Fiscal Year <u>(need year)</u> <p>Workgroup Feedback</p> <table border="0"> <tr> <td data-bbox="478 1312 630 1339"><u>Suggestion</u></td> <td data-bbox="1230 1312 1566 1339"><u>MHSOAC Staff Response</u></td> </tr> <tr> <td data-bbox="478 1352 953 1380">Keep it simple, as much as possible.</td> <td data-bbox="1230 1352 1331 1380">Agreed.</td> </tr> <tr> <td data-bbox="478 1403 1146 1430">Expenditures on the stakeholder process should be</td> <td data-bbox="1230 1403 1745 1430">This item is in the DHCS parking lot list.</td> </tr> </table>	<u>Suggestion</u>	<u>MHSOAC Staff Response</u>	Keep it simple, as much as possible.	Agreed.	Expenditures on the stakeholder process should be	This item is in the DHCS parking lot list.
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14. Expenditure Plan (Continued)	<p>available.</p> <p>Evaluation expenditures should be separated to make them explicit.</p> <p>Require counties to allocate some funds to contract with community groups with the capacity to serve diverse communities.</p>	<p>This item is in the DHCS parking lot list.</p> <p>MHSOAC staff believes this should be a local decision, not a state requirement. The benefits of doing this could be addressed through TA.</p>		
15. Impact on need and cost for additional services to individuals with serious mental illness	<p>MHSA Statute 5892(a)(4): The expenditure for prevention and early intervention may be increased in any county in which the department determines that the increase will decrease the need and cost for additional services to severely mentally ill persons in that county by an amount at least commensurate with the proposed increase.</p>			
	<p>Staff Suggestions Presented at August Workgroup Meeting (Concepts not exact words for regulations) Will need to determine if DHCS needs additional information to support their capacity to make this determination.</p> <p>Rationale - N/A</p> <p>Workgroup Feedback</p> <table border="0" data-bbox="453 812 2003 1112"> <tr> <td data-bbox="453 812 1213 1112"> <p><u>Suggestion</u></p> <p>Concerned this is a barrier to increase PEI funding.</p> <p>Cultural delivery tied to cultural humility.</p> <p>Only apply when revenues grow.</p> </td> <td data-bbox="1213 812 2003 1112"> <p><u>MHSOAC Staff Response</u></p> <p>The law provides for this determination to be made by DHCS. Will discuss with DHCS what additional information they would need to make the determination.</p> <p>This could be addressed though TA.</p> <p>This does not seem to have been the intent behind the clause in the Act. Part of discussion with DHCS.</p> </td> </tr> </table>		<p><u>Suggestion</u></p> <p>Concerned this is a barrier to increase PEI funding.</p> <p>Cultural delivery tied to cultural humility.</p> <p>Only apply when revenues grow.</p>	<p><u>MHSOAC Staff Response</u></p> <p>The law provides for this determination to be made by DHCS. Will discuss with DHCS what additional information they would need to make the determination.</p> <p>This could be addressed though TA.</p> <p>This does not seem to have been the intent behind the clause in the Act. Part of discussion with DHCS.</p>
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Misc.	<p>Other Workgroup/Public Feedback</p> <table border="0" data-bbox="453 1169 2003 1451"> <tr> <td data-bbox="453 1169 1213 1451"> <p><u>Suggestion</u></p> <p>Use other multiple terms such as “responder” “gatekeeper” “helper” “extender” “supporter”</p> <p>Call-out suicide prevention</p> </td> <td data-bbox="1213 1169 2003 1451"> <p><u>MHSOAC Staff Response</u></p> <p>The concept of support to language defining outreach to gatekeepers was added. (See draft Section 1(c)(2).)</p> <p>A whole optional program component was added to address this suggestion. (See draft Section 1(d)(3).)</p> </td> </tr> </table>		<p><u>Suggestion</u></p> <p>Use other multiple terms such as “responder” “gatekeeper” “helper” “extender” “supporter”</p> <p>Call-out suicide prevention</p>	<p><u>MHSOAC Staff Response</u></p> <p>The concept of support to language defining outreach to gatekeepers was added. (See draft Section 1(c)(2).)</p> <p>A whole optional program component was added to address this suggestion. (See draft Section 1(d)(3).)</p>
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<p>Misc. (Continued)</p>	<p>How can statewide PEI projects and framework be used for this effort?</p> <p>OAC should report on review and findings of county PEI plans</p> <p>PEI focused stakeholder process</p> <p>Call out family law players</p> <p>Authority to set specific reporting requirements</p>	<p>MHSOAC staff intention with regard to PEI regulations is to include two key elements of CalMHSA/RAND PEI Evaluation Framework: classify all PEI programs (where is the money going?) and use population measures (statewide and regional) for an element of statewide PEI evaluation. Both of these goals require further development. The proposed regulations classify programs into five broad categories and by intended MHSA outcomes, but classification requires more refinement. MHSOAC intends to collaborate with DHCS to collect county data for, among other goals, eventual use with population measures. The topic of reporting data is on the priority discussion list.</p> <p>This item needs further discussion. Parking lot for Evaluation and Policy.</p> <p>This is essential for DHCS regulations and would also be relevant to T/TA. Have added some language that counties must ensure that stakeholders and staff understand purpose and requirements of PEI. (See draft Section 3(a)(1).)</p> <p>This can be addressed through TA.</p> <p>Parking lot for policy recommendations.</p>