

**Matrix of Public Comments with Staff's Recommended Responses
Proposed PEI Regulation Sections 3705 - 3740**

Section #	Comment Author	Comment Summary	Response	Action	Rationale
3705	Commenter #3	<p><u>Comment 3.09</u> MIPO submits the following comments on proposed section 3705: As discussed above, MIPO's proposed changes to section 3705 are necessary to bring the regulation into conformity with the MHSA. MHSOAC does not have the power to convert a statutory mandate that uses the term "shall" into a permissive "may." The consequences of MHSOAC ignoring the statutory mandate are enormous: severely mentally ill people will continue to die, go to jail, become homeless, lose jobs, leave school, or be taken away from their families because MHSOAC will never fund statutorily-mandated programs for the severely mentally ill. See Welf. & Inst. Code § 5840(d)(reciting negative outcomes of untreated mental illness). This completely undermines the basic purposes of the law. See generally MHSA Sections 2 and 3, Findings and Declarations, Purpose and Intent.</p> <p>MHSOAC's proposed regulations have not merely reversed a central statutory mandate, they have turned a double mandate in the law into something doubly permissive: they do this by taking a provision that has two statutory mandates-a "shall" within a "shall" - and turning it into a double permissive - a "may" within a "may." Here is the double mandate contained in the MHSA:</p>	Reject	Retain existing language with no change	<ol style="list-style-type: none"> Proposed PEI Regulations require a County's PEI Component which is all of the programs and strategies that the County implements pursuant to the Welfare and Institutions Code (WIC) Section 5840 to include everything that the MHSA requires in WIC 5840. All the MHSA requirements referenced in Comment 3.09 (WIC 5840(a) & (c)) as "shall" are in fact a "shall" in the proposed regulations. Both of these requirements are implemented through the Early Intervention program which is required. See proposed regulation Section 3705(a) and Section 3710. The requirement that a County <i>shall</i> include at least one Early Intervention Program complies with the MHSA mandate that the County's PEI program includes "mental health services similar to those provided under other programs effective in preventing mental illnesses from becoming severe" and shall also include components similar to programs that have been successful in "assisting people in quickly regaining productive lives." From a mental illness services/treatment standpoint (research), prevention of relapse is an element of an effective Early Intervention Program. Therefore, relapse prevention is included as part of the required Early Intervention program. See proposed regulation section 3710. Proposed PEI Regulations do not enumerate all the effective elements of Early Intervention Programs (for example, positive therapeutic alliance, clear case formulation, symptom reduction, recovery focus, cultural appropriateness and competence, effective means to assess and address suicidality and other crises, etc.). The arguments that the regulations turn a "shall" into a "may" and that the regulations disregard the statutory structure and bifurcate programs into "prevention" and "early "intervention" are based on the Commenter's own

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		<p>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. The program shall emphasize improving timely access to services for underserved populations. * * *</p> <p>The program ... 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>Welf. & Inst. Code § 5840(a) & (c) (emphasis added). In contrast, here are MHSOAC's proposed regulations, which eliminate the statute's double mandate:</p> <p>The County may include in its Prevention and Early Intervention Component:</p> <p>One or more Prevention programs as defined in Section 3720. ***</p> <p>Prevention program services may include relapse prevention for individuals in recovery from a serious mental illness.</p> <p>MHSOAC Proposed Regulations §§ 3705(b)(1) and 3720(d) (emphasis added).</p> <p>MIPO has also corrected MHSOAC's</p>			<p>definition of “prevention” and not based on the definition that is used in the proposed regulations. The comment defines a “Prevention Program” as “relapse prevention”, which differs from the Proposed PEI Regulations’ definition of a “Prevention Program.” As mentioned above in response #3, “relapse prevention” is a part of Early Intervention Program which is in fact required by the regulations.</p> <p>5. Counties have the option to offer a combined Prevention and Early Intervention Program, as long as they report separately on costs, program data, and evaluation outcomes for individuals at risk and for individuals with early onset of a mental illness. MHSOAC staff has suggested additional language to make explicit that this is an option for a County.</p> <p>6. Comment 3.09 is incorrect in its statement that the regulations move “anti-discrimination and anti-stigma provisions from mandatory to discretionary” because proposed regulation Section 3735(a)(2) requires all programs to be designed, implemented, and promoted using strategies that are non-stigmatizing and non-discriminatory. This proposed regulatory provision reflects and addresses the MHSOAC requirement that the PEI program shall include “reduction in stigma associated with either being diagnosed with a mental illness or seeking mental health services” and “reduction in discrimination against people with mental illness.” The optional provision referenced in proposed regulation Section 3705(b) gives Counties the option <i>in addition</i> of offering a Stigma and Discrimination Reduction Program under proposed regulation Section 3725.</p> <p>7. Comment 3.09’s argument that the Proposed Regulations do not comply with WIC 5840(c) regarding effective practices similar to programs that have demonstrated their success is not accurate. Proposed</p>

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		<p>decision to move anti-discrimination and anti-stigma provisions from mandatory to discretionary, though they are subject to only one "shall" rather than two. Presumably, MHSOAC feels-as does MIPO-that far too much money is being spent on indirect and non-evidentiary based efforts to address stigma against the mentally ill (because studies show that the best way to erase stigma is to help the most severely ill, who are the ones who cause it), and discrimination against the mentally ill (because disability discrimination is already illegal under both federal and California law). This is a reason to put appropriate constraints on use of these monies. It does not excuse changing mandatory provisions of the statute into permissive ones.</p> <p>MIPO's remaining changes to proposed section 3705 are necessary for conformity to the statute, and for clarity and effectiveness. The PEI provisions of the MHSA treat "prevention" and "early intervention" as one program, for good reason: most effective PEI programs necessarily contain both prevention and early intervention elements because shifts in mental status-from no mental illness, or "mental illness" into "severe mental illness" - can occur almost instantaneously in persons predisposed towards "severe mental illness." When this occurs, treatment personnel have to</p>			<p>Regulations require all programs to increase access to treatment for individuals with a severe mental illness, which is essential to reducing the duration of untreated mental illness. Proposed Regulations also require counties to offer an Early Intervention Program, which is intended to help individuals with early onset of a mental illness regain productive lives. Both approaches, as well as all PEI programs and strategies, require effective practices that have demonstrated their success. See proposed regulation Sections 3735(a)(1), 3710, and 3740.</p> <p>8. Comment 3.09's argument that regulations "misquote" and "distort" the statute in mandating Outreach for Increasing Recognition of Early Signs of Mental Illness is wrong because the "potentially severe and disabling" language requested by the Comment is already included in the definition of "outreach" in proposed regulation Section 3715(b).</p>

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		<p>shift into early intervention mode just as abruptly. Moreover, the line between the two concepts is often hard to draw. MHSOAC, however, has chosen to disregard the statutory structure and bifurcate programs into "prevention" and "early intervention." To correct this deficiency, MIPO has suggested adding the phrase, "Every such program may contain Prevention elements, as defined in Section 3720, as well as Early Intervention elements, as defined in section 3710," to both of the definitions in proposed section 3705(a).</p> <p>MHSOAC also misquoted and distorted the statute in mandating "Outreach for Increasing Recognition of Early Signs of Mental Illness." MIPO's proposed changes to section 3705(a)(2) are to add the language that is contained in the MHSOAC: "potentially severe and disabling."²⁰ This statutorily-mandated change in emphasis is necessary in light of the ten year history of wasting MHSOAC funds on people who are not, and will never be "mentally ill," much less "severely mentally ill." The statutory focus on "potentially severe and disabling mental illnesses" is critical, because these are crippling and potentially life-threatening conditions. Educating people about "early signs of mental illness" blurs this critical focus because "mental illness" is now very broadly-defined in the mental "health"</p>			

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		community: any negative life experience (now called "trauma") is an early sign of "mental illness." The voters did not intend MHSAC to fund philosophical discussions. To address severe illness and save lives, outreach needs to focus on "potentially severe and disabling" mental illness, as the statute requires and the voters intended.			
3705(a)	Commenter #8	<p><u>Comment 8.33</u> (a) The County shall include in its Prevention and Early Intervention Program or Components:</p> <p style="padding-left: 20px;">(1) Evidence based programs that "Prevent Mental Illness from becoming Severe and Disabling"</p> <p style="padding-left: 20px;">(2) Evidence-based programs that reduce the duration of untreated severe mental illness,</p> <p style="padding-left: 20px;">(4) At least one All Early Intervention programs as defined in Section 3710.</p> <p style="padding-left: 20px;">(3) At least one Outreach for Increasing Recognition of Early Signs of Mental Illness program or strategy as defined in Section 3715.</p> <p style="padding-left: 20px;">(4) The strategies defined in Section 3735.</p>	Reject	Retain existing language with no change	<ol style="list-style-type: none"> 1. The Comment's addition of the word, "Program" is not necessary because "Prevention and Early Intervention Component" is defined in proposed regulations broadly to include all programs and strategies. See proposed regulation Section 3200.245. This definition encompasses what the MHSAC refers to as "the PEI program," which is the collective effort. 2. The Comment's addition of evidence based language is inconsistent with proposed regulation Section 3740. Proposed regulation Section 3740 requires both Prevention and Early Intervention programs to use methods that have demonstrated their effectiveness to bring about their intended MHSAC outcomes for the intended population consistent with one of three defined standards of effective methods. Evidence based is one of the three defined standards.
3705(a) and (a)(1)	Commenter #3	<p><u>Comment 3.06</u> MIPO proposes the following changes to MHSOAC's proposed regulation section 3705. As discussed below, MIPO's proposed changes are necessary to conform the regulation to statute, and</p>	Reject in part and accept in part	Amend proposed regulation 3710 to add new subdivision (f) to clarify that Early Intervention and Prevention programs	<ol style="list-style-type: none"> 1. Comment 3.06 bases the suggested changes on the same arguments listed in Comment 3.09 above for proposed regulation Section 3705. The suggestions are rejected for the same reasons stated in responses #1 through 5 and 7 to Comment 3.09 above to proposed regulation Section 3705.

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		<p>also for clarity and to avoid a burdensome and ineffective regulation.</p> <p>Section 3705. Prevention and Early Intervention Component General Requirements.</p> <p>(a) The county shall include in its Prevention and Early Intervention Component Program:</p> <p>(1) At least one Early Intervention program as defined in Section 3710. <u>Every such program may contain Prevention elements, as defined in Section 3720, as well as Early Intervention elements, as defined in Section 3710.</u></p> <p>Reference/Authority/Necessity for the substitution of "Program" for "Component": Welfare & Institutions Code section 5840(a) provides that "the State ... shall establish a <i>program</i> designed to prevent mental illnesses from becoming severe and disabling." (Emphasis added.) Section 5840(c) mandates what the program is to include: "The <i>program shall</i> include mental health services similar to those provided under other <i>programs</i> effective in preventing mental illnesses from becoming severe and shall also include components similar to <i>programs</i> that have been successful in reducing the duration of untreated severe mental illnesses and assisting people in quickly regaining productive lives.... " (Emphasis</p>		<p>can be combined if all requirements for individual programs are met.</p> <p>Proposed regulation Section 3710(f): <u>A County may combine an Early Intervention Program with a Prevention Program, as long as the requirements in Section 3710 and Section 3720 are met.</u></p>	<p>2. The suggestion to allow a Prevention and an Early Intervention program to be combined is consistent with the proposed regulations. However, staff recommends that the clarifying language be added to proposed section 3710 and not to proposed section 3705. Staff's recommendation to add a new subdivision (f) to proposed regulation Section 3710 would clarify that the counties have the option of combining a Prevention and an Early Intervention program. This option is already referenced in the proposed regulation section 3510.010 related to reporting requirements for the Revenue and Expenditure Report.</p>

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		<p>added.) Other "components" of the "program," including "outreach," are specified in section 5840(b).</p> <p>Reference/Authority/Necessity for the added sentence: MHSOAC has no statutory authority to create an artificial distinction between prevention and early intervention services. Section 4 of the MHSA draws no such distinction. If MHSOAC did not intend to create this artificial bifurcation, MIPO's proposed change is necessary for clarity.</p> <p>MIPO's added sentence is also necessary to conform the regulation to the statute. Further, unless amended as indicated, the regulation will create burdensome requirements and ineffective programs. Effective PEI programs necessarily contain both prevention and early intervention elements because shifts in mental status, from no mental illness or from mental illness into severe mental illness, can occur suddenly.</p>			
3705(a)(2)	Commenter #3	<p><u>Comment 3.07</u> (2) At least one Outreach for Increasing Recognition of Early Signs of <u>Potentially Severe and Disabling</u> Mental Illness program or strategy <u>component</u> as defined in Section 3715.</p> <p>Reference/Authority for the deletion: Welfare & Institutions Code section</p>	Accept in part Reject in part	Clarify proposed regulations by adding definitions of "program" and "strategy" as follows: New Section #: (a) <u>"Program" as used in the Prevention and</u>	1. The comment uses the terms "component," "program," and "strategy" differently than the way the terms are defined and used in the Proposed PEI Regulations. Because terminology in the MHSA is internally inconsistent, staff recommends two new definitions be added to the proposed PEI Regulations: "program" and "strategy". The proposed regulations currently only define "component" and these additional two definitions would help clarify the terms used in the MHSA.

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		<p>5840(a) mandates that "the State ...shall establish a <i>program</i> designed to prevent mental illnesses from becoming severe and disabling." (Emphasis added.) "Components" of the program are specified in section 5840(b)(1), which provides: "The program shall include the following <i>components</i>: "Outreach to families, employers, primary care health care providers, and others to recognize the early signs of potentially severe and disabling mental illnesses...." (Emphasis added.)</p> <p>Reference/Authority for the added phrase, "Potentially Severe and Disabling": As noted above, section 5840(b)(1) provides for "[o]utreach to families, employers, primary care health care providers, and others to recognize the early signs of <i>potentially severe and disabling</i> mental illnesses." MHSOAC has no statutory authority to address early signs of mental illness. Under section 5840(b)(1), its authority extends only to addressing early signs of "potentially severe and disabling" mental illness. <i>See also</i> the statutory language of Welf. & Inst. Code section 5840(a) ("The State Department of Health Care Services, in coordination with counties, shall establish a program designed to <i>prevent mental illnesses</i> from becoming <i>severe and disabling</i>") (emphasis added), and § 5840(b)(2) ("medically necessary care provided by</p>		<p><u>Early Intervention regulations means organized and planned work, action or approach that evidence indicates is likely to bring about mental health outcomes either for individuals and families with or at risk of serious mental illness or for the mental health system. A program is a stand-alone, discreet unit of service delivery.</u></p> <p>New Section #: <u>"Strategy" as used in the Prevention and Early Intervention regulations</u> means a planned and specified method within a program intended to achieve a defined goal.</p>	<p>2. The suggestion to add the phrase "potentially severe and disabling" because the "MHSOAC has no statutory authority to address early signs of mental illness" fails to acknowledge that proposed regulation Section 3705 is a general section that lists all of the programs and strategies that are specifically cross-referenced to the section that defines the applicable programs and strategies. As stated above in response #8 to Comment 3.09 for proposed regulation Section 3705, the language proposed by Comment 3.07 is already in proposed regulation Section 3715(b), which requires a County to provide outreach to people in a position to recognize early signs of potentially severe and disabling mental illnesses either as a program or as a strategy within a program.</p>

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		<p>county mental health programs for children with <i>severe mental illness</i>, as defined in Section 5600.3, and for adults and seniors with <i>severe mental illness</i>, as defined in Section 5600.3, as early in the onset of <i>these conditions</i> as practicable")(emphasis added).</p> <p>Necessity for the added phrase, "Potentially Severe and Disabling": For clarity and conformity to statute. Further, the ten year history of waste and misuse of MHSA funds demonstrates that this addition is necessary to change existing practices at the county level, and to ensure that MHSA funds are being spent on those who have a severe or potentially severe and disabling mental illness.</p>			
3705(b)	Commenter #3	<p><u>Comment 3.25</u> Section 3705. Prevention and Early Intervention Component General Requirements. (b) The County may include in its Prevention and Early Intervention Component: (1) [renumbered] One or more Suicide Prevention programs/ approaches as defined in Section 3730. <u>(2) To address homelessness, one or more "Housing First" programs modelled on programs effective in preventing mental illnesses from becoming severe, such as the Corporation for Supportive Housing's Health, Housing Integrated</u></p>	Reject	Retain existing language with no change	<p>1. The MHSA requires counties to develop programs within the PEI Component in accordance with established stakeholder engagement and planning set forth in WIC Section 5848. The proposed regulations do not prescribe the specific programs that counties must develop. Instead, the proposed regulations set the framework within which counties, with community stakeholders, can determine effective program approaches that are best suited for their local priorities in preventing mental illnesses from becoming severe and disabling and to fulfill the outcomes specified in WIC 5840. Many counties already utilize a number of the approaches that the comment suggests. Proposed PEI Regulations do not specify or require particular program models because such requirement would be contrary to MHSA and the existing community planning</p>

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		<p><u>Services Network program in San Francisco, provided that the program shall be limited to persons who are mentally ill or severely mentally ill, as defined herein.</u> <u>(3) To address incarceration and unemployment, one or more programs established under the Mentally Ill Grant Offender Program, as incorporated by reference in Welfare & Institutions Code section 5813.5(£), for mentally ill and severely mentally ill individuals, as defined herein, who are leaving local jails under community supervision, provided, that such programs are modelled on prior programs effective in preventing mental illnesses from becoming severe.</u> <u>(4) To address school failure and removal of children from their homes, one or more programs modelled on previous programs effective in preventing mental illness from becoming severe, and designed to keep mentally ill and severely mentally ill students defined as "emotionally disturbed" by the federal Individuals with Disabilities in Education Act at home and attending local schools with appropriate supports.</u> <u>(5) To address suicide and incarceration, one or more crisis intervention units as defined in Welfare & Institutions Code section 5008 that are modelled on previous programs, such as the Memphis model, that have been successful in reducing the duration of</u></p>			<p>regulations (Title 9 California Code of Regulations, Sections 3300 through 3315).</p> <p>2. Proposed PEI Regulations permit a County to offer a Prevention Program or an Early Intervention Program that has demonstrated its effectiveness for reducing suicide for individuals at risk of (Prevention) or with early onset of (Early Intervention) a potentially serious mental illness. Proposed regulations also permit a County to offer a broad Suicide Prevention Program, defined as “organized activities that the County undertakes to prevent suicide as a consequence of mental illness” that “does not focus on or have intended outcomes for specific individuals at risk of or with a serious mental illness.” In all three kinds of efforts, the required link to potential or actual serious mental illness is explicit. An estimated 90% of people who die by suicide have a diagnosable mental disorder.</p> <p>3. The argument that “MHSOAC’s statutory authority to spend millions of dollar on something listed in the statue not as a program, but as a strategy is very tenuous” misstates the requirements in the Proposed Regulations and in the MHSA. The required “strategies” in the proposed regulations specifically comply with and implement WIC 5840(a) and (b): link people across the lifespan with severe mental illness to treatment, improve timely access to mental health services for underserved populations, and offer services in ways that are non-stigmatizing and non-discriminatory.</p> <p>4. In response to the comment that the regulations should establish other discretionary programs that “actually” meet the statutory requirement of being “effective” and successful, it is important to note that the proposed regulation Section 3740, requires all PEI programs to have evidence of their effectiveness for bringing about applicable MHSA PEI outcomes for the intended populations.</p>

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		<p><u>untreated severe mental illnesses and assisting people in quickly regaining productive lives; (6) To address all negative outcomes pertaining to adults in section 5840(d), any Laura's Law program duly authorized by the county and meeting all requirements in Welfare & Institutions Code sections 5345- 5349.5.</u></p> <p>MIPO's comments regarding proposed section 3705(b): MIPO submits that discretionary programs based on "strategies to reduce negative outcomes" should also include programs that actually address mental illness and severe mental illness. Under MHSOAC's prior "policies" and pseudo-regulations, millions of dollars were spent on duplicative and wasteful suicide prevention programs that did not focus on, and likely did not even reach, the seriously/severely mentally ill. MIPO will address MHSOAC's "suicide prevention" program in a future comment proposing changes to MHSOAC's proposed regulation section 3730. For now, MIPO wishes to note that MHSOAC's statutory authority to spend millions of dollars on something listed in the statute not as a program, but as a "strategy," is very tenuous. Good programs for the severely mentally ill will always have a "strategy" for dealing with suicidality, because suicide attempts and suicides are very frequent in this population. MHSOAC's</p>			

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3705(b)		<p>unfocused, generalized education program about suicide, designed for the general public, is yet another example of its predilection for spending money on people who are not covered by the statute.</p> <p>Assuming that programs based on section 5840(d)'s "strategies to reduce negative outcomes" are statutorily permitted, MHSOAC's approach begs an obvious question: why not establish other discretionary programs that actually meet the statutory requirement that PEI programs be modelled on existing "effective" and "successful" programs for the people the statute was intended to address - the severely mentally ill, and the "mentally ill" who are at risk of "severe mental illness"? There are many effective and successful programs that prevent one or more of the "negative outcomes" listed in section 5840(d) that occur when "mental illness" goes untreated. MIPO's proposed changes to section 3705 identify several that should have received PEI funding years ago, because they actually meet the statutory requirements. These include:</p> <ul style="list-style-type: none"> • Crisis Intervention Units: Composed of mental health professionals who can call specially-trained police teams for backup when needed, these units were created by California to intervene early in the 			

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		<p>relapses of severely mentally ill people "to alleviate personal or family situations which present a serious and imminent threat to the health or stability of the person or the family." See Welf. & Inst. Code § 5008(e). Without such early intervention, the severely mentally ill who are in relapse commit crimes or become dangerous to themselves or others before they can get help. See Welf. & Inst. Code § 5150. Funding for crisis intervention units is insufficient and some work poorly because counties have not been required to follow successful models, as they would if using MHSA authorized PEI funds under properly-constituted regulations. See Welf. & Inst. Code § 5840(c)(requiring relapse prevention programs "similar to programs that have been successful. .."). There are many successful programs to provide good models. Statistics show that these programs substantially cut arrests and deaths of severely mentally ill people, as well as the number of crisis calls.</p> <ul style="list-style-type: none"> • Housing First programs: When properly constituted to combine housing with good case management, these programs are effective at cutting not only homelessness, but also rates of emergency hospitalizations and residential mental health treatment for the severely mentally ill. 			

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		<p>• Laura's Law is a relapse prevention/early intervention program for the severely mentally ill who refuse treatment and who have a history of violence and/ or repeated involuntary hospitalizations based on dangerousness. See Welf. & Inst. Code § 5346(a)(4) and (5). It is a form of "assisted outpatient treatment" ("AOT") that has both "prevention" and "early intervention" elements. The "prevention" element is heavily-enhanced case management. See Welf. & Inst. Code § 5348(a)(1). The "early intervention" provision allows the county to compel a 72-hour evaluative hospitalization <i>before</i> patients become dangerous again, when they go off their medications. See Welf. & Inst. Code § 5346(f). Patients typically go back on their meds rather than choosing early hospitalization. Laura's Law and its New York analogue, Kendra's Law, have proved highly effective at reducing <i>all</i> the statutory markers for severe mental illness.</p> <p>At present, Laura's Law funding takes money away from other programs for the severely mentally ill. Since Laura's Law is a true prevention/early intervention program that has been highly "successful in reducing the duration of untreated severe mental illnesses and assisting people in quickly regaining productive lives," (Welf. & Inst. Code § 5840(c)),</p>			

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		<p>counties should be able to preserve existing funds for the severely mentally ill and choose Laura's Law as a PEI program in lieu of the wasteful programs MHSOAC has encouraged in the past.</p> <ul style="list-style-type: none"> • AOT programs under the Mentally III Offender Crime Reduction Grant Program: Like Laura's Law, California's Mentally III Offender Crime Reduction Grant Program is an AOT, but limited to prisoners leaving county and local jails under "community supervision." Studies sponsored by the Department of Corrections show that these programs substantially cut rates of re-arrest and joblessness, as well as substance abuse. See Mentally III Offender Crime Reduction Grant Program: Overview of Statewide Evaluation Findings (California Department of Corrections March 2005). To MIPO's knowledge, <i>no</i> MHSOAC funding is flowing to these programs under MHSOAC Section 7(f), even though it is a statutory <i>mandate</i>. See Welf. & Inst. Code § 5813.5(f) ("Each county plan and annual update pursuant to Section 5847 <i>shall</i> consider ways to provide services similar to those established pursuant to the Mentally III Offender Crime Reduction Grant Program. Funds shall not be used to pay for persons incarcerated in state prison or parolees from state prisons"). This is likely because both MHSOAC and the now-defunct Department of Mental Health 			

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		<p>failed to mention the foregoing mandate in their regulations and pseudo-regulations.</p> <p>The need for relapse prevention/early intervention programs for local prisoners released from jail on community supervision is dire, because thousands of mentally ill prisoners are being "realigned" to the counties by the State as the result of the decision in <i>Brown v Plata</i> that California state prison conditions constitute "cruel and unusual punishment" for the mentally ill, among others. The pressures on local jails are enormous as the population of local mentally ill inmates has risen from 19% to at least 25%. Predictably, the United States Department of Justice recently found unconstitutional conditions in the Los Angeles County Jail, which is the largest mental institution in California, and at times, in the entire nation. County jails are already dumping mentally ill prisoners, who will commit new crimes and violence if there are not adequate relapse prevention/early intervention programs to keep them safe.</p> <p>In sum, the optional programs MIPO has identified in its proposed changes to regulation section 3705(b) are effective, consistent with the statute, and respond to severe public needs that MHSOAC has ignored and continues to ignore.</p>			

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3705(b)	Commenter #8	<p><u>Comment 8.34</u> (b) The County may <u>shall</u> include in its Prevention and Early Intervention Component:</p> <p>(1) One or more <u>All</u> Prevention programs as defined in Section 3720.</p> <p>(2) <u>The county may include</u> One <u>one</u> or more Stigma and Discrimination reduction programs/approached as defined in Section 3725.</p> <p>(3) <u>The county may include</u> One <u>one</u> or more Suicide Prevention programs/approaches as defined in Section 3730.</p>	Reject	Retain existing language with no change	<p>1. There is no basis in the MHSA nor in research to require a County to offer "all prevention programs." However, see rationale to Comment 60 below for requiring a Prevention Program.</p>
3705(b) & 3720(a)	Commenter #60	<p><u>Comment 60.02</u></p> <p>1. <i>In relation to Section 3720 (a), Prevention Program: UACF is concerned about the use of shall to imply required and may to imply optional:</i></p> <p>(c) <i>The county <u>shall include</u> in its Prevention and Early Intervention Program at least one Early Intervention Program</i></p> <p>(d) <i>The county <u>may include</u> in its Prevention and Early Intervention Program: One or more Prevention Programs</i></p> <p>UACF recommends the requirement of at least one Prevention program AND one Early Intervention program as they are both integral keys to the true purpose and success of the MHSA. Prevention</p>	Accept	Amend Sections 3705 and 3720 to require the county to include at least one Prevention Program and add an exemption for small counties defined as less than 200,000 (Title 9 California Code of Regulations Section 3200.260)	<p>1. MHSOAC legal counsel is of the opinion that changing a Prevention Program from optional to a requirement is legally permissible pursuant to the MHSOAC's authority to "implement" the PEI Component of the MHSA. The Administrative Procedures Act defines regulations as rules or standards to "implement, interpret, or make specific". The proposed regulations as adopted by the Commission were based on a strict construction of the MHSA; however, a less strict construction is legally tenable and defensible. The suggested change fits as one way to implement the overall purpose of the PEI Component which is to prevent mental illness from becoming severe and disabling.</p> <p>2. Staff agrees with the suggestion and recommends that counties, with the exception of small counties (population under 200,000) include at least one Prevention Program.</p> <p>One way of preventing mental illness from becoming severe and disabling is to intervene at the point of risk.</p>

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		<p>activities that provide outreach, linkage, and access will reduce the likelihood of the negative outcomes that may result from untreated mental illness.</p> <p>Current statistics show that as many as three million California children and youth can be expected to experience mental health problems in any given year. Children with unaddressed mental health problems are highly likely to experience a myriad of negative outcomes (as identified by the MHSA) that include suicide, incarceration, school failure or dropout, unemployment, prolonged suffering, homelessness, and removal of children from their homes as a consequence of untreated mental illness. Research shows that successful prevention models that have demonstrated positive outcomes with children and youth from diverse cultures and communities. However, among the populations of California, these programs are severely underutilized.</p> <p>According to the Little Hoover Commission, "Prevention offers the greatest opportunity to serve the most needs in the most cost-effective manner" and can avoid, reduce, or resolve many of the serious problems that affect children, youth, and their families. This approach offers the greatest possible benefit not only to children and their families, but also to California as a whole.</p>			<p>Research referenced in the Initial Statement of Reasons documents that this is a sound practice that can either prevent the mental illness from occurring or at least can prevent the devastating consequences if one develops. Research supports the demonstrated success in identifying and responding to a range of factors that put people across the lifespan, especially children and youth at risk for developing a mental disorder, as well as the value of strengthening protective factors for individuals with higher than average risk of a mental illness.</p> <p>The rationale for exempting small counties from the requirement to offer a Prevention Program is that because of their small population, it might not be as effective to dilute their efforts.</p>

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		<p>Eliminating the need for prevention programs within counties will have negative consequences for children, youth, and families in California and will mark a “one step forward, two steps back” effort. At one time, the MHSOAC put emphasis on prevention with regard to children and youth as a proactive measure to ensure that families and children, as well as underserved communities, have the necessary education and awareness to identify individuals at risk and access care in a manner that helps to reduce the need for emergency services and crisis management. Those proactive measures will also help to alleviate unnecessary stress on emergency rooms, diminish the perpetual school to prison pipeline, and the involvement of child welfare systems. Prevention efforts also ensure our systems maintains the true purpose of the MHSA which is to “help first”, not “fail first” by building a system where children, youth, and families are not underrepresented and unserved, accessing care only after a crisis has occurred.</p> <p>The well documented, significant personal, social, and financial toll that mental health disorders exact on our society makes outreach and prevention a necessary and responsible requirement. The total cost in the U.S. associated with behavioral health problems in children and youth is nearly \$247 billion per year.</p>			

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		<p>When considering the full life span, that number climbs to \$510 billion.</p> <p>Evidence-based prevention programs and policies are widely available for implementation. These programs have been found to reduce risk factors, strengthen protective factors and decrease psychiatric symptoms and disability and the onset of some mental disorders. They also improve positive mental health, contribute to better physical health and generate positive social and economic outcomes. Effective prevention interventions support children's healthy social, emotional, and mental health development which in turn will have positive effects on academic and life success. In contrast, unrecognized and untreated mental health problems in children have serious personal, family, and societal consequences. Childhood is a period of utmost importance with regard to prevention, awareness, and recognition of emotional and behavioral problems that often can lead to mental disorders that last well into adulthood and, if untreated or unnoticed, can and will worsen over time.</p> <p>Effective Prevention programs make a noticeable and lasting difference in communities. Currently, 97% of all California counties have Prevention programs already in place. This further demonstrates that our requests are not</p>			

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		<p>creating additional work or burdensome deliverables. We are simply asking to preserve what is already in place. Prevention and Early Intervention strategies provide the MHSOAC and California a wonderful opportunity to set an example of visionary leadership in children's mental health.</p>			
3705(b)(1)	Commenter #3	<p><u>Comment 3.08</u> (3) [moved from subsection (b) to subsection (a) to make it mandatory, and then renumbered] One or more Prevention programs as defined in Section 3720. <u>Every such program may contain Prevention elements, as defined in Section 3720, as well as Early Intervention elements, as defined in Section 3710.</u></p> <p>Authority/Reference for the change from discretionary to mandatory: MIPO moved subsection (b)(1) to a new subsection (a)(3) to make the program mandatory, rather than discretionary. MHSOAC has no authority to change a statutory mandate that uses the term "shall," into a discretionary "may." Welfare & Institutions Code section 5840(a) provides that "[t]he State Department of Health Care Services, in coordination with counties, <i>shall</i> establish a program designed to prevent mental illnesses from becoming severe and disabling." Section 5840(c) specifies that "[t]he program <i>shall</i> include mental health</p>	<p>Accept in part: make Prevention mandatory Reject in part: new language</p>	<p>See changes proposed above in response to Comment 60.02</p>	<ol style="list-style-type: none"> 1. For the rationale supporting recommendation to move Prevention from discretionary to mandatory, see above response to Comment 60.02 on proposed regulation Section 3705. 2. The comments regarding the authority to change "shall" to "may", the definition of "prevention" programs as relapse prevention, and the requirement for "effective" programs are the same as Comment 3.09. Therefore the responses are the same. See above responses to Comment 3.09 to proposed regulation Section 3705(a)

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		<p>services similar to those provided under other programs effective in preventing mental illnesses from becoming severe... " (emphasis added).</p> <p>Authority/Reference/Necessity for the added sentence: MHSOAC has no statutory authority to create an artificial distinction between prevention and early intervention services. Section 4 of the Mental Health Services Act draws no such distinction. If MHSOAC did not intend to create this artificial bifurcation, the proposed change is necessary for clarity.</p> <p>MIPO's proposed changes are also necessary to conform the regulation to the requirements of the statute. Further, unless amended as proposed by MIPO, the regulation will create burdensome requirements and ineffective programs. Effective PEI programs necessarily contain both prevention and early intervention elements because shifts in mental status, from no mental illness or "mental illness" into "severe mental illness" can occur suddenly.</p> <p>Authority for the change from discretionary to mandatory: MHSOAC has no authority to change a statutory mandate that uses the term "shall," into a discretionary "may." Welfare & Institutions Code section 5840(b) provides: "The program <i>shall</i> include the</p>			

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		<p>following components.... (3) Reduction in stigma associated with either being diagnosed with a mental illness or seeking mental health services. (4) Reduction in discrimination against people with mental illness.</p> <p>Necessity for change: Necessary for conformity to statute.</p> <p>Authority/necessity for changing "programs/approaches" to "components": Refer to statutory language quoted above. The statute identifies stigma and discrimination reduction as "components" of a "program," not as "programs/approaches" as set forth in MHSOAC's proposed regulation.</p> <p>(3) (5) [renumbered only] The strategies defined in Section 3735.</p> <p>(b) The county may include in its Prevention and Early Intervention Component:</p> <p>(3)[renumbered only] <u>(1)</u> One or more Suicide Prevention programs/approaches strategies as defined in Section 3730.</p>			
3710(a)-(b)	Commenter #3	<p><u>Comment 3.10</u> Section 3710. Early Intervention Program. (a) The county shall offer at least one Early Intervention program as defined in</p>	Accept in part and reject in part	Amend proposed Section 3710(b) and delete 3710(e) as follows:	<ol style="list-style-type: none"> 1. Staff proposes to clarify that Early Intervention includes relapse prevention by moving and modifying the language originally included as subdivision (e) into subdivision (b). 2. The comment confuses medically necessary treatment

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		<p>this section. (b) "Early Intervention program" means: services that provide treatment and other services and interventions to address and promote recovery and related functional outcomes for a <u>severe</u> mental illness early in its emergence, including the applicable negative outcomes listed in 5840(d) that result from untreated mental illness. <u>(1) medically necessary care 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. Each program shall include services similar to those provided under other programs effective in preventing mental illnesses from becoming severe.</u> [renumbered] (e) Early Intervention programs may include efforts to prevent relapses in an individual with early onset of a serious <u>severe</u> mental illness. <u>Each program shall emphasize strategies to reduce all applicable negative outcomes in Welfare and Institutions Code 5840(d). To qualify for an early intervention program, an individual must have a diagnosis of mental illness as defined herein; and</u> <u>(2) Programs designed to intervene early in relapses into severe mental illness, as defined herein. Such programs shall be similar to programs that have been successful in reducing the duration of</u></p>		<p>Proposed regulation Section 3710 (b): "Early Intervention Program" means treatment and other services and interventions, <u>including relapse prevention</u>, to address and promote recovery and related functional outcomes for a mental illness early in its emergence, including the applicable negative outcomes listed in WIC 5840, subdivision (d), that may result from untreated mental illness</p> <p>...</p> <p>(e) Early Intervention program may include efforts to prevent relapse in an individual with early onset of a mental illness</p>	<p>for individuals across the lifespan with a serious mental illness, as defined in 5600.3, which is funded under the Community Services and Supports component (Adult and Children's Systems of Care) component of the MHSA, with the PEI component, which includes a variety of approaches that collectively are intended to prevent mental illnesses from becoming severe and disabling.</p> <p>3. The Comment incorrectly interprets WIC 5840 (b)(2). Subdivision (b)(2) of WIC Section 5840, which requires the PEI Component to provide "access and linkage" (i.e. referrals) to medically necessary care provided by county mental health programs for children and adults with severe mental illness. PEI does not fund the service to which the person with severe mental illness, beyond early intervention, is referred.</p> <p>4. The suggested language that each program be required to emphasize strategies to reduce all applicable negative outcomes in WIC 5840(d) is already in the proposed regulations. Proposed regulations require all Early Intervention Programs to address the negative outcome of Reduced Prolonged Suffering, which is defined as reduced symptoms of a mental disorder, and the other negative outcomes that apply to the specific program.</p> <p>5. Diagnosis requirement: The MHSA does not require a "diagnosis" and therefore the suggested language requiring such a diagnosis is rejected. Proposed PEI regulations apply to and are consistent with the WIC 5600.3 definition of a "serious mental disorder": "a mental disorder that is severe in degree and persistent in duration, which may cause behavioral functioning which interferes substantially with the primary activities of daily living, and which may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long</p>

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		<p><u>untreated severe mental illnesses and assisting people in quickly regaining productive lives. Each program shall emphasize strategies to reduce all applicable negative outcomes in Welfare and Institutions Code 5840(d). An individual must have a diagnosis of severe mental illness as defined herein to qualify for programs that intervene early in relapses into severe mental illness, unless the program provides short term crisis services for those suspected of mental illness.</u></p> <p>Reference/Authority for the deletion: MHSOAC has no authority to alter, expand or amend the statute, which is both clear and sufficiently detailed to define "early intervention program." MHSOAC has no statutory authority to address "untreated mental illness." MHSOAC has no statutory authority to address "mental illness early in its emergence." MHSOAC also has no authority to ignore the "medical necessity" standard for care, or to leave the term "severe" out of its proposed regulation. MHSOAC has no statutory authority to attempt to prevent "mental illness," nor is it possible to do so. Its statutory authority relating to early intervention extends only to establishing programs that prevent "mental illness" from becoming "severe" mental illness pursuant to Welfare & Institutions Code section 5840(a), by providing "medically</p>			<p>or indefinite period of time. Serious mental disorders include, but are not limited to, schizophrenia, bipolar disorder, post-traumatic stress disorder, as well as major affective disorders or other severely disabling mental disorders." This definition does not limit a serious mental disorder based on diagnosis.</p> <p>6. Relapse prevention: The comment's suggested language regarding "relapse prevention" is rejected for the reasons stated in Response 3 Comment 3.09.</p> <p>7. The comment is incorrect that the MHSOAC has no statutory authority to address "untreated mental illness. One of the purposes of the MHSA is to reduce the long-term adverse impact resulting from untreated serious mental illness. (Uncodified Section 3(b)) With this overall purpose, the MHSA provides five different components that together work toward fulfilling this goal. PEI is one of the five components. WIC Section 5840(d) specifically requires the PEI programs to "emphasize strategies to reduce the negative outcomes of untreated mental illness". WIC Section 5840(d) does not use the term "serious".</p> <p>8. The comment is incorrect that the MHSOAC has no statutory authority to address mental illness early in its emergence." The statutory purpose of the PEI set forth in WIC Section 5840 of the MHSA is to prevent mental illnesses from becoming severe and disabling, not to treat severe mental illness that has already developed, beyond early intervention There is no agreement in the field of mental health that it is impossible in all instances to prevent a serious mental illness. There is widespread agreement that it is possible to prevent the negative and disabling consequences of serious mental illness. See references cited in the Initial Statement of Reasons.</p> <p>9. The MHSA (WIC 5840(b)(2)) refers to "severe mental illness, as defined in Section 5600.3." Section 5600.3</p>

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		<p>necessary" care pursuant to section 5840(c). See <i>also</i> the MHSA's provisions cited below under "Reference/Authority for the added language."</p> <p>Rationale/Necessity for deletion: Necessary for conformity to statute, which MHSOAC's Proposed amends, alters and enlarges. Also necessary to prevent continued waste of public funds, in contravention of statute, on individuals who are not mentally ill and will never be mentally ill, much less severely mentally ill.</p> <p>Reference/Authority for the added language: Subsection b(l), first sentence: taken straight from Welfare & Institutions Code section 5840(b)(2), which provides for "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 <i>these conditions</i> as practicable. Second sentence: taken straight from Welfare & Institutions Code section 5840(c) which provides: "The program shall include mental health services similar to those provided under other programs effective in preventing <i>mental illnesses</i> from becoming <i>severe</i>." Third sentence: taken from MHSOAC's</p>			<p>refers to "seriously emotionally disturbed children or adolescents" ((a)(1)) and to "adults and older adults who have a serious mental disorder" (b). Draft PEI regulations apply to and are consistent with the WIC 5600.3 definition of a "serious mental disorder," which includes the concept of severity. The reference in WIC 5840(b)(2) to "severe mental illness" "as defined in Section 5600.3" links to the definition of "serious mental illness," suggesting that these terms are used interchangeable in the MHSA</p> <p>10. The comment that the MHSOAC has "no authority to ignore the medical necessity standard" is based on incorrect interpretation of the MHSA. WIC Section 5840 (b)(2) cited in the comment requires referrals to medically necessary care provided by county mental health programs for children and adults with severe mental illness. PEI does not fund the service to which the person with severe mental illness, beyond early intervention, is referred. See Response 2 to Comment 3.10.</p>

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		<p>Proposed regulation. Fourth sentence: taken straight from Welfare & Institutions Code section 5840(d), which provides: "The program <i>shall</i> emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness: (1) Suicide. (2) Incarcerations. (3) School failure or dropout. (4) Unemployment. (5) Prolonged suffering. (6) Homelessness. (7) Removal of children from their homes. Final sentence: based on Welfare & Institutions Code section 5840(a), the introductory provision to the Prevention/Early Intervention requirements, which provides for a "program designed to prevent <i>mental illness</i> from becoming <i>severe</i> and disabling;" and section 5840(b)(2), which provides for "medically necessary care provided by county mental health programs for children with <i>severe mental illness</i>, as defined in Section 5600.3, and for adults and seniors with <i>severe mental illness</i>, as defined in Section 5600.3, as early in the onset of <i>these conditions</i> as practicable" (emphasis added). See also the MHSA's Findings, Declarations, Purposes and Intent provisions.</p> <p>Subsection b(2), first sentence: taken straight from Welfare & Institutions Code section 5840(c), which provides that PEI programs "<i>shall also</i> include components similar to programs that have been successful in reducing the duration of</p>			

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		<p>untreated <i>severe mental illnesses</i> and assisting people in quickly regaining productive lives." Second sentence: taken straight from Welfare & Institutions Code section 5840(d), which provides: "The program <i>shall</i> emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness: (1) Suicide. (2) Incarcerations. (3) School failure or dropout. (4) Unemployment. (5) Prolonged suffering. (6) Homelessness. (7) Removal of children from their homes. Third sentence: based on Welfare & Institutions Code section 5840(c), quoted above. Final sentence: MIPO believes an exception to the statutory requirement of a diagnosis of severe mental illness (<i>see Welfare & Institutions Code 5840(b)(2) and (c)</i>), is necessary for crisis interventions, when taking time to obtain a diagnosis is neither appropriate or practical.</p> <p>Rationale/Necessity for added language: Subsection b(1): Necessary for conformity to statute, which MHSOAC has attempted to alter, amend and enlarge. Subsection b(2): Necessary for conformity to statute, which MHSOAC has attempted to alter by ignoring the double statutory mandate (a "shall" within a "shall") for relapse early intervention programs. Also necessary to ensure proper expenditures are made pursuant to the foregoing mandate,</p>			

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		which has been ignored for ten years.			
3710 (a) and (b)	Commenter #3	<p><u>Comment 3.13</u> MIPO's comments regarding proposed section 3710(a) and (b): MHSOAC's proposed section 3710(b) alters and enlarges the MHSA, most glaringly in its omission of the term "severe." This is a continuation of what MHSOAC has done for over ten years with its "policies" and pseudo-regulations. See MIPO Comment No.1.</p> <p>Nothing in the MHSA authorizes MHSOAC's attempts to help people in "early onset" of "mental illness." MHSOAC's misguided approach has resulted in millions of dollars in wasted funds, as counties created programs to try to make people happier, on the theory that negative life experiences (referred to by mental health professionals as "trauma") cause "mental illness," which can somehow be addressed by dance programs, drumming circles, horseback riding, anti-bullying programs, and the like. The Proposers of the MHSA wisely attempted to forestall this kind of waste by requiring a diagnosis of, at minimum, a "mental illness" that may become a "severe mental illness," in order for individuals to qualify for prevention/early intervention programs.</p> <p>MHSOAC should not be permitted to</p>	Reject	Retain existing language with no change	<ol style="list-style-type: none"> 1. The comment that the proposed regulations alter and enlarge the MHSA is based on a lack of understanding of the MHSA and an erroneous interpretation of WIC Section 5840. The purpose of the PEI Component of the MHSA is set forth in WIC Section 5840(a) which is to prevent mental illnesses from becoming severe and disabling. The PEI Component is not intended to treat individuals who are already severely mentally ill. The CSS component is the part of the MHSA that is intended to treat individuals who are already severely mentally ill. Proposed PEI Regulations permit counties to offer a Prevention Program to prevent relapse for individuals in recovery from a severe mental illness, since they constitute a high-risk group. This is in addition to the requirement to offer at least one Early Intervention Program, which includes relapse prevention. See Responses to Comment 3.10 above. 2. The comment that MHSOAC does not have authority to "help people in early onset of mental illness" is incorrect. Responding to people early in the onset of a potentially serious mental illness is one way to prevent mental illnesses from becoming severe and returning people to effective functioning, as required by the MHSA (WIC Section 5840). Prevention and Early Intervention Programs are required to focus on risk or early onset of a mental illness that may become a severe or serious mental illness. 3. The proposed regulations do not rewrite nor expand upon the MHSA. The proposed regulations clarify, interpret, and implement the programs as is permitted by the Administrative Procedures Act because the statutory language is not sufficiently clear. 4. For additional detailed responses see the responses to

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		<p>rewrite and expand upon the statute's early intervention provisions when those provisions are sufficiently clear to define the programs that are to be provided. MIPO's proposed changes to section 3710 prove this point as they use <i>only</i> statutory language. The language from the MHSA requires <i>two</i> kinds of early intervention: one for individuals who are in the early stages of "severe mental illnesses," as early in "these conditions " as possible (see Welf. & Inst. Code § 5840(b)(2); and one for individuals who are already severely mentally ill, but who are in relapse, so as to "reduc[e] the duration of untreated severe mental illnesses and assist[] people in quickly regaining productive lives (<i>id</i> at §5840(c). These are two very different populations, and they require very different programs. MIPO has therefore addressed them in separate subsections, both of which simply quote the statute.</p> <p>In the last sentence of each subsection, MIPO reiterates the statutory minimums that qualify individuals for each program: in subsection (1), an existing "mental illness" that is in danger of becoming "severe mental illness," for intervention "as early in these conditions as possible"; and in subsection (2), a "severe mental illness," for relapse prevention programs. (MIPO created an exception for short term crisis interventions targeted to the severely</p>			<p>Comment 3.10 on proposed regulation Section 3710.</p>

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		mentally ill, when taking time for a diagnosis is neither appropriate nor practical.) MHSOAC, in contrast, requires no mental illness diagnosis whatsoever in any of its regulations. MHSOAC has also completely ignored the statutory mandate requiring relapse prevention/early intervention services for people who already have severe mental illness, just as MHSOAC has done for the past ten years under its "policies" and pseudo-regulations.			
3705(b) General Requirements	Commenter #42	<u>Comment 42.01</u> I would like Stigma and Discrimination Reduction Programs to be required of every county, <u>not optional.</u> I understand that this could be a burden for small counties. However, couldn't small (or any) counties have the option of contributing to CalMHSA statewide Stigma and Discrimination program to meet this requirement?	Reject	Retain existing language with no change	The proposed regulations currently already require all counties to fulfill the stigma and discrimination reduction requirement by designing, promoting, and implementing all PEI programs in ways that are non-stigmatizing and non-discriminatory. In addition, counties also have the option to offer a Stigma and Discrimination Program. The suggestion is rejected because given the small size of many California counties and the existence of a statewide stigma and discrimination reduction program, funded by PEI it seems more efficient to allow counties through the community program planning process to decide whether to have an additional program.
3705(b)	Commenter #39	<u>Comment 39.04</u> I agree with Sally Zinman's comment regarding the use of the word "may" in section 3705(b). It should be "shall."	Reject	Retain existing language with no change	See Response to Comment 42.01
3710(a)-(c)	Commenter #8	<u>Comment 8.35</u> (a) The County shall offer at least all one Early Intervention programs as defined in this section. "Early Intervention program" means treatment and other services and	Accept in part and Reject in part	Same suggested changes as listed above in response to Comment 3.10.	1. Proposed PEI Regulations require all counties to offer at least one Early Intervention Program. There is no reason or basis to require a County to offer "all Early Intervention Programs." An additional way to prevent a mental illness from becoming severe and disabling is by

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		<p>interventions to address and promote recovery and related functional outcomes for a mental illness early in its emergence, including the applicable programs that reduce negative outcomes listed in Welfare and Institutions Code Section 5840, subdivision (d) that result from untreated mental illness; <u>Access and linkage to medically necessary care 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. Each program shall include services similar to those provided under other programs effective in preventing mental illnesses from becoming severe;</u> Early Intervention program 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, in which case early intervention services shall not exceed four years. (b) Early Intervention program services may include services to parents, caregivers, and other family members of the person with early onset of a mental illness, as applicable. (c) Early Intervention program may <u>shall</u> include efforts to prevent relapse in an individual with <u>as</u> early <u>in</u> onset of a <u>severe</u> mental illness</p>			<p>intervening at the point of risk, before a mental illness has developed. Doing so can in some instances prevent the serious mental illness from occurring and/or can significantly reduce negative consequences if a serious mental illness develops.</p> <ol style="list-style-type: none"> 2. The proposed regulations require all Early Intervention Programs to address the applicable MHSA outcomes (WIC 5840(d)) that may result from untreated mental illness. It is unrealistic for all Early Intervention Programs to address all the negative outcomes in WIC 5840(d) as suggested by the comment. A program to reduce suicidality in older adults with early onset of major depressive disorder is not intended to reduce school failure, for example. Proposed regulations require all Early Intervention Programs to address the negative outcome of Reduced Prolonged Suffering, which is defined as reduced symptoms of a mental disorder, and the other negative outcomes that apply to the specific program. 3. Access and linkage to medically necessary care: The comment's suggested language is rejected because proposed regulation Section 3735(a)(1) require all PEI programs, including Early Intervention Programs, to provide access and linkage to medically necessary care for people across the lifespan with serious mental illness, as required by WIC 5840(b)(2). 4. Deleting the time limit for early intervention programs confuses the Early Intervention Program under PEI programs with treatment under the CSS programs. Early intervention services may not exceed 18 months because the expectation is that individuals receiving services through Early Intervention Programs will improve within that timeframe, thereby enabling the individual to avoid more extensive mental health services. If an individual with mental illness is likely to need treatment or other interventions for a longer

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		<p>as practical. And <u>(2) Programs designed to intervene early in relapses into severe mental illness. as defined herein. Such programs shall be similar to programs that have been successful in reducing the duration of untreated severe mental illnesses and assisting people in quickly regaining productive lives. Each program shall emphasize strategies to reduce applicable negative outcomes in Welfare and Institutions Code 5840(d). An individual must have a diagnosis of severe mental illness as defined herein to qualify for programs that intervene early in relapses</u></p>			<p>duration, the individual is better served by initiating treatment within the Children's or Adult System of Care. There is an exception for individuals with a psychotic disorder because evidence suggests that they can benefit from early interventions that last longer than 18 months.</p> <p>5. Relapse prevention: Proposed PEI Regulations specify that relapse prevention is both an important element of an Early Intervention Program and also an allowable population at risk for the focus of a Prevention Program. The suggested language is rejected because the Proposed PEI Regulations do not specify all the essential elements of an Early Intervention Program, such as a focus on relapse prevention. MHSOAC staff suggests a modification to the language in proposed regulation Section 3710(b) to make it explicit that Early Intervention Programs include relapse prevention. See Response to Comment 3.10</p> <p>6. Suggestion to include language regarding successful programs is rejected because that requirement is already in proposed regulation Section 3740, which requires all programs to use methods that have demonstrated their effectiveness for the intended population.</p> <p>7. Required diagnosis: See response above to Comment 3.10 on proposed regulation Section 3710.</p>
3710(c)	Commenter #44	<p><u>Comment 44.06</u> Section 3710(c) provides for maximum program duration of 18 months unless the individual is experiencing psychotic features, and then deletes reference to the definition as found in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, criteria for Schizophrenia Spectrum and Other Psychotic Disorders.</p>	Agreed	<p>Add a new subpart to subdivision (c) as follows: Section 3710(c)(1) <u>For purpose of this section, "serious mental illness or emotional disturbance with psychotic features"</u></p>	<p>To clarify the regulations it is recommended that the definition from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition be added to the Proposed PEI Regulations. Currently, the reference to and definition from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition is included in the Initial Statement of Reasons.</p>

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		<p>RECOMMENDATION: Restore reference to the DSM V criteria for Schizophrenia Spectrum and Other Psychotic Disorders.</p> <p>COMMENT and RATIONALE: without a required standard reference such as the DSM there is no consistency and reliability in deciding who is allowed an additional period of services under this regulation. Further, there will be no way to determine for oversight and accountability purposes whether admissions to such programs are appropriate. County data will also lack comparability if each county is free to make up whatever standard it chooses. There may be inequities in the availability of services both within counties and between counties who may have similar services but exercise different internal definitions. Having no standard creates a muddle.</p>		<p><u>means, Schizophrenia spectrum and other psychotic disorders include schizophrenia, other psychotic disorders, and schizotypal (personality) disorder). They are defined by abnormalities in one or more of the following five domains: delusions, hallucinations, disorganized thinking (speech), grossly disorganized or abnormal motor behavior (including catatonia), and negative symptoms.</u></p>	
3710 (c)	Commenter #3	<p><u>Comment 3.14</u> MIPO's comments regarding proposed section 3710(c): MHSOAC has no statutory authority to limit services to people who are at risk of "severe mental illness." The arbitrary time limits of 18 months and four years in proposed section 3710(c) has no basis in statute. MHSOAC's rationale seems to be that people with minor conditions will not need long term treatment, but MHSOAC is not supposed to be funding</p>	Reject	Retain existing language with no change	<ol style="list-style-type: none"> 1. Proposed regulation Section 3710(c) does not limit services to people who are at risk of severe mental illness as stated in the comment. 2. It is incorrect that the MHSOAC lacks authority to set time limits for PEI programs. The Administrative Procedures Act provides for regulations to implement statute. One of the purposes of the MHSA is to reduce the long-term adverse impact resulting from untreated serious mental illness. (Uncodified Section 3(b)) Toward this overall purpose, the MHSA provides five different components that together work toward fulfilling this goal. Because of the MHSA's structure of having CSS

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		<p>programs for people with minor conditions, a past practice that was contrary to statute and must stop.</p> <p>People who are truly at risk of "severe mental illness" may need services for many years, to prevent their conditions from becoming "severe and disabling." By definition, if such programs are successful, they will continue to stave off "severe mental illness" entirely. And severely mentally ill people need relapse prevention services over the course of an entire lifetime. (In fairness, MHSOAC did not suggest otherwise, because once again, it did not address the severely mentally ill at all in this provision, despite the statutory mandate that services be provided to them.)</p>			<p>program promote recovery for individuals with serious mental illness and PEI programs to prevent mental illness from becoming severe and disabling, there is a need to differentiate these two components. See above Response to Comment 8.35 on proposed regulation Section 3710.</p> <p>3. Relapse prevention for individuals who are in recovery from a serious mental illness is an allowable focus of a Prevention Program, which has no time limit.</p>
3710(c)	Commenter #3	<p><u>Comment 3.11</u> (c) Early Intervention program 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, in which case early intervention services shall not exceed four years.</p> <p>Reference/Authority/Necessity for the deletion: Necessary for conformity to</p>	Reject	Retain existing language with no change	Comment that "nothing in the MHSA authorizes denial of services after a specific time" misunderstands the structure of the MHSA and the relationship of the CSS and PEI programs. The proposed regulations are limited to PEI and do not cover CSS.

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		<p>statute, because nothing in the MHSA authorizes denial of services after a specified period.</p> <p>Necessity for the deletion: Necessary for conformity to statute, which MHSOAC's proposed regulation alters and amends.</p>			
3710(d)	Commenter #3	<p><u>Comment 3.12</u> (d) Early Intervention program services may include services to parents, caregivers, and other family members of the person with early onset mental illness <u>or severe mental illness as defined herein, as long as such services have been shown to be effective in preventing the mental illness of patients from become severe, or successful in reducing the duration during which a patient's severe mental illness goes untreated.</u></p> <p>Reference/Authority for the deletion: MHSOAC has no statutory authority to intervene in "early onset" of "mental illness," nor is it possible to do so. MHSOAC's authority under the MHSA is to address an existing "mental illness" that may become "severe and disabling" with "medically necessary" care. See the MHSA's Findings, Declarations, Purposes and Intent provisions. See also Welfare & Institutions Code section 5840(a) which provides, "The State... shall establish a program designed to prevent <i>mental illnesses</i> from becoming <i>severe and disabling</i>;" section 5840(c),</p>	Reject	Retain existing language with no change	<ol style="list-style-type: none"> 1. An individual who is already seriously mentally ill, beyond early onset, is not eligible for or an appropriate recipient of a Prevention Program or an Early Intervention Program, which are intended to prevent a mental illness from becoming severe and disabling. 2. The requirement for services to have been shown to be effective is already in the proposed regulations Section 3740. This requirement includes programs that involve family members. 3. The comment that the MHSOAC lacks statutory authority to intervene in "early onset" of mental illness is the same argument as set forth in Comment 3.10 to proposed regulation Section 3710 above. See Responses to Comment 3.10 above. 4. The comment regarding the "medically necessary care" under WIC 5840(b)(2) is the same as set forth in Comment 3.10 to proposed regulation Section 3710 above. Therefore the responses are the same. See Responses to Comment 3.10. 5. The requirement that a County <i>shall</i> include at least one Early Intervention Program implements the MHSA mandate that the County's PEI program includes "mental health services similar to those provided under other programs effective in preventing mental illnesses from becoming severe" and shall also include components similar to programs that have been successful in "assisting people in quickly regaining productive lives." An additional way to prevent a mental illness from becoming severe and disabling is by

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		<p>which provides, "The program <i>shall</i> include mental health services similar to those provided under other programs effective in <i>preventing mental illnesses</i> from becoming <i>severe</i>;" and section 5840(b)(2), which authorizes only "<i>medically necessary</i> care provided by county mental health programs for children with <i>severe mental illness</i>, as defined in Section 5600.3, and for adults and seniors with <i>severe mental illness</i>, as defined in Section 5600.3, as early in the onset of <i>these conditions</i> as practicable" (emphasis added). <i>See also the MHSA's Purpose and Intent</i> section 3(c) (referencing "medically necessary" care.)</p> <p>Rationale/Necessity for the deletion: Necessary for conformity to statute, which MHSOAC's proposed regulation alters and enlarges.</p> <p>Reference/Authority for the added language: Taken straight from Welfare & Institutions Code section 5840(c), which provides: "The program shall include mental health services similar to those provided under other programs effective in preventing mental 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." MHSOAC's</p>			<p>intervening at the point of risk, before a mental illness has developed.</p> <p>6. The comment is incorrect that "MHSOAC's only authority to provide programs for family members/caregivers is limited to education." Providing the option to include family members in various capacities of service delivery, including as direct recipients, is necessary because of the great toll that onset of a serious mental illness imposes on family members, the numerous, multi-dimensional contributions family members make to recovery from serious mental illness, the fact that most people with serious mental illness prefer that their family members be involved, and robust evidence that offering services to family members is effective and valuable. This section is necessary to ensure consistency with the Findings and Declarations section of the MHSA, which states that programs "emphasize client-centered, family-focused and community-based serves that are culturally and linguistically competent and are provided in an integrated system."</p>

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		<p>only authority to provide programs for family members/caregivers is limited to education, i.e., "to recognize the early signs of potentially severe and disabling mental illnesses" pursuant to Welfare & Institutions Code section 5840(b)(1). MHSOAC's only authority to extend treatment programs to families/caregivers is if such treatment is "effective in preventing mental illnesses from becoming severe" or "successful in reducing the duration of untreated severe mental illnesses and assisting people in quickly regaining productive lives," and thus a component of "medically necessary care" pursuant to Welfare & Institutions Code section 5840(b)(1).</p> <p>Rationale/Necessity for the additional language: Necessary for conformity to statute, which MHSOAC's proposed regulation amends, alters and enlarges.</p>			
3710(d)	Commenter #3	<p><u>Comment 3.15</u> MIPO's comment regarding proposed section 3710(d):</p> <p>Once again, proposed section 3710(d) seeks to intervene "early onset" of "mental illness," when the statute only authorizes intervention in "early onset" of "severe mental illness." On this ground alone, the regulation must be changed to conform to the statute. Additionally, MHSOAC's proposed regulation fails to recognize</p>	Reject	Retain existing language with no change	<ol style="list-style-type: none"> 1. This comment confuses medically necessary treatment for individuals across the lifespan with a serious mental illness, as defined in WIC 5600.3, which is funded under the CSS component of the MHSA, with the PEI component, which includes a variety of approaches that collectively prevent mental illnesses from becoming severe and disabling. See Responses to Comment 3.10 2. Comment is incorrect that the proposed regulations do not distinguish between education and treatment for family members and caregivers. The proposed regulations have two sections separately dealing with these two areas. Proposed regulation Section 3715 sets

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		<p>the MHSA's distinction between education and treatment programs for family members and caregivers. Education outreach programs are explicitly authorized to help family members (and others) "recognize the early signs of potentially severe and disabling mental illnesses." In contrast, early intervention treatment programs for family members (and others) must meet the same qualifications as treatment programs for the underlying patient: they must be (a) "effective in preventing the mental illness from becoming severe," in the case of early intervention in existing "mental illnesses" that are in danger of becoming "severe," or (b) "successful in reducing the duration of untreated severe mental illness," in the case of relapse prevention programs for the severely mentally ill. MIPO's suggested changes to the proposed regulation correct this deficiency.</p>			<p>from the requirements for education and proposed regulation Section 3710(d) deals with services.</p> <p>3. Early Intervention Programs that include services to parents, caregivers, and other family members must meet the same standards of effectiveness that apply to any other Early Intervention Program with regard to MHSA-specified outcomes for individuals with early onset of a potentially serious mental illness.</p> <p>4 The MHSA PEI requirement to reduce the duration of untreated mental illness refers to reducing the time between the onset of the mental illness and entry into treatment. For this reason, Proposed PEI Regulations require all PEI programs to include strategies to create access and linkage to treatment for individuals with severe mental illness (proposed regulation Section 3735(a)(1)(A)), to use effective methods for this purpose (proposed regulation Section 3740), and to measure the duration between onset of symptoms and entry into treatment (proposed regulation Section 3560.010(b)(3)(C)).</p>
3715(c)	Commenter #6	<p><u>Comment 6.04</u> Please call out Family Law mediators, courts, etc. in this list, even if it's stated that "responders" are not limited to . . .</p>	Accept in part and reject in part	<p>Amend subdivision (c) of Proposed Section as follows:</p> <p>Section 3715(c): "Potential responders" include, but are not limited to, families, employers, primary health care providers, <u>visiting nurses</u>, school personnel, community service providers, peer</p>	<p><u>Added example is useful and relevant.</u></p>

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				<p>providers, cultural brokers, law enforcement personnel, emergency medical service providers, people who provide services to individuals who are homeless, <u>family law practitioners such as mediators, child protective services,</u> leaders of faith-based organizations, and others in a position to identify early signs of potentially severe and disabling mental illness, provide support, and/or refer individuals who need treatment or other mental health</p>	
3715(c)	Commenter #8	<p><u>Comment 8.36</u> (c) "Potential responders" include, but are not limited to, <u>to, families, of people with serious mental illness employers,</u> primary health care providers, school personnel, community service providers, peer providers, <u>cultural brokers,</u> law enforcement personnel, emergency medical service providers, people who provide services to individuals who are homeless, leaders of faith-based organizations, and others <u>more likely than the general population to come into contact with those who -have in a</u></p>	Reject	Retain existing language with no change	<p>1. Deleting "employers" would be inconsistent with the MHSA because "employers" are specifically listed in WIC Section 5840(b)(1)</p> <p>2. "Cultural brokers" is one example of "and others" in WIC Section 5840(b)(1). The potential responders listed are examples of those who are well positioned to be able to recognize early signs of potentially severe and disabling mental illness. There is no reason to eliminate cultural brokers from the list. Cultural brokers are particularly likely to recognize early signs and symptoms of potentially severe and disabling mental illness among diverse and underserved ethnic and cultural groups, and are an especially essential focus of outreach in order to address the PEI goal to improve timely access to services for underserved populations (WIC 5840(a)).</p>

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		position to identify early signs of potentially severe and disabling mental illness, provide support, and/or refer individuals who need treatment or other mental health services			<p>3. Existing language in Proposed PEI Regulations lists families of people with mental illness, which includes families of people with severe mental illness. There is no rational basis to exclude families of people with a mental illness that has not yet become severe from the list of examples of potential responders.</p> <p>4. Existing language in Proposed PEI Regulations related to others in a position to identify early signs of potentially severe mental illness is consistent with WIC 5840(b)(1); suggested language referring to those “more likely than the general population” is not necessary.</p>
3715(c)	Commenter #36	<p><u>Comment 36.06</u> Section 3715, subdivision (c) <i>Recommendation:</i> Call out Family Law mediators, courts, Child Protective Services, and the use of culturally responsive strategies. <i>Rationale:</i> Diverse families involved in the legal system are vulnerable to developing mental health problems, which may be especially true in ethnic groups for whom concepts within the legal system (such as mandated reporting) are often not clearly understood.</p>	Accept	Same suggested changes as listed above in response to Comment 6.04	Added example is useful and relevant.
3715(e)	Commenter #39	<p><u>Comment 39.02</u> In the version I did find (labeled “5/14/2014(Final)”), Section 3715(e) contains two typographical errors. “Early Sings” should be “Early Signs”, “an strategy” should be “a strategy”. I hope these typos will be corrected.</p>	Agree	Change existing language as suggested to correct proofreading errors.	Final draft will correct these typographical errors.
3715(e)	Commenter #8	<p><u>Comment 8.37</u> (e) Outreach for Increasing Recognition of Early Sings of Mental Illness may be a stand-alone program, a strategy within a</p>	Reject	Retain existing language with no change	Existing language in proposed regulation Section 3715(e) that allows a County to meet the requirement to offer Outreach for Increasing Recognition of Early signs of Mental Illness as a strategy within a Prevention or an Early

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		Prevention <u>and</u> Early Intervention program, a strategy within a <u>Prevention Program</u> or a Early Intervention program, a strategy within another program funded by Prevention and Early Intervention funds, or a combination thereof.			Intervention Program applies when a County combines the two kinds of programs into a single program, so there is no need for the additional language that the comment suggests.
3715(e)	Commenters #4, <u>5</u> , 10, 11, 12, 16, 17, 22, 24, 27, 28, 37, 43, 46, 62, 69, 70, 72	<p><u>Comments 4.01, 5.01, 10.01, 11.01, 12.01, 16.01, 17.01, 22.01, 24.01, 27.01, 28.01, 37.02, 43.01, 46.01, 62.01, 69.01, 70.02, 72.02</u></p> <p>Recognize cross-program county outreach. Consistent with Mental Health Services Act (MHSA) directives to integrate services across funding silos, clarify that outreach for increasing recognition of early signs of mental illness may be funded through alternative Mental Health Services Act (MHSA) components.</p> <p>Recommendation: Section 3715. Outreach for Increasing Recognition of Early Signs of Mental Illness [Subdivision (e)]: Add the following language: <i>Outreach, for this purpose, may be provided through other Mental Health Services Act components.</i></p>	Accept	<p>Add subdivision (f) to proposed Section 3715 as follows:</p> <p>(f) <u>An Outreach program may be provided through other Mental Health Services Act components as long as it meets all requirements in this Section</u></p>	<p>The MHSA (WIC 5840(b)(1)) states that the PEI program shall include “outreach to families, employers, primary care health care providers, and others to recognize the early signs of potentially severe and disabling mental illnesses.” Proposed Regulations require a county to conduct this outreach in at least one PEI program, or to provide this outreach as a stand-alone Program. For example, if a County offered an early intervention program to TAY with early onset of schizophrenia, the County could fulfill the requirement by conducting one workshop with people in the community who work with TAY regarding manifestations of early signs of psychosis and the great promise of recovery with early and effective treatment.</p> <p>A possible advantage of the approach suggested in the comment is that it provides flexibility to counties, who would be allowed to spend other MHSA funds for the purpose of outreach to increase recognition of early signs of potentially severe mental illness. The program would still be required to comply with all applicable regulations regarding the use of the specific MHSA fund. The county would still be required to use all of their PEI funds for allowable purposes. In effect, additional funds would be utilized for PEI purposes, which is a long-term goal of the MHSA (WIC 5892(a)(4)).</p> <p>A possible disadvantage of this approach is that it can weaken or dilute the definition of the “PEI program shall include.” Regarding a CSS-funded program as part of the PEI component could also be confusing for counties and stakeholders. Alternative approaches would be for a County</p>

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					<p>to shift the CSS-funded outreach to PEI funding or to offer another outreach effort with PEI funds, in addition to whatever was being funded with CSS or other MHSA funds, since the need for improved identification of and response to early signs and symptoms of potentially severe mental illness is unlikely to have been met completely by the CSS-funded program.</p> <p>The regulations that govern CSS and set forth the requirement for outreach under CSS have different requirements than the requirements for the outreach under this section. A county wishing to offer this outreach program under CSS would have to meet all of the regulatory requirements for both CSS and PEI.</p>
3715(e)	Commenter #38	<p><u>Comment 38.02</u> The California Behavioral Health Directors' Association has submitted their recommendations, and the Council agrees with the first two recommendations:</p> <ul style="list-style-type: none"> • Adding "Outreach, for this purpose, may be provided through other Mental Health Services Act components" to Section 3715. 	Accept	Same suggested changes as listed above in response to Comment 4.01 et al	See above responses to Comment 4.01 et al
3715(e)	Commenter #32	<p><u>Comment 32.04</u> <u>Recommendation: Section 3715(e). Outreach for Increasing of Early Signs of Mental Illness.</u></p> <p>We strongly support section 3715(e) as it stands in regulation, proposed by the MHSOAC.</p> <p>We highly value county outreach efforts</p>	Reject		<p>MHSOAC staff agrees that a potential disadvantage of the proposed change could be confusion for counties and stakeholders. However, the suggested change in language makes it explicit that any funds used to meet this requirement must specifically address all the provisions of proposed regulation Section 3715, so the outreach would have to be designed specifically to educate and learn from people in a position to identify and respond to early signs of potentially severe and disabling mental illness.</p> <p>See Response to Comments 4.01 et al.</p>

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		<p>for Increasing Recognition of Early Signs of Mental Health, and believe it is best administered and tracked when using funds explicitly earmarked for PEI. Allowing PEI outreach to be funded through other sources would be confusing and hard to determine, especially if merged together with CSS outreach. We have found it to be ineffective when counties have utilized a single outreach effort to cover multiple components to the MHSA; as different populations should be targeted for PEI then for CSS.</p> <p>For this reason, should other funding sources be authorized for PEI, it must be clear to the counties that additional funds can only be used to supplement and not supplant these outreach efforts.</p>			
3715(e)	Commenter #74	<p><u>Comment 74.04</u> REMHDCO strongly supports the language as proposed by the MHSOAC</p> <p>Allowing PEI outreach to be funded by other components of the MHSA will lead to confusion and opens the door to the blurring of funding and programs. In the minds of many community stakeholders, the people targeted for PEI outreach and programs are often different than the people targeted for CSS outreach and programs. Blending the two was not effective. For these reasons, we oppose other MHSA funding streams outside of</p>	Reject		See Response to Comment 32.04

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		PEI funds to be utilized for PEI outreach.			
3720	Commenter #3	<p><u>Comment 3.23</u> A. MHSOAC has no statutory authority to address "risk factors" for mental illness. MHSOAC may have made its Prevention Program discretionary because it recognizes that the programs it has funded for the past ten years have nothing to do with what actually is in the statute. However, the program delineated in the MHSA is mandatory; MHSOAC has no choice about creating it. And MHSOAC is obligated to follow the language of the statute, which is clear and explicit. MHSA was passed to help people who are <i>already sick</i>: the mentally ill who are at risk of serious/severe mental illness, and the severely mentally ill who are at risk of relapses into severe mental illness. One need only read the Findings and Declarations provisions to see that this is the case: SECTION 2. Findings and Declarations The people of the State of California hereby find and declare all of the following: (a) Mental illnesses are extremely common; they affect almost every family in California. They affect people from every background and occur at any age. 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</p>	Reject	Same suggested changes as listed above in response to Comment 60.02	<ol style="list-style-type: none"> 1. It is not accurate that MHSOAC has no statutory authority to address "risk factors for mental illness." The comment is based on a lack of understanding of the MHSA and an erroneous interpretation of WIC 5840. The purpose of the PEI component of the MHSA is set forth in WIC Section 5840(a) which is to prevent mental illnesses from becoming severe and disabling. Proposed regulation Section 3720 is specifically focused on one of several ways to prevent mental illness from becoming severe and disabling: intervene at the point of risk in order to prevent a mental illness from becoming severe and disabling. Research referenced in the Initial Statement of Reasons supports that there is demonstrated success in identifying factors that put people across the lifespan, especially children and youth, at risk for developing a potentially serious mental disorder, as well as in enhancing protective factors that maximize the potential for positive development and outcomes. 2. A County can use a universal prevention approach if and only if there is evidence to suggest that it is likely to bring about the MHSA's PEI intended outcomes set forth in WIC 5840 subdivision (d) for individuals and/or groups at greater than average risk of a mental illness. There are many instances in which interventions with groups, communities, or the general public have demonstrated their effectiveness in reducing risk and contributing to positive outcomes for individuals or groups with greater than average risk of developing a potentially serious mental disorder. Such approaches are included among universal prevention efforts, and are also referred to as ecological or community-based approaches. In these instances, any benefits to individuals who are not at greater than average risk for developing a potentially serious mental illness are

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		<p>seniors in California are affected by a potentially disabling mental illness every year.</p> <p>People who become disabled by mental illness deserve the same guarantee of care already extended to those who face other kinds of disabilities.</p> <p>b) Failure to provide timely treatment can destroy individuals and families. No parent should have to give up custody of a child and no adult or senior should have to become disabled or homeless to get mental health services as too often happens now. No individual or family should have to suffer inadequate or insufficient treatment due to language or cultural barriers to care. Lives can be devastated and families can be financially ruined by the costs of care. Yet, for too many Californians with mental illness, the mental health services and supports they need remain fragmented, disconnected and often inadequate, frustrating the opportunity for recovery.</p> <p>(c) Untreated mental illness is the leading cause of disability and suicide and imposes high costs on state and local government. Many people left untreated or with insufficient care see their mental illness worsen. Children left untreated often become unable to learn or participate in a normal school environment. Adults lose their ability to work and be independent; many become homeless and are subject to frequent</p>			<p>beneficial by-products of the program but not the allowable MHSAs purpose.</p> <p>3. This comment is based on a lack of understanding that the PEI component is only one of five programs under the MHSAs. Uncodified Section 2 quoted in the comment applies to all of the MHSAs programs and not just to PEI. The intent of the MHSAs was to use all of the five components collectively to achieve the overall goal of reducing the long-term adverse impact resulting from untreated serious mental illness. The MHSAs allocates most funds for treating individuals across the lifespan who have a serious (severe) mental illness. The 20% allocated to PEI is intended to prevent mental illnesses from becoming severe and disabling.</p>

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		<p>hospitalizations or jail. State and county governments are forced to pay billions of dollars each year in emergency medical care, long-term nursing home care, unemployment, housing, and law enforcement, including juvenile justice, jail and prison costs.</p> <p>(d) In a cost cutting move 30 years ago, California drastically cut back its services in state hospitals for people with severe mental illness. Thousands ended up on the streets homeless and incapable of caring for themselves. Today thousands of suffering people remain on our streets because they are afflicted with untreated severe mental illness. We can and should offer these people the care they need to lead more productive lives.</p> <p>(e) With effective treatment and support, recovery from mental illness is feasible for most people. The State of California has developed effective models of providing services to children, adults and seniors with serious mental illness.....</p> <p>California voters did not pass a new tax to fund "universal prevention programs" that "target a population that has not been identified on the basis of risk," as set forth in MHSOAC's proposed section 3720(e)(1). Neither did the voters authorize programs that "build in protective factors" for people who have "risk factors for mental illness," such as "adverse childhood experiences," "ongoing stress," "poverty, family conflict</p>			

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		<p>or domestic violence, " and/or "experiences of racism and social inequality." See MHSOAC's proposed section 3720(c)(1). The MHSA created a fund of public money for sick people, not people who might someday become sick because they have difficult or stressful lives. While ordinary life experiences-including grief, and stress and family conflict - put <i>all of us</i> at risk of "mental illness," as that term is currently defined in the mental health field, the statutory language is very explicit: the MHSA only allows intervention with public funds when the individual (a) <i>already has</i> a "mental illness" that may become a "severe mental illness," as defined in California's welfare laws, or (b) has an existing "severe mental illness" and is in need of relapse prevention services" similar to programs that have been successful in reducing the duration of untreated severe mental illnesses and assisting people in quickly regaining productive lives," Welf. & Inst. Code § 5840(c).</p> <p>MHSOAC, through its proposed regulations, is attempting to continue "policies" and pseudo-regulations that for the past ten years have resulted in the expenditure of millions of dollars on programs not authorized by the MHSA. It is time for the waste of funds to stop.</p>			
3720	Commenter #3	<u>Comment 3.24</u>	Reject		1. The comment regarding the requirement for "relapse

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		<p>B. MHSOAC is legally required to fund relapse prevention programs. Because MHSOAC has again ignored the statutory mandate to address relapse prevention, MIPO is proposing language to define "Relapse Prevention Program, "using only the terms of the statute, which are sufficiently clear and detailed to create such a program. MIPO also has made the Relapse Prevention Program mandatory, because the <i>statute</i> makes it mandatory. Indeed, as MIPO previously pointed out, the MHSA imposes a double mandate (a "shall" within a "shall") that MHSOAC's proposed regulation converts to a permissive "may." See MIPO's Comment No.4 (submitted July 8, 2014). Without mandatory relapse prevention/early intervention programs, thousands of very sick Californians will continue to die (usually by suicide or "suicide by cop"), go to jail, or lose their homes and families. The statute does not permit continued diversion of these funds for " universal prevention activities" for people who are not and will never be mentally ill.</p>			<p>prevention" is the same argument listed in comment 3.09 to proposed regulation Section 3705. As such, the responses are the same. See responses to Comment 3.09 to proposed regulation Section 3705. Also see recommended amendment to proposed regulation Section 3710(a) above that clarifies relapse prevention is included in early intervention.</p> <ol style="list-style-type: none"> 2. The comment that the regulations ignore a "double mandate (a shall within a shall)" and make it a "may" is the same as comment 3.09 to proposed regulation Section 3705. As such, the responses are the same. See response to Comment 3.09 3. For a response to the comment about universal prevention approaches see Response to Comment 3.23 to proposed regulation Section 3720 above.
3720(d)	Commenter #3	<p><u>Comment 3.21</u> <u>(d) "Relapse Prevention Program"</u> <u>means a program that is similar to</u></p>	Reject	Retain existing language with no change	<ol style="list-style-type: none"> 1. Proposed PEI Regulations specify that relapse prevention for individuals in recovery from a serious mental illness is, under Proposed PEI Regulations

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		<p><u>programs that have been successful in reducing the duration of untreated severe mental illnesses and assisting people in quickly regaining productive lives. Relapse Prevention Programs may include services to parents, caregivers and other family members as long as such services have been shown to be successful in reducing the duration of untreated severe mental illness and assisting people in quickly regaining productive lives. Each program shall emphasize strategies to reduce all applicable negative outcomes in Welfare and Institutions Code 5840(d). To qualify for a relapse prevention program, an individual must have a severe mental illness as defined herein.</u></p> <p>Authority/Reference for new subsection (d): First and second sentences: taken straight from Welfare & Institutions Code section 4820(c), which provides: "The program ... <i>shall a/so</i> 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." (Emphasis added.) Third sentence: taken straight from Welfare & Institutions Code section 5840(d), which provides: "The program <i>shall</i> emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness: (1) Suicide. (2) Incarcerations. (3) School</p>			<p>Section 3720 an allowable focus of a Prevention Program, as well as an important element of an Early Intervention Program. There is no need for a separate category of relapse prevention program. The purpose of the PEI component is to prevent mental illnesses from becoming severe and disabling, which can be accomplished in a variety of ways. While individuals in recovery from a mental illness are at risk of relapse, and therefore eligible as the focus of a Prevention Program, they are not the only individuals at risk of a potentially serious mental illness. See above responses to Comments 3.03 and Comment 3.05.</p> <p>2. Regarding the double statutory mandate argument, see responses to Comment 3.09.</p>

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		<p>failure or dropout. (4) Unemployment. (5) Prolonged suffering. (6) Homelessness. (7) Removal of children from their homes." Final sentence: required by section 5840(c), quoted above.</p> <p>Necessity/Rationale for new subsection (d): Necessary for conformity to statute, which MHSOAC's proposed regulation alters and amends by ignoring the MHSA's double statutory mandate. See MIPO Comment No.4 (submitted July 8,2014).</p>			
3720	Commenter #44	<p><u>Comment 44.07</u> Section 3720 of these regulations seems unclear as to the aims of prevention programs because it does not directly relate back to the purposes of prevention programs as defined in MHSA statute, WIC Section 5840. WIC 5840 defines the aim of prevention and early intervention programs as "designed to prevent mental illness from becoming severe and disabling" which this section omits. Further, WIC 5840 specifically references "access and linkage to medically necessary care" which this section omits. As well, reference to WIC 5840 requirements to authorize only those programs that have been identified as "effective in preventing mental illness from becoming severe ... and reducing the untreated duration of mental illness."</p> <p>RECOMMENDATION: Reference the explicit language of WIC 5840</p>	Reject	<p>For clarification, add the following subdivision to proposed regulation Sections 3710, 3715, 3720, 3725, and 3730:</p> <p>The County shall include all of the strategies referenced in Section 3735.</p>	<ol style="list-style-type: none"> 1. Current proposed Section 3735 requires all the programs listed in proposed Sections 3710, 3715, 3720, 3725, and 3730 to include the strategies listed in Section 3735. Adding corresponding language in these sections is a non-substantive clarifying change that provides an internal cross-reference. 2. Proposed regulation Section 3720 implements WIC Section 5840 as one of the activities in the PEI regulations aimed at preventing mental illness from becoming severe and disabling. See the Initial Statement of Reasons for the supporting research. 3. The Prevention program under proposed regulation Section 3720, as with all PEI programs are required to provide access and linkage to medically necessary care for people with a severe mental illness. See proposed regulation Section 3735(a)(1) that sets forth this requirement. 4. The proposed regulations do require all PEI programs and required strategies within programs to use effective approaches, not only to prevent mental illness from becoming severe and also, where applicable, to reduce the duration of untreated mental illness, but also to bring about the applicable negative outcomes as a

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		<p>requirements in this section for clarity and consistency with the supporting statute, particularly in relation to prevention of mental illness from becoming severe and disabling, access to medically necessary services, and reliance on programming which has demonstrated reduction in the duration of untreated mental illness.</p> <p>COMMENT and RATIONALE: These recommendations conform the proposed regulation in Section 3720 to the authorizing statute, WIC Section 5840, without which it is confused and unclear.</p>			<p>result of untreated mental illness listed in 5840(d). See proposed regulation Section 3740 for this requirement.</p>
3720(a)	Commenter #74	<p><u>Comment 74.06</u> REMHDCO recommends that the PEI regulations require the counties to provide one or more Prevention Programs.</p> <p>Under the current and proposed language in this section, "(a) The County may offer one or more Prevention Programs as defined in this section", the language clearly indicates that Prevention Programs are optional when they should be required. For many racial and ethnic communities, the potential for reducing mental health disparities lies in Prevention Programs. Since the passage of the MHSA, we have not seen as many prevention approaches and programs that we support (as opposed to treatment) funded with PEI funds. As many other community stakeholders, we</p>	<p>Agree: Require a Prevention Program</p> <p>Reject: language regarding voluntary programs</p>	<p>Same suggested changes as listed above in response to Comment 60.02</p>	<ol style="list-style-type: none"> 1. The rationale for making the Prevention Program mandatory is set forth in the response to Comment 60.02 to proposed regulation Section 3705(b) above. 2. The suggested new subdivision (f) is rejected because the existing MHSA regulations that apply to all MHSA programs, including PEI, require the programs to be designed for voluntary participation and require that no individual shall be denied access based upon their voluntary or involuntary legal status (Title 9 California Code of Regulations Section 3400(b)(2)).

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		<p>would like to see more PEI funds directed toward Prevention as opposed to Early Intervention.</p> <p>The "Rationale/Necessity" section for Section 3720(a) found in the Initial Statement of Reasons of the PEI Regulations at page 18 provides the reason for making it optional to have a Prevention Program. As stated, "Providing the County the option to intervene at the point of risk is important because there is considerable and growing evidence that intervening at the point of risk can prevent a range of serious mental illnesses and/or to prevent devastating, disability consequences of mental illness..." By the authors' own admission, a Prevention Program is important to prevent further decompensation or the consequences of mental disorders. Prevention Programs should not be optional but required.</p> <p>By requiring a county to "administer at least one Early Intervention Program", the language as proposed implies that Prevention Programs may be optional. For many racial and ethnic communities, the potential for reducing mental health disparities lies in Prevention Programs. Since the passage of the MHSA, we have not seen as many prevention approaches and programs that we support (as opposed to treatment)</p>			

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		<p>funded with PEI funds. As many other community stakeholders, we would like to see more PEI funds directed toward Prevention as opposed to Early Intervention.</p> <p>Additionally, REMHDCO recommends that the following language be added to this section:</p> <p><i><u>(f) Prevention programs should be designed to emphasize services that are voluntary over services that are involuntary as a response to reduce stigma in receiving mental health services.</u></i></p> <p>In the Proposed Prevention and Early Intervention Regulations at Section 3725 regarding “Stigma and Discrimination Reduction Program/Approaches”, the current proposed language supports voluntary services. Counties are to reduce negative feelings, attitudes, beliefs, perceptions, stereotypes and/or discrimination related to a diagnosis of mental illness, or seeking mental health services and to increase acceptance, inclusion, dignity, and equity for individuals with mental illness. Emphasizing and offering voluntary services reduces stigma, reflects inclusion and supports dignity for the individual with a mental illness. Involuntary services have the opposite effect by reducing inclusion, eroding</p>			

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		dignity and increasing stigma.			
3720(a)	Commenter #3	<p><u>Comment 3.16</u> (a) The County may <u>shall</u> offer one or more Prevention Programs as defined in this section.</p> <p>Authority for the change of "may" to "shall": MHSOAC has no authority to change a statutory mandate, using the term "shall," into a permissive "may." Prevention programs are the subject of a double statutory mandate. See Welf. & Inst. Code § 5840(a) which provides, "The State... <i>shall</i> establish a program designed to prevent <i>mental illnesses</i> from becoming <i>severe and disabling</i>" and § 5840(c) ("The program <i>shall</i> include mental health services similar to those provided under other programs effective in <i>preventing mental illnesses</i> from becoming <i>severe</i>").</p> <p>Rationale/Necessity for change of "may" to "shall": By changing the double statutory "shall" to a permissive "may," MHSOAC has altered and amended the statute.</p>	Agree	Same suggested changes as listed above in response to Comment 60.02	<ol style="list-style-type: none"> 1. The rationale for making prevention a mandatory program is set forth in response to Comment 60.02 to proposed regulation Section 3705(b). 2. The argument that the regulations have disregarded a double mandatory are the same as presented in Comment 3.09 to proposed regulation Section 3705. Therefore the responses are the same. See responses to Comment 3.09 to proposed regulation Section 3705.
3720(a)	Commenter #8	<p><u>Comment 8.38</u> (a) The County may offer one or more <u>shall offer all the</u> Prevention Programs as defined in this section.</p>	Agree	Same suggested changes as listed above in response to Comment 60.02	The rationale for making prevention a mandatory program is set forth in response to comment 60.02 to proposed regulation Section 3705(b).
3720(a)	Commenter #23	<p><u>Comment 23.02</u> <u>1. Recommendation: Section 3720 (a). Prevention Program.</u> Proposed regulations require the</p>	Agree	Same suggested changes as listed above in response to Comment 60.02	The rationale for making prevention a mandatory program is set forth in response to comment 60.02 to proposed regulation Section 3705(b).

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		<p>counties to administer at least one Early Intervention Program, while leaving Prevention Programs optional. <u>We strongly recommend that PEI regulations require counties to offer at least one Prevention Program.</u></p> <p>Many of the risk factors outlined in section 3720(c)(1) disproportionately affect underserved communities, and therefore a lack of prevention programs will adversely affect the MHSA goal of reducing mental health disparities. We feel strongly that making prevention programs optional leaves these programs vulnerable and may adversely impact the at-risk populations these programs currently serve.</p> <p>Although Welfare and Institutions Code Section 5840 does not <i>explicitly</i> mandate prevention, we believe that prevention is encompassed within the mandate for programs to be “designed to prevent mental illness from becoming severe and disabling.”</p> <p>Welfare and Institutions Code Section 5840(f) also states, “<i>In consultation with mental health stakeholders, and consistent with guidelines from the Mental Health Services Oversight and Accountability Commission, pursuant to Section 5846, the department shall revise the program elements in Section 5840 applicable to all county mental health programs in future years to reflect</i></p>			

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		<p><i>what is learned about the most effective prevention and intervention programs for children, adults, and seniors.”</i></p> <p>In order to make it possible to learn from “<i>the most effective prevention and intervention programs for children, adults, and seniors,</i>” the state must ensure that prevention programs, and programs for children, continue to be offered by counties.</p>			
3720(a)	Commenter #32	<p><u>Comment 32.05</u> 4. Recommendation: Section 3720 (a). Prevention Program.</p> <p>We strongly recommend that PEI regulations <u>require</u> the counties to offer one or more Prevention Programs.</p> <p>Proposed regulations require the counties to administer at least one Early Intervention program, while leaving Prevention Programs <u>optional</u>.</p> <p>Risk factors, as outlined in section 3720(c)(1) include “adverse childhood experiences, experience of trauma, ongoing stress, exposure to drugs or toxins including the womb, poverty, family conflict or domestic violence, experience of racism and social inequity”(7).</p> <p>The above-mentioned risk factors are social determinants of health that</p>	Agree	Same suggested changes as listed above in response to Comment 60.02	The rationale for making prevention a mandatory program is set forth in response to comment 60.02 to proposed regulation Section 3705(b).

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		<p>disproportionately affect racial and ethnic communities of color and other underserved communities. Therefore a lack of prevention programs will <i>adversely</i> affect reducing mental health disparities, which is a priority of the MHSA.</p> <p>The well documented and significant personal, social, and financial toll that mental health disorders exact on our society makes outreach and prevention a necessary and responsible requirement. The total cost in the U.S. associated with behavioral health problems in children and youth is nearly \$247 billion per year. When considering the full life span, that number climbs to \$510 billion.</p> <p>Mental health disorders represent not only an immense psychological, social and economic burden to society, but also increase the risk of physical illnesses. In addition, five of the ten leading causes of disability and premature death worldwide are a result of mental illness and/or psychiatric conditions. The only responsible method for reducing the impact of mental health disorders is prevention programs.</p> <p>Evidence-based prevention programs and policies are widely available for implementation. These programs have been found to reduce risk factors, strengthen protective factors and</p>			

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		<p>decrease psychiatric symptoms and disability and the onset of some mental disorders. They also improve positive mental health, contribute to better physical health and generate positive social and economic outcomes.</p> <p>We feel strongly that making these programs optional leaves current Prevention focused programs potentially vulnerable, and may adversely impact the at-risk populations these programs serve. In the vein of needing to catch a condition before it becomes severe, prevention is critical. If you remove this leg of the stool it will force our communities to cycle in and out of care without ever having the opportunity to prevent it.</p> <p>Although Welfare and Institutions Code Section 5840 does not explicitly mandate prevention, we feel that prevention is encompassed within the mandate for programs to be “designed to prevent mental illness from becoming severe and disabling”. We feel that prevention is embedded in the mandate, <u>despite</u> proposed regulations defining and separating prevention as “intervening at the point of risk” and Early Intervention as services performed at “early onset,” therefore only requiring Early Intervention programs of the counties.</p>			

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		<p>Lastly, Welfare and Institutions Code Section 5840(f) states “<i>In consultation with mental health stakeholders, and consistent with guidelines from the Mental Health Services Oversight and Accountability Commission, pursuant to Section 5846, the department shall revise the program elements in Section 5840 applicable to all county mental health programs in future years to reflect what is learned about the most effective prevention and intervention programs for children, adults, and seniors</i>”.</p> <p>In this spirit, as stakeholders, we call on the state Department of Health Care Services to revise program elements in Welfare and Institutions code 5840 (also, Section 4 part 3.6 of the MHSA) to explicitly mandate prevention, so as to make robust and meaningful learning from effective prevention programs possible.</p>			
3720(a)	Commenter #35	<p><u>Comment 35.03</u> 3. Protection of Prevention Programs: Section 3720 (a). Prevention Program states “The county may offer one or more Prevention Programs” making prevention programs optional.</p> <p>Recommendation: Due to the preponderance of evidence that “Prevention offers the greatest opportunity to serve the most needs in the most cost-effective manner” (Little Hoover Commission), the California</p>	Agree	Same suggested changes as listed above in response to Comment 60.02	The rationale for making prevention a mandatory program is set forth in response to comment 60.02 to proposed regulation Section 3705(b).

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		Alliance recommends the requirement of <i>at least one</i> Prevention program AND one Early Intervention program as they are both integral keys to the true purpose and success of the MHSA.			
3720(b)	Commenter #3	<p><u>Comment 3.17</u> (b) "Prevention Program" means a set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors. The goal of this program is to bring about mental health and related functional outcomes including reduction of the applicable negative outcomes listed in 5840(d) as a result of untreated mental illness for individuals and members of groups or populations whose risk of developing a serious mental illness is significantly higher than average and, as applicable, their parents, caregivers, and other family members. The goal of this program is to reduce risk factors for developing a potentially serious mental illness and to build protective factors. <u>mental health services similar to those provided under programs that have proven effective in preventing mental illnesses, as defined herein, from becoming severe and disabling. The program shall include mental health services similar to those provided under other programs effective in preventing mental illnesses from becoming severe. Such programs may address patients' diagnoses, to prevent</u></p>	Reject	Retain existing language with no change	<ol style="list-style-type: none"> 1. This comment is incorrect because the MHSOAC does have authority to define Prevention Programs as set forth in subdivision (b). Prevention Programs intervene at the point of risk, to prevent a mental illness from developing or from becoming severe and disabling if it develops. Individuals in recovery from a serious mental illness, who are at risk of relapse, are eligible for a Prevention Program. This comment cites these same arguments in Comments 3.06 (3705(a)(1)); Comment 3.07 (3705(a)(2)); Comment 3.08 (3705(b)(1)); Comment 3.09 (3705); Comment 3.10 (3710); Comment 3.12 (3710(d)); Comment 3.13 (3710(a) and (b)); Comment 3.14 (3710(c)); Comment 3.23 (3720); and Comment 3.24 (3720). See the responses to these ten comments 2. The proposed regulations do not rewrite nor expand upon the MHSA. The proposed regulations clarify, interpret, and implement the programs because the statutory language is not sufficiently clear. 3. Suggestion for effective programs: Proposed regulation Section 3740 requires all Prevention Programs to use practices that have demonstrated their effectiveness to prevent mental illnesses from becoming severe and disabling and to bring about applicable MHSA PEI outcomes for the intended populations for individuals with risk factors for a potentially serious mental illness. 4. Suggestion for a required diagnosis is rejected: Same argument as in Comment 3.10. See Responses to Comment 3.10 to proposed regulation Section 3710(a)-(b)

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		<p><u>them from becoming more severe diagnoses, or prevent one or more negative outcomes of mental illness as set forth in Section 5840(d), or a combination thereof. Each program shall emphasize strategies to reduce all applicable negative outcomes in Welfare and Institutions Code 5840(d). Prevention Program services may include services to parents, caregivers and other family members as long as such services have been shown to be effective in preventing patients' mental illness from become severe and disabling. To qualify for a "prevention program," an individual must have a "mental illness" or "severe mental illness" as defined herein.</u></p> <p>Authority for the deletion in subsection (b): There is no statutory authority for the provisions that MIPO proposes be deleted. MHSOAC has no authority to rewrite the statute, which is both clear and sufficiently detailed to define "the program." MHSOAC has no authority to attempt to "reduce risk factors for developing a <i>potentially</i> serious mental illness and to build protective factors." MHSOAC has no authority to address "mental <i>health</i> and related functional outcomes." MHSOACs authority under the MHSA is to address an existing "mental illness" that may become "severe <i>and</i> disabling." See the MHSA's Findings, Declarations, Purposes and</p>			<ol style="list-style-type: none"> 5. Suggestion regarding parents and family members is rejected: See Response to Comment 3.15. 6. Suggestion that severe mental illness be a necessary qualification for participation in a Prevention Program is rejected: See Responses to Comment 3.10, and Comment 3.21. 7. Suggestion regarding medically necessary treatment for people with severe mental illness is rejected: See Responses to Comment 3.10 to proposed regulation Section 3710(a)-(b) 8. Suggestion regarding focus on negative outcomes is rejected: See Response Comment 3.10

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		<p>Intent provisions; see also Welf. & Inst. Code § 5840(a), which provides, "The State... shall establish a program designed to prevent <i>mental illnesses</i> from becoming <i>severe and disabling</i>"; Welf. & Inst. Code § 5840(c), which provides, "The program shall include mental health services similar to those provided under other programs effective in <i>preventing mental illnesses</i> from becoming <i>severe</i>"; and Welf. & Inst. Code § 5840(b)(2), which authorizes only "<i>medically necessary care</i> provided by county mental health programs for children with <i>severe mental illness</i>, as defined in Section 5600.3, and for adults and seniors with <i>severe mental illness</i>, as defined in Section 5600.3, as early in the onset of these conditions as practicable." (Emphasis added.)</p> <p>Rationale/necessity for deletion in subsection (b): Necessary for conformity to statute, because MHSOACs proposed regulation alters, amends and expands the statute.</p> <p>Authority for the substituted definition in subsection (b): First and second sentences: taken straight from Welf. & Inst. Code § 5840(c), which provides, "The program shall include mental health services similar to those provided under other programs effective in preventing <i>mental illnesses</i> from becoming <i>severe</i>." Third sentence: clarifies that prevention</p>			

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		<p>may address not only the "severity" of diagnosis, but also the "disabling" negative outcomes of severe mental illness. Fourth sentence: taken straight from Welf. & Inst. Code § 5840(d), which provides, "The program <i>shall</i> emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness: (1) Suicide. (2) Incarcerations. (3) School failure or dropout. (4) Unemployment. (5) Prolonged suffering. (6) Homelessness. (7) Removal of children from their homes. Final sentence: based on the foregoing, and on Welf. & Inst. Code § 5840(a), which provides, "The State Department of Health Care Services, in coordination with counties, <i>shall</i> establish a program designed to prevent <i>mental illnesses</i> from becoming <i>severe and disabling</i>." (Emphasis added.)</p> <p>Rationale/necessity for substituted definition in subsection (b): Necessary for conformity to statute. The substituted definition uses only language found in the statute, which is sufficiently clear and detailed to define "the program."</p>			
3720(b)	Commenter #8	<p><u>Comment 8.39</u> (b) "<u>Prevention Program</u>" <u>means evidence-based interventions that prevents mental illness from becoming severe and disabling a set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors.</u></p>	Reject	Retain existing language with no change	<p>All of the suggested changes are rejected for the same reasons as previously mentioned on the topics as follows:</p> <ol style="list-style-type: none"> 1. "Evidence-based interventions: The proposed regulation Section 3740 requires all programs including Prevention programs to use effective methods to bring about intended outcomes and evidence-based evidence is one of three options. See Response to Comment 3.17 to proposed regulation Section 3720(b)

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		The goal of this program is to bring about mental health <u>prevent people with mental illness from having it become severe and disabling.</u> Including <u>It includes a</u> reduction of the applicable negative outcomes listed in Welfare and Institutions Code Section 5840, subdivision (d) as a result of untreated mental illness for individuals and members of groups or populations whose risk of developing a serious for people with mental illness is significantly higher than average and, as applicable, their. <u>Preventing the progression of mental illness to serious mental illness may necessitate implementing programs for</u> parents, caregivers, and other family members.			<p>2. Deleting reduction of risk factors: See Response to Comment 60.02 et al to proposed regulation Section 3705</p> <p>3. Inclusion of family members: The proposed regulations already provide for such services and suggested language is not necessary. See Responses to Comment 3.12.</p>
3720(b)	Commenter #26	Comment 26.05 Section 3720. Prevention Program (b) "Prevention Program" should be better defined as a set of related activities <i>that have been shown through scientifically sound standards (e.g., evidence-based programs)</i> to reduce the risk factors for developing a potentially serious mental illness...	Reject	Retain existing language with no change	See Response to Comment 8.39 to proposed regulation Section 3720(b) The issue here is not about the requirement to offer effective programs that have demonstrated their success, but about the kinds of evidence that can be used to demonstrate effectiveness and success. Proposed PEI Regulations require Counties to use effective methods likely to bring about intended outcomes for all PEI programs and strategies within programs, based on one of the following defined standards or a combination of the following standards: evidence-based practice, promising practice, and/or community and practice-based evidence standard.
3720(c)	Commenters #6 and #36	<u>Comments 6.05 and 36.07</u> (c) "Risk factors for mental illness" means conditions or experiences that are associated with a higher than average risk of developing a potentially serious mental illness. Kinds of risk	Reject	Retain existing language with no change	Loss and prolonged isolation are not the same. Loss is a broad, concept and a universal human experience. Allowable risk factors for Prevention Programs require greater than average risk, beyond universal experiences. Examples of risk factors listed in Proposed PEI Regulations are "not limited to" examples. Multiple or complicated loss

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		<p>factors include, but are not limited to, biological including family history and neurological, behavioral, social/economic, and environmental. (1) Examples of risk factors include, but are not limited to, a serious chronic medical condition, adverse childhood experiences, experience of severe trauma, ongoing stress, exposure to drugs or toxins including in the womb, poverty, family conflict or domestic violence, experiences of racism and social inequality, loss and prolonged isolation, having a previous mental illness, a previous suicide attempt, or having a family member with a serious mental illness.</p> <p>(loss alongside isolation as shown above is strongly encouraged to be listed)</p> <p><u>Comment 36.07</u> Section 3720, subdivision (c) Recommendation: List "loss" alongside prolonged isolation among examples of risk factors.</p> <p><i>Rationale:</i> Loss experiences occur throughout the lifespan and often trigger emotional trauma and potentially debilitating mental health issues.</p>			<p>could, in some instances, constitute a risk factor for major depressive disorder, for example. Current language provides counties with options based on local priorities.</p>
3720(c)	Commenter #3	<p><u>Comment 3.18</u> (c) "Risk factors for mental illness" means conditions or experiences that are associated with a higher than</p>	Reject	Retain existing language with no change	<p>1 It is not accurate that MHSOAC has no statutory authority to address risk factors for mental illness or to address potentially serious mental illness. The arguments listed here are the same that are listed in</p>

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		<p>average risk of developing a potentially serious mental illness. Kinds of risk factors include, but are not limited to, biological including family history and neurological, behavioral, social/economic, and environmental.</p> <p>Authority/Reference for deleting subsection (c): There is no statutory authority for the provision. MHSOAC has no statutory authority to address "risk factors for mental illness" because it has no statutory authority to attempt prevention of "mental illness," which is, in any event, impossible. Similarly, MHSOAC has no statutory authority to address "a <i>potentially</i> serious mental illness," much less a "a higher than average risk of developing a <i>potentially serious</i> mental illness." MHSOAC's authority under the MHSA is to address an existing "mental illness" that may become "severe <i>and</i> disabling" as those terms are defined within the MHSA and under California law, as incorporated by reference. See the MHSA's Findings, Declarations, Purposes and Intent provisions; see <i>also</i> Welf. & Inst. Code § 5840(a), which provides, "The State... shall establish a program designed to prevent <i>mental illnesses</i> from becoming <i>severe and disabling</i>"; Welf. & Inst. Code § 5840(c), which provides, "The program <i>shall</i> include mental health services similar to those provided under other programs effective in <i>preventing mental</i></p>			<p>Comment 3.23 to proposed regulation Section 3720 above. See response to Comment 3.23 to proposed regulation Section 3720.</p> <p>2 The argument regarding "medically necessary care" is the same as that listed in Comment 3.10 to proposed regulation Section 3710(a)-(b). See responses to Comment 3.10.</p>

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		<p><i>illnesses from becoming severe</i>"; and Welf. & Inst. Code § 5840(b)(2), which authorizes only "<i>medically necessary</i> care provided by county mental health programs for children with <i>severe mental illness</i>, as defined in Section 5600.3, and for adults and seniors with <i>severe mental illness</i>, as defined in Section 5600.3, as early in the onset of <i>these conditions</i> as practicable." (Emphasis added.)</p> <p>Rationale/necessity for deleting subsection (c): Necessary for conformity to statute, because MHSOAC's proposed regulation alters, amends and expands the statute</p>			
3720(c)	Commenter #8	<p><u>Comment 8.40</u> (c) "Risk factors for mental illness" means conditions or experiences that are associated with a higher than average risk of developing a potentially serious mental illness. Kinds of risk factors include, but are not limited to, biological including family history and neurological, <u>and</u> behavioral, social/economic, and environmental.</p> <p>(1) Examples of risk factors include, but are not limited to, a serious chronic medical condition, adverse childhood experiences, experience of severe trauma, ongoing stress, exposure to drugs or toxins including in the womb, poverty, family conflict or domestic</p>	Reject	Retain existing language with no change	<ol style="list-style-type: none"> 1. The comment recommends a list of risk factors that is considerably more limited than the research evidence. See the references cited in the Initial Statement of Reasons. 2. The suggestion to limit Prevention Programs to relapse prevention for individuals with serious mental illness is rejected for the same reasons stated in Responses to Comment 3.21. 3. Suggestion about universal Prevention is rejected: See Responses to Comment 3.23.

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		<p>violence, experiences of racism and social inequality, prolonged isolation, having a previous mental illness, a previous suicide attempt, or having a family member with a serious mental illness.</p> <p>(d) Prevention program services may <u>shall</u> include relapse prevention for individuals in recovery from a <u>with</u> serious mental illness</p> <p>4. Prevention programs may include universal prevention efforts as defined below if there is evidence to suggest that the universal prevention effort is likely 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.</p> <p>(1) Universal prevention efforts mean efforts that target a population that has not been identified on the basis of risk.</p>			
3720(c)(1)	Commenter #3	<p><u>Comment 3.19</u> (1) Examples of risk factors include, but are not limited to, a serious chronic medical condition, adverse childhood experiences, experience of severe trauma, ongoing stress, exposure to drugs or toxins including in the womb, poverty, family conflict or domestic violence, experiences of racism and social inequality, prolonged isolation,</p>	Reject	Retain existing language with no change	<ol style="list-style-type: none"> 1. This comment lists the same arguments listed under Comment 3.18 for section 3720(c). See responses to Comment 3.18. 2. The listed examples deleted by this comment are all risk factors for a potentially serious mental illness and should remain in the proposed section. See the references cited in the Initial Statement of Reasons

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		<p>having a previous mental illness, a previous suicide attempt, or having a family member with a serious mental illness.</p> <p>Authority/Reference for deleting subsection(c)(1): There is no authority for this provision. The examples of "risk factors" identified by MHSOAC are those for "mental illness." MHSOAC has no authority to prevent or intervene early in "mental illness." As noted in the MHSA, mental illnesses "are extremely common; they affect almost every family in California." MHSA Section 2(a). Preventing mental illness is impossible, precisely because all negative life experiences are risk factors. MHSOAC's authority under the MHSA is to address an <i>existing</i> "mental illness" that may become "severe and disabling." See the MHSA's Findings, Declarations, Purposes and Intent provisions; see also Welf. & Inst. Code § 5840(a), which provides, "The State... shall establish a program designed to prevent <i>mental illnesses</i> from becoming <i>severe and disabling</i>"; § 5840(c), which provides, "The program shall include mental health services similar to those provided under other programs effective in <i>preventing mental illnesses</i> from becoming <i>severe</i>; and § 5840(b)(2), which authorizes only "<i>medically necessary care</i> provided by county mental health programs for children with <i>severe mental illness</i>, as</p>			

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		<p>defined in Section 5600.3, and for adults and seniors with <i>severe mental illness</i>, as defined in Section 5600.3, as early in the onset of <i>these conditions</i> as practicable." (Emphasis added.)</p> <p>Necessity/Rationale for deleting subsection (c)(1): Necessary for conformity to statute, because MHSOAC's proposed regulation alters, amends and expands the statute.</p>			
3720(c)(1)	Commenter #36	<p><u>Comment 36.08</u> Section 3720, subdivision (c) (1)</p> <p>Recommendation: Include incarceration, environmental factors, and military service as risk factors.</p> <p>Rationale: Members of unserved and underserved communities are disproportionately found in the criminal justice system and in the military, where they could experience severe trauma that places them at high risk for mental illness and suicide.</p>	Reject	Retain existing language with no change	While the three examples listed in the comment are all potential risk factors, environmental factors are already mention in proposed regulation Section 3720(c) and military experience and experience of incarceration are already addressed through these broad examples (for example: trauma, prolonged isolation). Counties are not limited to these examples when they determine the local priorities for risk factors to be addressed in their Prevention Programs.
3720(d)	Commenter #3	<p><u>Comment 3.20</u> (d)(c)[renumbered] Prevention program services may <u>shall</u> include <u>at least one</u> relapse prevention <u>program</u> for individuals in recovery from a serious <u>severe</u> mental illness.</p> <p>Authority/Reference for the change of "may" to "shall" in renumbered</p>	Reject	Retain existing language with no change	<ol style="list-style-type: none"> 1. The comment uses the same arguments regarding the "double mandate" used in Comments 3.09, 3.21, and others. The responses are the same. See responses to Comments 3.09 and 3.21. 2. Suggestion to require a Prevention Program to focus on relapse prevention: There is no legal requirement to address relapse prevention as part of a Prevention Program. The purpose of the PEI component is to prevent mental illnesses from becoming severe and

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		<p>subsection (c): MHSOAC has no authority to change a statutory mandate that used the term "shall," into a permissive "may." As explained in MIPO Comment No.4 (submitted July 8,2014), the MHSA contains a double mandate for relapse prevention programs: See Welfare & Institutions Code section 5840(a) which provides, "The State... <i>shall</i> establish a program designed to prevent mental illnesses from becoming severe and disabling" ; and section 5840(c), which provides: "The program .. <i>shall</i> also include components similar to programs that have been successful in reducing the duration of <i>untreated severe mental illnesses</i> and assisting people in quickly regaining productive lives." (Emphasis added.)</p> <p>Necessity for the change of "may to "shall" in renumbered subsection (c): Necessary for conformity to statute, which MHSOAC's proposed regulation alters and amends.</p> <p>Authority/Reference for the change of "serious" to "severe" in renumbered subsection (c): MHSOAC has no authority to intervene early in or to prevent "serious" mental illness or "potential serious mental illness." The PEI provisions of the MHSA consistently use the term "severe, ' which incorporates by reference the statutory definition of severe and disabling mental</p>			<p>disabling, which can be accomplished in a variety of ways. While individuals in recovery from a mental illness are at risk of relapse, and therefore are eligible as the focus of a Prevention Program, they are not the only individuals at risk of a potentially serious mental illness. The choice of risk population is a local discretion.</p> <p>3. The argument regarding "serious" vs "severe" is the same as in Comment 3.10. See response to Comment 3.10.</p>

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		<p>illness in Welfare & Institutions Code section 5600.3. See Welf. & Inst. Code §§ 5840(a), (b)(1), (b)(2) and (c).</p> <p>Necessity for the change from "serious" to "severe" in renumbered subsection (c): Necessary for conformity to statute, which MHSOAC's proposed regulation alters, expands and amends.</p>			
3720(e) and (e)(1)	Commenter #3	<p><u>Comment 3.22</u> (e) Prevention programs may include universal prevention efforts as defined below as targeting a population that has not been identified on the basis of risk, only if there is evidence to suggest that the universal prevention effort is likely 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. (1) Universal prevention efforts mean efforts that target a population that has not been identified on the basis of risk.</p> <p>Authority for deleting proposed subsections (e) and (e)(1): There is no statutory authority for these provisions, which are holdovers from MHSOAC's former pseudo-regulations and the source of the long history of misuse and waste of MHSA PEI funds. See MIPO Comment No.1 (submitted June 27, 2014). MHSOAC has no authority to</p>	Reject	Retain existing language with no change	<ol style="list-style-type: none"> 1. The Comment uses the same arguments that MHSOAC does not have the authority to address risk factors for mental illness as those listed in Comment 3.23 to proposed regulation Section 3720 above. See responses to Comment 3.23. 2. The comment uses the same argument about "medically necessary" as that listed in Comment 3.10 to proposed regulation Section 3710(a)-(b). See responses to Comment 3.10. 3. Regarding universal prevention see Response to Comment 3.23.

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		<p>"target a population that has not been identified on the basis of risk." MHSOAC has no authority to address "mental health and related functional outcomes" for the general population based on "likelihood" of helping individuals who are at "risk of developing a serious mental illness." MHSOAC's authority under the PEI provisions of the MHSA is to address an existing "mental illness" that may become "severe and disabling." See the MHSA's Findings, Declarations, Purposes and Intent provisions; see also Welf. & Inst. Code § 5840(a), which provides, "The State... shall establish a program designed to prevent mental illnesses from becoming severe and disabling"; Welf. & Inst. Code § 5840(c), which provides, "The program shall include mental health services similar to those provided under other programs effective in preventing mental illnesses from becoming severe; and Welf. & Inst. Code § 5840(b)(2), which authorizes only "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 these conditions as practicable." (Emphasis added.)</p> <p>Necessity/Rationale for the deletion of subsections (e) and (e)(1): Necessary for conformity to statute, which MHSOAC's</p>			

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		proposed regulation alters, amends and expands. Also necessary to halt the ten year history of spending MHSA PEI funds on individuals who are not and will never be mentally ill, much less severely mentally ill, and on programs that have nothing to do with mental illness.			
3720(e) and (e)(1)	Commenter #7	<u>Comment 7.01</u> I read through these and have a couple of concerns. The regulations seem to heavily lean towards the indicated category of prevention which are the moderately and seriously mentally ill. The language used is clearly treatment oriented. But, a concrete technical error in the document is on page 8 at the top in section e and its subsection 1. This section contradicts itself and says this focus is people at risk of developing serious mental illness, and then says that this category is for populations that that have not been identified on the basis of risk.	Accept	Amend proposed regulation Section 3720(e)(1) as follows: (1) Universal prevention efforts means efforts that target using effective practices that engage individuals population that has who <u>have not been identified on the basis of risk in order to bring about MHSA outcomes for individuals who are at greater than average risk of developing a potentially serious mental illness.</u>	Valid comment that existing language in (e)(1) is not clear. Recommend amending proposed Section 3720(e)(1) to clarify.
3720	Commenter #7	<u>Comment 7.04</u> Also, shouldn't suicide prevention and stigma and discrimination reduction be under be directly under 3720, as they are prevention strategies under prevention and not a separate type of service. In addition, why doesn't the regulation mirror that CalOMS categories as they are the same type of services, but simply focus on mental illness instead for			<ol style="list-style-type: none"> 1. The suggestion is rejected because the proposed regulations define "strategies" in a specific way that is different than suggested. Further, there is a need to differentiate a Stigma Discrimination Reduction Program, which is optional, from the requirement that all PEI Programs be implemented in ways that contribute to reducing stigma and discrimination related to having a mental illness or seeking mental health services (proposed regulation Section 3735(a)(3)). 2. It is not possible to use the same categories for PEI

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		<p>substance use. It would really help with services integration to call the same type of service the same name. In SUD the titles are Information Dissemination, Education, Problem Identification and Referral, Community Based Process, Alternatives and Environmental. You are actually missing Community Based Process, Alternatives and Environmental, which are needed for large scale changes.</p>			<p>services as those used with CalOMS because proposed PEI Regulations are based on the MHSA, specifically on WIC 5840. The structure of the MHSA is different from the structure of CalOMS categories.</p>
3725	Committer #3	<p><u>Comment 3.26</u> Section 3725. Stigma and Discrimination Reduction Program/Approaches. (a) The County may <u>shall</u> offer one or more Stigma and Discrimination Reduction Programs/ Approaches as defined in this section. (b) "Stigma and Discrimination Reduction Programs/Approaches" means the County's direct activities to reduce negative feelings, attitudes, beliefs, perceptions, stereotypes and/ or discrimination related to being diagnosed with a mental illness, having a mental illness, or to seeking mental health services and to increase acceptance, dignity, inclusion, and equity for individuals with mental illness, and members of their families. (1) Examples of Stigma and Discrimination Reduction Programs/Approaches include, but are not limited to programs <u>designed to assist people diagnosed with a mental illness or seeking mental health services</u></p>	Accept in part and reject in part	<p>Amend language in proposed regulation Section 3725(b)(1) as follows:</p> <p>(1) Examples of Stigma and Discrimination Reduction Programs/Approaches include, but are not limited to, social marketing campaigns, speakers' bureaus and other direct-contact approaches, targeted education and training, anti-stigma advocacy, web-based campaigns, efforts to combat multiple stigmas <u>that have been shown to discourage individuals from seeking mental health services, that have an impact on</u></p>	<ol style="list-style-type: none"> 1. The suggested change to language describing the impact of multiple stigmas with regard to seeking mental health services is accurate and useful. 2. While the MHSA requires the PEI program to include efforts to reduce stigma associated with either being diagnosed with a mental illness or seeking mental health services and also efforts to reduce discrimination against people with mental illness, it does not specify any particular method by which the reduction is to be accomplished. The proposed regulations implement the WIC section 5847(b)(3) and (b)(4) provision by requiring all PEI programs to contribute to the reduction of stigma and discrimination through the ways in which PEI programs are designed, promoted, and implemented. In addition, counties also have the option to offer a Stigma and Discrimination Program. These optional programs are set forth in proposed regulation Section 3725 3. Reject deletion of the reference to services that increase acceptance, dignity, inclusion and equity for individuals with a mental illness and for members of their families because this language is consistent with the Substance Abuse and Mental Health Services Administration (SAMHSA) recommendation to using positive language to frame mental illness-related stigma and discrimination reduction goals in positive terms.

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		<p>and may include 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 <u>that have been shown to discourage individuals from seeking mental health services, have an impact on mental illness, and efforts to encourage self-acceptance as long as such programs are targeted to assist people who are diagnosed with a mental illness or seeking mental health services.</u></p> <p><u>(2) A county may choose to combat stigma by addressing its root cause, through programs modelled on successful programs that reduce violence by the severely mentally ill, such as Laura's Law and assistant outpatient treatment programs under the Mentally Ill Offenders Crime Reduction Grant Program.</u></p> <p>Authority/Reference for the deletions and added language to subsection (b)(1): Welfare & Institutions Code section 5840(b) provides that the program "shall include the following components.... (3) Reduction in stigma associated with either being diagnosed with a mental illness or seeking mental health services. (4) Reduction in discrimination against people with mental illness."</p> <p>Necessity for the deletions and added</p>		<p>mental illness and efforts to encourage self-acceptance for individuals with a mental illness.</p>	<ol style="list-style-type: none"> 4. Proposed PEI Regulations require a Stigma and Discrimination Reduction Program specifically to address negative attitudes and behaviors associated with either being diagnosed with a mental illness or seeking mental health services, consistent with WIC 5840(b)(3) and (4). 5. The fundamental goal of Stigma and Discrimination Programs is to assist people with a mental illness or who seek or who might consider or benefit from seeking mental health services. Assisting such individuals directly is not the only method by which this goal can be accomplished. 6. Since a root cause of stigma and discrimination is misperception that people with a mental illness are inherently violent, following this recommendation would perpetuate stigma and discrimination, not reduce it. The "root cause" of stigma and discrimination is not violent acts committed by individuals with a serious mental illness, which, of course, is a very small percentage. Stigma and Discrimination Reduction Programs intend to change attitudes, knowledge and behavior associated with stigma and discrimination related to mental illness or seeking mental health services. This requirement does not preclude a County from addressing attitudes, knowledge, and behavior of individuals with a mental illness that express or contribute to stigma and discrimination, including violence. Internalized stigma, which can manifest in a wide range of behaviors, is a very serious dimension of stigma and discrimination. See Response to Comment 8.41. 7. All PEI programs, including Stigma and Discrimination Programs, are required to use effective methods to bring about their intended MHSA outcomes, per proposed regulation Section 3740.

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		<p>language to subsection (b)(1): Necessary for conformity to statute, which MHSOAC's proposed regulation expands, alters and amends. Also necessary to prevent further waste and misuse of PEI funds on programs that have nothing to do with mental illness or severe mental illness.</p> <p>Authority/Necessity for proposed subsection (b)(2): MIPO is aware of no evidence that stigma reduction campaigns are actually effective. There is evidence that targeting the root cause of stigma can be effective.</p>			
3725	Commenter #3	<p><u>Comment 3.27</u> MIPO's comments regarding proposed section 3725:</p> <p>Stigma and anti-discrimination programs are mandatory, pursuant to Welfare & Institutions Code section 5840(b). 31 MIPO suggests striking from MHSOAC's proposed regulation various subjective terms and phrases that have little or nothing to do with stigma or discrimination, because they encourage continued waste of funds on programs outside the scope of the legislation.</p> <p>The MHSA's anti-stigma and anti-discrimination provisions target only</p>	Reject	Retain existing language with no change	Comment uses the same arguments as are listed in Comment 3.26 regarding stigma and discrimination programs. See Responses to Comment 3.26.

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		<p>"[r]eduction in stigma associated with either being diagnosed with a mental illness or seeking mental health services," and in "discrimination against people with mental illness." Welf. & Inst. Code § 5840(b)(3) and (4). In the past, counties have put together programs for groups such as LGBT teens that had no apparent connection either to mental illness or to seeking mental health services. It is not clear whether these were considered anti-stigma programs, or indirect efforts to prevent "mental illness" by providing support groups for individuals who were not mentally ill (and probably never will be) based on an unfounded and offensive premise that LGBT individuals are more likely to become severely mentally ill than the general public. Either way, such programs should not have been funded because they lacked connection to either those who had been diagnosed with mental illness or those seeking mental health services. Given this past history, MHSOAC's regulations need to be tightened to ensure that MHSA PEI funds are dedicated only to the mentally ill and those who are seeking mental health services.</p> <p>MIPO proposes adding subsection (b)(2) because one sure way to fight stigma is to attack its root cause. Research suggests that the best approach to reducing stigma is to get help for the</p>			

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		<p>violent mentally ill-as they are a significant cause of the stigma against the mentally ill generally. See http://www.treatmentadvocacycenter.org/resources/consequences-of-lackoftreatment/violence/1372. As Dr. E. Fuller Torrey puts it, "The public...glance[s] at the poster proclaiming that mentally ill people make good neighbors. Then they see the news about the latest violent act by an untreated person with mental illness. The public knows which one to believe."</p>			
3725(b)	Commenter #6	<p><u>Comment 6.06</u> (b) "Stigma and Discrimination Reduction Programs/Approaches" means the County's direct activities to reduce negative feelings, attitudes, beliefs, perceptions, stereotypes and/or discrimination related to being diagnosed with a mental illness, having a mental illness, or to seeking mental health services and to increase acceptance, dignity, inclusion, and equity for individuals with mental illness, and members of their families. (1) Examples of Stigma and Discrimination Reduction Programs/Approaches include, but are not limited to, social marketing campaigns, speakers' bureaus and other direct-contact approaches, targeted education and training (e.g., stigma manifests in distinct ways among different ethnic groups, so dispelling the</p>	Reject	Retain existing language with no change	This level of detail is more appropriate for the Statement of Reasons than for inclusion in the PEI Regulations. While the Proposed PEI Regulations include some examples, the level of detail in this suggestion is beyond what staff considers appropriate for the regulations.

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		<p><u>myths about mental illness and associated substance use disorders in cultural communities; e.g., Filipino, Pacific Islander, Chinese, Latino, etc., must be addressed</u>), anti-stigma advocacy, web-based campaigns, efforts to combat multiple stigmas that have an impact on mental illness, and efforts to encourage self-acceptance for individuals with a mental illness.</p>			
3725(b)	Commeneter #8	<p><u>Comment 8.41</u> (b)“Stigma and Discrimination Reduction Programs/Approaches” means the County’s direct activities to reduce negative feelings, attitudes, beliefs, perceptions, stereotypes and/or <u>discrimination related discrimination related to being diagnosed with a mental illness, having a mental illness, or to seeking mental health services and to increase acceptance, dignity, inclusion, and equity for individuals with mental illness, and members of their families.</u> (1) Examples of Stigma and Discrimination Reduction Programs/Approaches include, <u>but are not limited to programs targeted at those “either being diagnosed with a mental illness of seeking mental health services, and may include social marketing campaigns, violence reduction initiatives such as services to facilitate 5150 interventions,</u></p>	Reject	Retain existing language with no change	<ol style="list-style-type: none"> 1. See responses to Comment 3.26 for rationale for rejecting deletion of positive language_and for rejecting the limited target population for these programs 2. Reject suggested violence reduction initiatives: Efforts to reduce violence by individuals with early onset of a mental illness who are at risk of violence (obviously, not all individuals with early onset of a mental illness) is an allowable intended outcome of an early intervention program in Proposed PEI Regulations, as long as the program also intends and uses effective methods to reduce symptoms of and promote recovery from the mental illness for which there was early onset. See Response to Comment 3.26. Reducing violence exhibited by individuals with a mental illness is not one of the outcomes listed in WIC 5840(d). However, counties can include additional relevant outcomes, in addition to those listed in WIC 5840(d), as an added value.

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		<u>guardianships, conservatorship[s] and treatment under AB-1421, speakers' bureaus and other direct-contact approaches, targeted education and training, anti-stigma advocacy, web-based campaigns, efforts to combat multiple stigmas that have an impact on mental illness, and efforts to encourage self-acceptance as long as such programs are targeted at those "either being diagnosed with a mental illness or seeking mental health services. for individuals with a mental illness.</u>			
3725(b)(1)	Commenter #36	<p><u>Comment 36.09</u> Section 3725, subdivision (b) (1) <i>Recommendation:</i> Include "approaches that are culturally congruent with the values of the populations to be served" and "community-defined stigma reduction approaches"</p> <p><i>Rationale:</i> Recognize the role of paraprofessional approaches in stigma and discrimination reduction. Stigma of mental illness manifest in distinct ways among various racial, ethnic, and cultural groups, so dispelling the myths of mental illness and substance abuse requires strategies that most effectively build rapport with affected communities regardless of background</p>	Accept	<p>Add subpart (2) to subdivision (b) of Section 3725 as follows:</p> <p><u>(2) Stigma and discrimination programs shall include approaches that are culturally congruent with the values of the populations for whom changes in attitudes, knowledge, and behavior are intended</u></p>	<ol style="list-style-type: none"> 1. Added language reinforces the requirement for culturally competent practice, a MHSA General Standard. Also this additional language reinforces the requirement in proposed regulation Section 3740 that each program demonstrate its effectiveness for the intended population. Since cultural groups have varying beliefs, values, and attitudes toward mental illness and seeking mental health services, culturally and linguistically appropriate approaches are essential to reduce mental illness-related stigma and discrimination in and in recognition of the diversity of California's population. 2. Proposed PEI Regulations allow practice- or community-defined evidence of effectiveness of PEI-funded programs for the intended populations (proposed regulation Section 3740(a)(3)).
3730	Commenter #3	<u>Comment 3.30</u>	Reject	Retain existing	<ol style="list-style-type: none"> 1. The suggested language for programs that focus on or

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		<p>MIPO proposes the following changes to proposed regulation section 3730: Section 3730. Suicide Prevention Programs and Approaches. (a) The County may offer one or more Suicide Prevention Programs/Approaches as defined in this section. (b) Suicide Prevention Programs/Approaches means organized activities that the County undertakes to prevent suicide as a consequence of mental illness. This category of programs does not focus on or have intended outcomes for specific individuals at risk of or with serious mental illness. This category of programs must focus on or have intended outcomes for individuals or populations with mental illness or severe mental illness. <u>(1) Suicide prevention activities that aim to reduce suicidality for specific <u>mentally ill and severely mentally ill</u> individuals at risk of or with early onset of a potentially serious mental illness can be a focus of a Prevention program pursuant to Section 3720 or a focus of an Early Intervention program pursuant to Section 3710.</u></p> <p>Authority for deletions and added language in subsection (b): Welfare & Institutions Code section 5840(d)(1) restricts the use of PEI funds to those programs that reduce suicides resulting from "untreated mental illness."</p>		<p>language with no change</p>	<p>have intended outcomes to reduce suicidality for individuals with early onset of a mental illness, as long as they also focus on direct mental health outcomes (reduced symptoms, recovery) are classified in Proposed PEI Regulations as Early Intervention Programs. Proposed PEI Regulations allow counties the option, in addition, to offer a broad Suicide Prevention effort that does not focus on outcomes for specific individuals at risk of suicide, but approaches the issue at a more systemic issue. It is these approaches that are the focus of proposed regulation Section 3730.</p> <ol style="list-style-type: none"> 2. There is a difference between the goal of reducing risk or completion of mental illness-related suicide with the mistaken idea that the only effective approach is to offer programs "aimed at high-risk populations" or that "serve individuals with untreated mental illness." Proposed PEI Regulations differentiate the goal from the method, which must have evidence of effectiveness, and which is not limited to particular approaches. 3. Public information campaigns are allowable Suicide Prevention Programs, as long as they use effective methods to bring about intended changes in attitude, knowledge, and behavior for the intended audience, related to reducing mental illness-related suicides, which are the vast majority of suicides. 4. While removal of lethal means has been demonstrated as effective in preventing suicides, it is legally beyond the scope of PEI regulations. There are constitutional and other legal issues with regard to removing firearms or other weapons from individuals.

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		<p>MHSOAC's proposed regulation would permit the expenditure of funds on programs directed to those who do not have an untreated mental illness, or even any mental illness at all.</p> <p>Necessity for deletions and added language in subsection (b): Necessary to conform the proposed regulation to the MHSA statutory requirements.</p> <p>(c) Suicide Prevention programs and approaches pursuant to this section include, but are not limited to, public and targeted information campaigns, suicide prevention networks, <u>firearms removal, knives removal, dangerous medication removal, and other means removal programs; outreach and support programs for those who have attempted suicide or are first degree relatives of those who attempted suicide</u>, capacity building programs, culturally specific approaches, screening programs, suicide prevention hotlines or web-based suicide prevention resources, and training and education <u>aimed at high risk populations</u>.</p> <p>Authority for deletions and added language in subsection (c): Welfare & Institutions Code section 5840(d)(1) authorizes funding of suicide programs that serve individuals with an untreated mental illness, not the public generally. There is also a substantial body of</p>			

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		<p>literature that shows suicide campaigns targeted to the public (or students) do not reduce suicide and may, in fact, increase it. See, e.g., Suicide Prevention Strategies: A systematic review, (2005) published in the Journal of the American Medical Association. (J. John Mann, Alan Apter, et al. (Available at http://jama.jamanetwork.com/article.aspx?articleid=201761 (12/28/13)</p> <p>Necessity for deletions and added language in subsection (c): The deletions are necessary to conform MHSOAC's proposed regulation to the MHSA statutory requirements. The added language is necessary because "means removal" is one of the most evidence-based ways to reduce suicide in people with mental illness, especially those at highest-risk, i.e., those who have attempted it before. See, e.g., Yip et al, "Means Restriction for Suicide Prevention," <i>The Lancet</i> v. 379 pp. 2393-2399 (2012), abstract available at http://hub.hku.hk/handle/10722/152519. "Means removal" is far more successful than the other interventions listed in MHSOAC's proposed regulation. For example, MHSA PEI funds were recently approved for the installation of a net under the Golden Gate Bridge. Finally, the suicide literature is clear that those most likely to attempt or complete suicide are those who have previously attempted it, and those who are first</p>			

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		degree relatives of those who previously attempted or completed suicide. In order to ensure efficient and effective use of PEI funds, these individuals must be given priority attention. See, e.g., Tsuang, "Risk of suicide in the relatives of schizophrenics, manics, depressives, and controls," Journal of Clinical Psychiatry 44(11):396-7, 398-400 (Nov. 1983), available at http://www.ncbi.nlm.nih.gov/pubmed/6643403 (1983).			
3730(b) and (b)(1)	Commenter #8	<p><u>Comment 8.42</u> (b) Suicide Prevention Programs/Approaches means organized activities that the County undertakes to prevent suicide as a consequence of mental illness. This category of programs does not focus <u>must focus on</u> or have intended outcomes for specific individuals or populations at risk of or with serious mental illness.</p> <p>(1) 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 <u>Prevention and Early Intervention Program</u> or Prevention program pursuant to Section 3720 or a focus of an Early Intervention program pursuant to Section 3710.</p>	Reject	Retain existing language with no change	1. See responses to Comment 3.30 on proposed regulation Section 3730(b) above.
3730(c)	Commenter #6	<p><u>Comment 6.07</u> (c) Suicide Prevention programs and approaches pursuant to this section</p>	Accept concept	See suggested changed language in Response to Comment 36.10	While this level of detail regarding suicide prevention networks is unnecessary, suicide attempt survivors can be important contributors to suicide prevention networks as

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		include, but are not limited to, public and targeted information campaigns, suicide prevention networks (including suicide attempt survivors), capacity building programs, culturally specific approaches, screening programs, suicide prevention hotlines or web-based suicide prevention resources, and training and education.		below	well as the other strategies listed as examples. See Response to Comment 36.10. In addition, a focus on suicide attempt survivors is allowed under both Prevention and Early Intervention programs. For example, suicide attempt survivors are an excellent example of a high-risk group that would be the appropriate focus of a Prevention Program or, if the suicide survivors also had early onset of a mental illness, of an Early Intervention Program.
3730(c)	Commenter #8	Comment 8.43 (c) Suicide Prevention programs and approaches pursuant to this section include, but are not limited to, public and targeted information campaigns, suicide prevention networks, <u>firearms removal. knives removal. dangerous medication removal. and other means removal programs;</u> <u>outreach and support programs for those who have attempted suicide or are first degree relatives of those who attempted,</u> capacity building programs, culturally specific approaches, screening programs, suicide prevention hotlines or webbased suicide prevention resources, and training and education <u>aimed at high-risk populations.</u>	Reject		<ol style="list-style-type: none"> 1. Reject removal of lethal means: See Responses to Comment 3.30 to proposed regulation Section 3730 above. 2. Reject high-risk populations language: See Response to Comment 6.07.
3730(c)	Commenter #36	Comment 36.10 Section 3730, subdivision (c) Recommendation: To include suicide survivor-based models among suggested strategies. Rationale: Including and making good use of as many tools to prevent serious personal harm, including tools derived	Accept	Amend subdivision (c) of Section 3730 as follows: 3730(c) Suicide Prevention programs and approaches pursuant to this section include, but are not limited to, public	MHSOAC staff agrees that the expertise of survivors of suicide is an exceedingly important resource informing effective approaches to suicide prevention.

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		from suicide survivors and recovery models for families of individuals who complete suicide, leverages the professional value of “starting where the client is” in the therapeutic and help-seeking relationship.		and targeted information campaigns, suicide prevention networks, capacity building programs, culturally specific approaches, suicide <u>survivor-informed models</u> , screening programs, suicide prevention hotlines or web-based suicide prevention resources, and training and education.	
3735	Commenter #8	<u>Comment 8.47</u> Add new subdivision 3735(a)(4) <u>(4) Be designed to ensure only those who meet the inclusion criteria defined in 5600.3 are served.</u>	Reject	Retain existing language with no change	<ol style="list-style-type: none"> 1. Inclusion criteria are already specified so repetition is not needed 2. The suggestion to limit all PEI programs and Strategies to those individuals defined in W&I Code Section 3600.3 is based on a misunderstanding of the entire structure of the MHSa and that PEI is one of five parts. See responses to Comment 8.35 above.
3735(a) – (a)(1)(B)	Commenter #8	<u>Comment 8.44</u> (a) The County shall include all of the following strategies as part of each program listed in Sections 3710 through 3730 of Article 7: <ol style="list-style-type: none"> (1) Be designed and implemented to help create <u>Treatment or Access and Linkage to Treatment- for</u> <ol style="list-style-type: none"> (A) “Access and Linkage to Treatment” means connecting children with severe mental illness, as defined 	Reject	Retain existing language with no change	<ol style="list-style-type: none"> 1. “The suggested change misinterprets the provision set forth in WIC 5840(b)(2). Proposed regulation Section 3735(a)(1) implements WIC Section 5840(b)(2), which requires PEI to provide “access and linkage to treatment, which would be provided under the CSS component, or other medically necessary treatment. 2. In addition to referrals to CSS, treatment that is suggested by this comment is already provided under proposed regulation Section 3710, which provides treatment for individuals with early onset of mental illness.

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		<p>in Welfare and Institutions Code Section 5600.3, and adults and seniors with severe mental illness, as defined in Welfare and Institutions Code Section 5600.3, as early in the onset of these conditions as practicable, to medically necessary care and treatment, including but not limited to care provided by county mental health programs.</p> <p>(B) <u>Treatment, Access and Linkage to Treatment</u> can be a stand-alone program, an element of a <u>Prevention and Early Intervention</u> program, <u>Prevention Program</u> or an element of an Early Intervention program, or a combination thereof.</p>			
3735(a)(2)(A)	Commenter #6	<p><u>Comment 6.08</u> (A) "Improving Timely Access to Services for Underserved Populations" means to increase the extent to which an individual or family from an underserved population as defined in Title 9 California Code of Regulations Section 3200.300 who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in the onset as practicable, through program features such as accessibility,</p>	Reject	Retain existing language with no change	While the perspective expressed in the comment reflects important elements of cultural respect, humility, and appropriateness, existing language in the proposed section is consistent with the suggestions and provides appropriate examples. See Response to Comment 8.35. This suggestion could be incorporated into training and technical assistance efforts.

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		<p>awareness about cultural values and knowledge of language including appropriateness and avoidance of stigmatic or alienating words, transportation, family focus, hours available, and cost of services. is a process that requires humility to develop and Utilizing the cultural humility approach enhances care by effectively weaving an attitude of learning about cultural customs and conventions into the outreach and service encounters with individuals and families of ethnic and cultural backgrounds. It requires humility to develop and maintain mutually respectful and dynamic partnerships with underserved communities.</p>			
3735(a)(2)(A)	Commenter #36	<p>Comment 36.11 Section 3735, subdivision (2) (A)</p> <p><i>Recommendation:</i> Add cultural and linguistic competency as a way to build and maintain effective partnerships with unserved and underserved communities</p> <p><i>Rationale:</i> Using cultural humility as an approach enhances care by effectively weaving an attitude of learning into service encounters. It requires humility to develop and maintain mutually respectful and dynamic partnerships with unserved and underserved communities.</p>	Reject	Retain existing language with no change	Proposed PEI Regulations focus on the MHSA's, especially 5840, intended outcomes and required actions and do not prescribe specific methods. These suggestions and observations can be an appropriate and valuable focus of training and technical assistance.
3735(a)(2)-(a)(2)(B)	Commenter #8	<p>Comment 8.45 (2) Be designed, implemented, and promoted in ways that Improve Timely Access to Mental Health Services for</p>	Accept in part and reject in part	Amend proposed Section 3735(a)(2)(B) as follows:	<ol style="list-style-type: none"> 1. Addition of shelters to listed examples is useful and relevant. 2. Reject suggestion to delete risk: Improving timely access to mental health services for individuals and

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		<p>Individuals and/or Families from Underserved Populations.</p> <p>(A) "Improving Timely Access to Services for Underserved Populations" means to increase the extent to which an individual or family from an underserved population as defined in Title 9 California Code of Regulations Section 3200.300 who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in the onset as practicable, through program features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available, and cost of services.</p> <p>Programs shall provide services in convenient, accessible, acceptable, culturally appropriate settings such as primary healthcare, <u>doctor's offices, shelters, homeless camps,</u> schools, family resource centers, community-based organizations, places of worship, and public settings <u>unless a mental health when those settings are as good as or superior than mental health settings in improving</u> enhances access to quality services and outcomes for underserved</p>		<p>Programs shall provide services in convenient, accessible, acceptable, culturally appropriate settings such as primary healthcare, schools, family resource centers, community-based organizations, places of worship, <u>shelters,</u> and public settings unless a mental health setting enhances access to quality services and outcomes for underserved populations.</p>	<p>families from underserved populations encompasses access to a range of mental health services, which includes prevention (addressing risk) of a potentially serious mental illness.</p> <p>3. It is not necessary to add "doctor's offices" because "primary healthcare" includes doctor's offices.</p> <p>4. Suggested alterations to the language regarding the preference for offering services in accessible culturally appropriate is not consistent with the 2001 Surgeon General's Report on Mental Health, which observed that the most fundamental shift in mental health service delivery has been from institutions to the community. Locating services in accessible community settings increases opportunities for innovative collaborations and partnerships. The result is likely to be accessible services, a goal that might not be achievable in more traditional settings. The option to offer services in a mental health setting if such a location would fulfill the statutory purpose of improving timely access to services for underserved populations is necessary to provide counties with flexibility for specific programs and circumstances.</p>

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		populations.			
3735(a)(3)(B)	Commenter #39	<p><u>Comment 39.03</u> (I did speak on these point in Public Comment, But I will repeat it here.)</p> <p>I approve of section 3735(a) in its entirety, but especially section (a)(3). In (a)(3)(B) the phrase “promoting positive attitudes and understanding of recovery among mental health providers;” is very good but there should be something similar about family members too. There should be education of providers, family members, consumers, and even the general public on “recovery, wellness, and resilience”. This would go a long way towards reducing stigma, preventing mental health challenges, and promoting early intervention success.</p>	Reject	Retain existing language with no change	<p>1. MHSOAC staff agrees with the goal reflected in the comment regarding the need, in some instances, to including family members, consumers, providers, the general public, and others in efforts to reduce stigma and discrimination. The focus in the requirement in subdivision (a)(3) to utilize Non-Stigmatizing and Non-Discriminatory approaches for all PEI programs is on how services are delivered, which is why there is emphasis on service providers. A PEI program might prioritize reducing any of the MHSA negative outcomes (WIC 5840(d)) or emphasizing one of the MHSA’s PEI access goals, not necessarily on reducing stigma and discrimination as its primary purpose. However, the way the program is employed must contribute to the reduction of stigma and discrimination in all instances, according to this provision of Proposed PEI Regulations.</p> <p>2. The suggestion about changing attitudes of family members is already allowed by the proposed regulations because counties have the option, in addition, of offering a Stigma and Discrimination Program, which attempts explicitly to change specified attitudes, knowledge, and behavior among specified individuals or groups.</p>
3735	Public Hearing	<p><u>Comment H12.01</u> My name is Helena Liber, and I’m speaking for CAMHPRO. I wanted to comment on a section of the proposed regulations called 3735, which states the counties shall include all of the following strategies as each -- as part of each program.</p> <p>And I want to say that I very much agree with this particular part of the regulations</p>	Reject	Retain existing language with no change	See Response to Comment 39.03

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		<p>and call attention to Item 3735(a)(3), “Be designated, implemented, and promoted using strategies that are non-stigmatizing and non-discriminatory.”</p> <p>And Item 3735(a)(3)(B), “Non-stigmatizing and non-discriminatory approaches include, but are not limited to, using positive messages and approaches that focus on recovery, wellness, and resilience; use of a culturally-appropriate language and concepts,” and so on.</p> <p>And then, in the same section, “... promoting positive attitudes and understanding of recovery among mental health providers; inclusion and welcoming of family members; and employment of peers in a range of roles.”</p> <p>I very much agree with all of that. I really like that. I believe that it’s not being implemented in PEI programs now, and I like seeing it included in the regulations and hope that, in the future, these things will be included.</p> <p>I would also like to add that there are additional areas - if you’re promoting positive attitudes and understanding among mental health providers, I think the same should be promoted amongst family members. And thank you.</p>			
3735(a)(3)(B)	Commenter #36	<p><u>Comment 36.12</u> Section 3735, subdivision (3) (B)</p>	Reject	Retain existing language with no	While it is true that religious faith and spirituality serve as secure bases and essential supports for recovery for many

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		<p>Recommendation: Include “faith-based” in list of identified approaches.</p> <p>Rationale: Recognize the role of faith-based strategies in the design, implementation, and promotion of non-stigmatizing and non-discriminatory PEI. Religious faith and spirituality serve as reliable “secure bases” for many communities because these remind us that both grief and loss are normative, that there is no right or wrong way to cope with loss, and that we do not have to go through loss over the lifespan alone, but with the mercy of our maker and the generosity of the cosmos.</p>		change	individuals, proposed regulation Section 3735 refers to the requirement that all PEI Programs use approaches that are non-stigmatizing and non-discriminatory, which would include the need to embrace and support individuals’ varying relationships to faith and spirituality.
3735(a)(3)-(a)(3)(B)	Commenter #8	<p><u>Comment 3.46</u></p> <p>(3) Be designed, implemented, and promoted using Strategies that are Non-Stigmatizing and Non-Discriminatory</p> <p>(A) “Strategies that are Non-Stigmatizing and Non-Discriminatory” means 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.</p> <p>(B) Non-Stigmatizing and Non-Discriminatory approaches</p>	<p><u>Accept in part and Reject in part</u> except additions to listed examples</p>	<p>Amend subdivision (a)(3)(B) to Section 3735 as follows:</p> <p>(B) Non-Stigmatizing and Non-Discriminatory approaches include, but are not limited to, using positive, <u>factual</u> messages and approaches with a focus on recovery, wellness, and resilience; use of culturally appropriate language, concepts, <u>and practices</u>; efforts to acknowledge and combat multiple social stigmas that affect</p>	<ol style="list-style-type: none"> 1. Adding the word “factual” is appropriate, helpful, and consistent with a positive approach. 2. Just adding “evidence-based practices” is not relevant to this section. Existing Proposed Regulation 3740 requires all PEI programs to use effective methods. The suggested concept that educating people that recovery from mental illness is possible through the use of effective methods is an allowable focus for a Stigma and Discrimination Reduction Program under proposed 3725 and therefore does not require any changes in the language. 3. Reject new proposed subdivisions (C) and (D) because they are not appropriate. While the overall goal of all PEI programs is to prevent mental illnesses from becoming severe and disabling, the goal of <u>subdivision (a)(3)</u> of proposed regulation Section 3735 is to require all PEI programs to be conducted in ways that are non-stigmatizing and non-discriminatory. This is both to increase access and also to improve the quality and

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		<p>include, but are not limited to, using positive <u>accurate truthful messages concerning diagnosis and prognosis</u> and approaches with a focus on <u>evidence-based practices like the use of medication, substance use avoidance, recovery, wellness, and resilience</u>; use of culturally appropriate language and concepts; efforts to acknowledge and combat multiple social stigmas that affect attitudes about mental illness and/or about seeking mental health services, including but not limited to race and sexual preference; co-locating mental health services with other life resources; promoting positive attitudes and understanding of recovery among mental health providers; inclusion and welcoming of family members; and employment of peers in a range of roles.</p> <p><u>(C) Are similar to other programs in reducing the duration of untreated serious mental illness</u></p> <p><u>(D) Prevent mental illness from becoming severe and disabling.</u></p>		<p>attitudes about mental illness and/or about seeking mental health services, including but not limited to race and sexual preference; co-locating mental health services with other life resources; promoting positive attitudes and understanding of recovery among mental health providers; inclusion and welcoming of family members; and employment of peers in a range of roles.</p>	<p>outcomes of services. The relationship of the requirement that all PEI programs be conducted in ways that are non-stigmatizing and non-discriminatory to the goal to reduce the duration of untreated mental illness is to increase the likelihood that individuals with risk or onset of a mental illness will be willing to seek and engage in services.</p>

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3740	Commenter #3	<p><u>Comment 3.28</u> MIPO proposes the following changes to proposed regulation section 3740. In the alternative, MIPO proposes that the definitions set forth below be added to MHSOAC's proposed "Definitions" section 3200.245:</p> <p>Section 3740. Effective Methods. (a) For each program and each strategy in Article 7, the County 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 mental health outcomes for the intended population <u>improvement in one or more of the negative outcomes listed in Section 5840(d)</u> including, but not limited to, <u>independent</u> scientific peer-reviewed research using randomized clinical trials. <u>Each Early Intervention Program and Prevention Program designed to prevent mental illness from becoming severe mental illness shall additionally be modelled on and similar to a previous program that has been proven effective at preventing mental illness from becoming severe, using an evidence-based practice standard.</u></p> <p>(2) Promising practice standard:</p>	Reject	Retain existing language with no change	<ol style="list-style-type: none"> 1. Proposed regulation Section 3740 properly implements the MHSOAC requirements that PEI include services similar to those provided under programs effective in preventing mental illness from becoming severe. The MHSOAC does not define "effective" as limited to services that are evidence-based. 2. There is no agreed-upon definition in the literature about what constitutes an evidence-based practice. The three definitions provided in proposed regulation Section 3740 as alternatives for counties to demonstrate effectiveness encompass the range of definitions provided in the literature which are listed in the Initial Statement of Reasons. 3. The effectiveness cannot be limited to the reduction of the negative outcomes because the requirement to use effective practices applies to Prevention and Early Intervention Programs, which is intended to bring about the applicable negative outcomes listed in WIC Section 5840(d), and also the other MHSOAC-mandated practices or intended outcomes listed in WIC 5840. These other MHSOAC goals do not address the seven negative outcomes in WIC 5840(d), but focus on other MHSOAC PEI goals such as the reduction in the duration of untreated mental illness by improving access to treatment for individuals with a serious mental illness. Therefore, the suggestions to insert a reference to the seven negative outcomes into the evidence-based practice standard, which applies to all MHSOAC programs, would not be applicable in all instances. 4. Re-define Promising Practice Standard: The mental health literature includes a number of definitions of and standards for what constitutes a "promising practice." Most describe research methods that are less rigorous than the standard that the entity uses to define an "evidence-based practice." The definition used in this provision reflects this general research-oriented

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		<p>Promising practice means programs and activities for which there is <u>independent research demonstrating effectiveness, including strong quantitative and qualitative data showing positive outcomes improvement in one or more of the negative outcomes listed in Section 5840(d), but the research does not meet the standards used to establish evidence-based practices and does not have enough research or replication either to support or negate generalizable positive public health outcomes improvement in one or more of the negative outcomes listed in Section 5840(d). Each Relapse Prevention Program established pursuant to [MIPO proposed] Section 3720(d) and Relapse Early Intervention Program established pursuant to [MIPO proposed] Section 3710(b)(2) shall additionally be modelled on and similar to a previous program that has been proven successful in reducing the duration of untreated severe mental illnesses and assisting people in quickly regaining productive lives using a promising practice standard.</u></p> <p>(3) Community and or practice based evidence standard: Community and or practice based evidence means a set of practices that communities have used and determined to yield positive results by community consensus over time,</p>			<p>approach to defining the promising practice standard.¹ The definition is consistent with the approach currently in use by a number of counties, including the largest, Los Angeles.</p> <p>5. Comment is incorrect that MHSOAC does not have authority to allow “community-based practice standard” as one option for counties to show that services are effective. Community-based practices is a valid standard to measure effectiveness. As mentioned above, the MHSA does not limit effectiveness to “evidence-based.</p> <p>6. Elimination of Community and Practice-Based Evidence Standard: There is a need to allow counties to implement programs that have documented their effectiveness solely based on practice-based or community defined evidence because at this stage in the evolution of research in the field of prevention and early intervention related to potentially serious mental illness, there are insufficient programs that meet the empirical research standards required for an evidence-based practice or promising practice, as defined in these regulations. The literature also documents numerous limitations to mandating application of the empirical evidence-based practice standard for public health programs. The task is to evaluate practices with community and/or practice-based evidence with scientific rigor to increase the number of evidence-based practices, not to limit implementation to the limited number that exist now. See Initial Statement of Reasons for more discussion and references on this topic.</p>

¹ Association of Maternal Child Health Programs. Emerging, promising, and best practices definitions..

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		<p>'which mayor may not have been measured empirically. Community and or practice defined evidence takes a number of factors into consideration, including worldview and historical and social contexts of a given population or community, which are culturally rooted.</p> <p>In the alternative, MIPQ proposes the following additions to MHSOAC's proposed "Definitions" section 3200.245:</p> <p>Section 3200.245. Prevention and Early Intervention.</p> <p>(b) For purposes of this Chapter, "services similar to those provided under other programs effective in preventing mental illnesses from becoming severe" means services modelled on a previous program or programs that have already been proven effective in preventing mental illness from becoming severe mental illness, using scientific evidence consistently showing improvement in one or more of the negative outcomes listed in Section 5840(d), including, but not limited to, independent scientific peer-reviewed research using randomized clinical trials.</p> <p>(c) For purposes of this Chapter, "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" means</p>			

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		<p>services modelled on a previous program or programs that have shown success at intervening early in and/or preventing relapses into severe mental illness, as defined herein, based on research demonstrating success, including strong quantitative and qualitative data showing improvement in one or more of the negative outcomes listed in Section 5840(d), but the research does not meet the standards used to establish evidence-based practices and does not have enough research or replication either to support or negate improvement in one or more of the negative outcomes listed in Section 5840(d).</p> <p>Authority/Reference for "evidence-based practice standard" as proposed by MHSOAC and "services similar to those provided under other programs <i>effective</i> in preventing mental illnesses from becoming severe" as proposed by MIPO: Welfare & Institutions Code section 5840(c), which provides: "The program <i>shall</i> include mental health <i>services similar to those provided under other programs</i> effective in preventing mental illnesses from becoming severe...." (emphasis added). <i>See also</i> MHS Section 3, the Purpose and Intent provision, subsection (c): "[T]o expand the kinds of successful, innovative service programs for children, adults and seniors begun in California....These</p>			

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		<p>programs have already proved their effectiveness. . ."; and Purpose (e): "To ensure that all funds are expended in the most cost effective manner and services are provided in accordance with recommended best practices. ..." See also MHSA section 2 Findings and Declarations provisions, subsections (f) and (e), which call for "expanding programs that have demonstrated their effectiveness,"; and for "effective treatment," "effective models," an approach "recognized in 2003 as a model program by the President's Commission on Mental Health," and "successful programs" (emphasis added).</p> <p>Authority/Reference for "promising practice standard" as proposed by MHSOAC and "similar to programs that have been successful in reducing the duration of untreated severe mental illnesses" as proposed by MIPO: Welfare & Institutions Code section 5840(c), which provides: "The program .. 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." (Emphasis added.) See <i>also</i> the language in MHSA's Purpose and Intent/Findings and Declarations provisions quoted above.</p>			

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		<p>Authority/Reference for deletion of MHSOAC's "community based practice standard" in subsection (a)(3): There is no statutory authority for a "community based practice standard." This standard is antithetical to the statutory provisions quoted immediately above, and additionally, to the requirement in section 5840(b)(2) for "medically necessary care." By relegating minority communities to second class care based on "world view" and "culturally rooted" practices, it also violates the MHSA anti-discrimination provisions, as well as those in other state and federal statutes.</p> <p>Necessity for "evidence-based practice standard" or the equivalent as proposed by MIPO: Necessary for conformity to statute, which requires evidence-based practices. Also necessary to change existing wasteful practices at the county level, and to address the criticisms of the California State Auditor.</p> <p>Necessity for "promising practice standard" or the equivalent proposed by MIPO: Necessary for conformity to statute, which incorporates a slightly relaxed standard for relapse prevention programs. Also necessary to change existing wasteful practices at the county level, and to address the criticisms of the California State Auditor.</p>			

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		<p>Necessity for deletion of MHSOAC's proposed "community based practice standard" in subsection(a)(3): Necessary for conformity to statute, which MHSOAC's proposed regulation expands, alters and amends. Also necessary to change existing wasteful practices at the county level, and to address the criticisms of the California State Auditor.</p>			
3740	Commenter #3	<p><u>Comment 3.29</u> MIPO's comments regarding proposed regulation section 3740: MHSOAC's proposal to adopt a "community consensus," non-empirical standard completely undermines the "evidenced-based" and "promising practice" standards that are not only required by the MHSOAC, but also</p>		Retain existing language with no change	<ol style="list-style-type: none"> 1. Practice and community defined-evidence: See Response to Comment 3.28 2. The disagreement here is not about the requirement to offer effective programs that have demonstrated their success, but about the kinds of evidence that can be used to demonstrate effectiveness and success. Proposed PEI Regulations require Counties to use effective methods likely to bring about intended outcomes for all PEI programs and all strategies within

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		<p>necessary to address the serious deficiencies in MHSOAC's oversight responsibilities as identified by the California State Auditor. MHSOAC's proposed 'community consensus' standard also represents precisely the type of justification that MHSOAC has used in the past to approve the expenditure of public money on things like yoga and Indian drumming circles. Indeed, because MHSOAC has insisted on involving clergy in its proposed "Access and Linkage" regulations, one could easily imagine the "community consensus" standard being used to justify payment for bus trips to Mexico to pray to the Virgin of Guadalupe, since there is a community consensus among certain priests that praying to the Virgin will "yield positive results." In addition to being outside the scope of the MHSA, such public subsidies of spiritual and prayer-based practices also would be probable violations of the First Amendment.</p> <p>MHSOAC's proposed adoption of a "community consensus", non-empirical standard should not be allowed because it is contrary to statute. Proposition 63 never authorized, much less encouraged, expenditures based on "worldview" "social contexts" and "culturally rooted" practices, which violate the anti-discrimination provisions in the statute because they are simply a</p>			<p>programs. See Response to Comment 26.05.</p> <p>3. These comments, specifically the reference to uncodified sections 2 and 3 of the MHSA, are based on a misunderstanding of the MHSA structure, which includes PEI as one of five components. See responses to Comments 3.10 and 3.13</p>

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		<p>way of consigning minority populations to substandard care. As MHSOAC itself makes clear in its own definitions of "evidence-based practice" and "promising practice," PEI programs are supposed to be grounded in science. The MHSA's Findings and Declarations, Purpose and Intent provisions also make this clear, as does the repeated statutory use of terms of art in the medical field, such as "recommended best practices," "effective," "cost effective" and "medically necessary." The statutory emphasis on reaching "underserved populations" is to coax them out of their cultural prejudices and into effective treatment regimens, i.e., "[t]o expand the kinds of successful, innovative service programs for children, adults and seniors begun in California, including culturally and linguistically competent approaches." MHSA's Purpose and Intent Section 3(c) (emphasis added). In sum, mentally ill and severely mentally ill minority populations are entitled under the MHSA to "effective" and "successful" programs, and to "medically necessary" treatment, like everyone else.</p> <p>MHSOAC also has failed to address another requirement of the MHSA, namely "effective" or "successful" models/prototypes for programs for the mentally ill and severely mentally ill:</p> <p>The program shall include mental</p>			

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		<p>health services <i>similar to those provided under other programs effective</i> in preventing mental illnesses from becoming severe, and shall also include <i>components similar to programs that have been successful</i> in reducing the duration of untreated severe mental illnesses and assisting people in quickly regaining productive lives.</p> <p>Welf. & Inst. Code § 5840(c)(emphasis added).</p> <p>In addition to the plain meaning of this statutory language, Proposition 63's Findings and Declarations and Purpose and Intent provisions - which courts consider to be key to discerning voter intent³⁴ -further demonstrate that voters were repeatedly promised that MHSA money would be used <i>only</i> on programs that were based on effective/ successful models. These provisions are quoted here in full, so the quoted language can be read in context:</p> <p>SECTION 2. Findings and Declarations The people of the State of California hereby find and declare all of the following: (a) Mental illnesses are extremely common; they affect almost every family in California. They affect</p>			

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		<p>people from every background and occur at any age. In any year, between 3% 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. People who become disabled by mental illness deserve the same guarantee of care already extended to those who face other kinds of disabilities.</p> <p>(b) Failure to provide timely treatment can destroy individuals and families. No parent should have to give up custody of a child and no adult or senior should have to become disabled or homeless to get mental health services as too often happens now. No individual or family should have to suffer inadequate or insufficient treatment due to language or cultural barriers to care. Lives can be devastated and families can be financially ruined by the costs of care. Yet, for too many Californians with mental illness, the mental health services and supports they need remain fragmented, disconnected</p>			

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		<p>and often inadequate, frustrating the opportunity for recovery.</p> <p>(c) Untreated mental illness is the leading cause of disability and suicide and imposes high costs on state and local government. Many people left untreated or with insufficient care see their mental illness worsen. Children left untreated often become unable to learn or participate in a normal school environment. Adults lose their ability to work and be independent; many become homeless and are subject to frequent hospitalizations or jail. State and county governments are forced to pay billions of dollars each year in emergency medical care, long-term nursing home care, unemployment, housing, and law enforcement, including juvenile justice, jail and prison costs.</p> <p>(d) In a cost cutting move 30 years ago, California drastically cut back its services in state hospitals for people with severe mental illness. Thousands ended up on the streets homeless and incapable of caring for themselves. Today thousands of suffering people remain on our streets because they are afflicted</p>			

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		<p>with untreated severe mental illness. We can and should offer these people the care they need to lead more productive lives.</p> <p>(e) With <u>effective treatment</u> and support, recovery from mental illness is feasible for most people. The State of California has developed effective models of providing services to children, adults and seniors with serious mental illness. A recent innovative approach, begun under Assembly Bill 34 in 1999, was recognized in 2003 as a <u>model program</u> by the President's Commission on Mental Health. This program combines prevention services with a full range of integrated services to treat the whole person, with the goal of self-sufficiency for those who may have otherwise faced homelessness or dependence on the state for years to come. Other innovations address services to other underserved populations such as traumatized youth and isolated seniors. These <u>successful programs</u> including prevention, emphasize client-centered, family focused and community-based services that are culturally and linguistically competent and are provided in an</p>			

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		<p>integrated services system.</p> <p>(f) By <u>expanding programs that have demonstrated their effectiveness</u>, California can save lives and money. Early diagnosis and adequate treatment provided in an integrated service system is very effective; and by preventing disability, it also saves money. Cutting mental health services wastes lives and costs more. California can do a better job saving lives and saving money by making a firm commitment to providing timely, adequate mental health services.</p> <p>(g) To provide an equitable way to fund these <u>expanded services</u> while protecting other vital state services from being cut, very high-income individuals should pay an additional one percent of that portion of their annual income that exceeds one million dollars (\$1,000,000). About 1/10 of one percent of Californians have incomes in excess of one million dollars (\$1,000,000). They have an average pre-tax income of nearly five million dollars (\$5,000,000). The additional tax paid pursuant to this represents only a small fraction of the amount of tax reduction they are</p>			

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		<p>realizing through recent changes in the federal income tax law and only a small portion of what they save on property taxes by living in California as compared to the property taxes they would be paying on multi-million dollar homes in other states.</p> <p>SECTION 3. Purpose and Intent. The people of the State of California hereby declare their purpose and intent in enacting this act to be as follows:</p> <p>(a) To define serious mental illness among children, adults and seniors as a condition deserving priority attention, including prevention and early intervention services and medical and supportive care.</p> <p>(b) To reduce the long-term adverse impact on individuals, families and state and local budgets resulting from untreated serious mental illness.</p> <p>(c) To <u>expand</u> the kinds of <u>successful</u>, innovative service programs for children, adults and seniors begun in California, including culturally and linguistically competent</p>			

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		<p>approaches for underserved populations. These programs <u>have already demonstrated their effectiveness</u> in providing outreach and integrated services, including <u>medically necessary</u> psychiatric services, and other services, to individuals most severely affected by or at risk of serious mental illness.</p> <p>(d) To provide state and local funds to adequately meet the needs of all children and adults who can be identified and enrolled in programs under this measure. State funds shall be available to provide services that are not already covered by federally sponsored programs or by individuals' or families' insurance programs.</p> <p>(e) To ensure that all funds are expended <u>in the most cost effective manner</u> and services are provided in accordance with <u>recommended best practices</u> subject to local and state oversight to <u>ensure accountability</u> to taxpayers and to the public.</p> <p>(Emphasis added.) The highlighted language makes clear that voters were promised that public money would be spent only on programs that were</p>			

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		<p>modelled on "effective" and "successful" prototypes.</p> <p>The California Administrative Procedure Act requires that regulations be "reasonably necessary to effectuate the purpose of the statute." Gov. Code § 11342.2. The ten year history of wasted PEI funds highlights the need for effective models for PEI programs. In the past ten years, county mental health authorities have been encouraged by MHSOAC to "reinvent the wheel" and fund whatever they like, as long as it benefitted people "prior to diagnosis." See MIPO Comment No.1 (submitted June 27, 2014, and exhibits cited therein. County authorities have done so enthusiastically, underwriting yoga, horseback riding, Indian drumming, hip hop car washes, and a host of other programs that have nothing to do with mental illness. MHSOAC is thus legislating against a ten year history of documented waste that has become ingrained and habitual. Funding only programs based on "effective" or "successful" prototypes already proven to help the mentally ill and severely mentally ill is necessary to get PEI funding back "on track."</p> <p>In addition to MIPO's proposed changes to section 3740, MIPO proposes that its standards be included in the "Definitions" section of MHSOAC's proposed</p>			

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		<p>regulation section 3200.245. MIPO believes that this is where the standards belong, and notes that some of the changes it has proposed to other proposed regulations will not work effectively without these standards being included in the "Definitions" section. Further, MIPO submits that regulatory standards grounded in the literal language of the statute will have more impact on counties that are used to having complete spending discretion, because they will reiterate the statutory requirement for "effective" and "successful" prototype programs.</p>			
3740	Commenter #8	<p><u>Comment 8.48</u> (a) For each program and each strategy in Article 7, the County 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 <u>outcomes as defined in 5840(d) mental health outcomes for the intended population individuals who meet the criteria of 5600.3,</u> including, but not limited to, scientific peer-reviewed research using randomized clinical trials. (2) Promising practice standard: Promising practice</p>	Reject	Retain existing language with no change	See responses to Comment 3.28.

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		<p>means programs and activities for which there is research demonstrating effectiveness, including strong quantitative and qualitative data showing positive outcomes, but the research does not meet the standards used to establish evidence-based practices and does not have enough research or replication to support generalizable positive public health outcomes.</p> <p>(3) — Community and or practice-based evidence standard: Community and or practice-based evidence means a set of practices that communities have used and determined to yield positive results by community consensus over time, which may or may not have been measured empirically. Community and or practice-defined evidence takes a number of factors into consideration, including worldview and historical and social contexts of a given population or community, which are culturally rooted.</p>			
3740	Commenter #32	<p><u>Comment 32.06</u> <u>5. Recommendation: Section 3740(3). Effective Methods</u></p> <p>We strongly support an inclusive definition of “effective” which encompasses community and</p>	<p>No response required because comment agrees with section as written</p> <p>Comment</p>	<p>Retain existing language with no change</p>	

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		<p>culturally defined practices.</p> <p>Currently, proposed regulations specify that programs must be "effective". We feel strongly that "effective" methods are successfully demonstrated in a variety of ways beyond what is currently accepted as "evidence-based".</p> <p>For this reason, we strongly propose that the regulations remain inclusive of community-defined practice, which is a set of practices that communities have used over time and found to have positive results. These types of practices may or may not have been measured empirically but have a level of acceptance in the community. One component of the first phase of the California Reducing Disparities Project focused is identifying community-defined PEI activities, and the second phase will focus on providing a small amount of funding to pilot and evaluate select PEI community-defined practices in the five target populations. Further, we suggest <u>that Innovation funds may be used to build the data for elevating community-defined practices to further substantiate these approaches.</u></p>	<p>regarding use of Innovation funds is outside the scope of the PEI regulations.</p>		
3740	Commenter #74	<p><u>Comment 74.07</u> REMHDCO recommends that the following language be added to this section:</p> <p><i>(A) If the Evidence-based practice</i></p>	Reject	Retain existing language with no change	Existing language in Proposed regulation Section 3740 requires use of effective practices for intended population, which covers the suggestion.

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		<p><u>standard is used and does not bring about the intended outcome, then the program shall use other effective methods as described in (2) and (3).</u></p> <p>In the Initial Statement of Reasons Prevention and Early Intervention Programs at pages 27-29, Section 3740, Effective Methods, the Rationale provides “..the MHSA does not mandate a specific standard of evidence for demonstrating program success or effectiveness. There is also no consensus among experts about a specific minimum threshold of evidence or cutoff point below which evidence should be considered sufficient or insufficient...” (p. 27).</p> <p>There are insufficient programs that emphasize practice based or community defined standards which would meet the empirical research standards for evidenced-based practices. Because of this, there is a need to allow counties to implement programs that are effective based on the practice in the community or relates to community defined evidence. There is the lack of evidence based research or promising practice standards that have included clinical subjects who identify as people of color. This fact further supports the need to include and strongly consider community-defined and practice-based evidence for PEI programs (p. 28-29).</p>			

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3740(a)(2) and (a)(3)	Commenter #36	<p><u>Comment 36.13</u> Section 3740, subdivision (a) (2, 3)</p> <p><i>Recommendation:</i> Add language ensuring targeted support for collecting community and practice-based evidence for both the “promising practice” and “practice-based evidence” standards.</p> <p><i>Rationale:</i> Recognizing that there may currently be no evidence for models used under the “promising practice” and “practice-based evidence” standards other than anecdotal and deeply-held cultural beliefs and practices, PEI regulations should proactively support efforts for the substantiation of such models.</p>	Reject	Retain existing language with no change	<ol style="list-style-type: none"> 1. Comment uses different definitions of an evidence-based practice and a promising practice from that used in proposed regulation Section 3740 (a)(1) and (a)(2), both of which require evidence. 2. If the comment intends to suggest the need to support the use of scientific evidence to assess practices offered under the standard of Community or Practice-based Evidence in order to move these practices to standards of Evidence-Based or Promising Practices, this support would occur as training and technical assistance, not with PEI Regulations.
No specified section	Commenter #1	<p><u>Comment 1.01</u> I am the mother of a 23 year old son who has been psychotic for at least half of the last 3 years due to difficulty obtaining appropriate treatment.</p> <p>I am commenting on the proposed PEI regulations. The law says you SHALL fund relapse prevention/early intervention for the severely mentally ill. The PEI regs need to require funding for programs like Assisted Outpatient Therapy, and “housing first” programs that combine housing and good case management. You need to find other funding sources to support things like cultural awareness events, parenting, anti-bullying, stigma prevention, yoga, tai</p>	Reject	See suggested changed language in response to Comment 3.10 above.	<ol style="list-style-type: none"> 1. Require relapse prevention: See Responses to comment 3.09 and to Comment 3.10.

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		<p>chi, and drumming. Those are worthy activities but they do not prevent serious mental illness. There is currently no way to predict who will experience psychosis; onset occurs often in late teens when brains malfunction. Therefore the only way to prevent psychosis from becoming serious mental illness is to provide patient-centered case management including medication and psychoeducation, so the patient learns the nature of the disease, how to cope with it, and how to seek treatment when symptoms exacerbate. Support must be provided for the patient to stabilize.</p> <p>The yearly PEI budget is around \$317 million and the bulk of this money should be going into life-saving programs such as those listed above for the severely mentally ill. Right now NONE of it is going to the severely mentally ill. Act now to help change this!</p>			
No specified section	Commenter #2	<p><u>Comment 2.01</u> I am the sole caregiver for my 22 year old godson who has schizoaffective disorder. In navigating the public mental health system, I've found so many obstacles and so much evidence of misspent money. I am commenting on the proposed PEI regulations. The law says you SHALL fund relapse prevention/early intervention for the severely mentally ill. The PEI regs need</p>	Reject	See suggested changed language in response to Comment 3.10 above.	Require relapse prevention: See Responses to comment 3.09 and to Comment 3.10.

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		<p>to require funding for programs like Crisis Intervention Training for first responders (not just law enforcement but EMTs and Fire personnel, as well). Another great use of MHPSEI funds is Assisted Outpatient Treatment (aka Laura's Law or AOT). These programs are both necessary in early intervention of illness.</p> <p>Soon after my godson had his first psychotic episode, he became suicidal. As I caregiver, I was shocked that four cop cars showed up and NO AMBULANCE! He has a medical illness, but these officers had little to no training in mental illness. They handcuffed my very sick godson and placed him in the back of a police car to transport him to the hospital. With CIT training, there would be a better, more peaceful way of handling the situation. Sacramento County has a great CIT program, but the funding is not indefinite. So far they rely on the tenuous and underfunded Homeland Security grant, when they should be funded by MHPSEI money.</p> <p>You need to stop wasting money on things like anti-bullying programs. These programs are important, but should NOT be funded by voter-approved Prop 63, which was designed to help the most seriously ill in our population, ie those with schizophrenia, bipolar disorder and other illnesses listed in WIC 5600.3.</p>			

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		Please ensure the PEI funds are spent appropriately and made available to CIT and AOT programs.			
No Specified Section	Commenter #8	<u>Comment 8.04</u> Prevention and Early Intervention programs "shall include mental health services similar to those provided under other programs effective in preventing mental 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" (emphasis added) These regulations intentionally drive funds from "effective" "successful" programs to programs that are neither effective, nor successful.	Reject	Retain existing language with no change	The proposed regulations require all programs and strategies to use methods that are effective to bring about the intended MHSA outcome. See responses to Comments 3.28 and 3.29
No Specified Section	Commenter #8	<u>Comment 8.06</u> The proposed regulations bifurcate prevention and early intervention programs into two separate entities and sever them from the statutory requirement that the components "prevent mental illnesses from becoming severe and disabling." This bifurcation makes the regulations needlessly cumbersome and difficult to understand and drives funds from their intended purpose	Reject	Retain existing language with no change	All of the proposed regulations focus on the overall intent of the PEI Component to prevent mental illness from becoming severe and disabling. The structure follows that set forth in the MHSA. See responses to Comments 3.04 through 3.09 above and response to Comment 8.19 below.
No Specified Section	Commenter #8	<u>Comment 8.08</u> The regulations redefined 'evidence based' to allow the funding of services that don't have evidence of efficacy. This	Accept concept	See proposed additional definitions, described in response to Comment 3.07 above	See responses to Comments 3.28 and 3.29

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		encourages the diversion of PEI funds to programs that should be funded with INN funds			
No Specified Section	Commenter #8	<p><u>Comment 8.19</u> Umbrella comments The PEI Section of legislation specifically says counties "shall establish a program designed to prevent mental illness from becoming severe and disabling."(emphasis added). The requirement is singular, not plural. In spite of this clear direction the proposed regulations make components optional The artificial bifurcation of Prevention and Early Intervention Programs into two components (a) prevention and (b) early intervention, as proposed in the proposed regulations is contrary to legislation. It complicates, confuses, and will likely end up diverting funds rather than helping to see they are spent appropriately. The legislation is clear that there shall be "a" program, not multiple «5840(a)». In addition 5840 (a), 5840 (b) and 5840 (c) all start by describing "The Program" not multiple programs.</p>		Same suggested change as in response to Comment 3.07 above.	See Response 1 to Comment 3.07, which includes suggested definitions intended to clarify this issue.
No Specified Section	Commenters #10, 25, 30, 50, 56, 57, 61, 64, 66, 73, H4, H5, H6, H13, H15	<p><u>Summary of Comments Listed Below:</u> All of the comments below state that the regulations should focus on prevention programs as defined in the regulations and prevention should be required instead of optional. Each comment is set forth verbatim below. <u>Comment 10.08</u> I would like to suggest that the PEI regulations include a focus on primary</p>	Accept	Same changes suggested in response to Comment 60.02	<ol style="list-style-type: none"> Proposed PEI Regulations include a focus on prevention. See Response to 60.02 for suggestion to require all counties, except very small counties, to offer at least one Prevention Program. Focus on trauma: Severe trauma is already listed as an example of a risk factor (proposed regulation Section 3720(c)(1)) that may be the focus of a Prevention Program.

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		<p>prevention of mental illness. Much of the work through PEI has been focused on working with folks who already have mental illnesses to be diagnosed early, get access to care, live a stigma free life, and get ancillary services. These interventions are important and are rightly part of the MHSA PEI approach.</p> <p>However, I think we should also be interested in preventing mental illnesses before they begin. This primary prevention approach would prevent human suffering, improve our economy, and save tax dollars used now on mental health treatment, incarceration, and child welfare services. The primary prevention approach that I think should be a strong focus of the MHSOAC is prevention of trauma. It is well documented that trauma causes mental illness. Studies have shown that early childhood trauma in particular, commonly referred to as Adverse Childhood Experiences (ACE) are associated with future substance abuse, need of psychotropic medication, school failure, unemployment, tobacco addiction, and other adverse social and health outcomes. Children and youth in the child welfare system, who have been abused and/or neglected, have a much higher incidence of mental illness and substance abuse disorders than the general child population. Sexual assault victims are plagued with PTSD, other</p>			

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		<p>anxiety, and depression following their assaults. PTSD is well documented among war veterans exposed to traumatic battlefield experiences. If trauma causes mental illness, we should be doing all we can to prevent trauma in people's lives, especially at young ages.</p> <p>Interventions that could be applied include: implementing the Strengthening Families framework, prevention of domestic violence, family supports to prevent marriage breakup, interventions for civil post-divorce interaction by parents, substance abuse screening and treatment for pregnant women and young parents, prevention of early child bearing through family planning, anti-date rape campaigns, etc. A lot of these things are going on in local communities, but there is not a cohesive statewide approach.</p> <p>Thank you for your consideration of this input.</p> <p><u>Comment 25.01</u> This memo (attached and repeated in the body of this note) is to call attention to the need to put the "primary prevention" back into the Mental Health Services Act (MHSA) regulations as they were initially placed. The failure to do so at this point will jeopardize all the prevention and early intervention efforts initiated with MHSA funding that has</p>			

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		<p>been utilized over the past five years to prevent mental disease, and not just attempt to ameliorate its' impact on our communities. For Los Angeles County, this means that over 500 pregnant and early parenting families will be at risk of losing their supportive Nurse-Family Partnership (NFP) services due to a diversion of MHSA funds away from "prevention" programming.</p> <p>NFP is an evidence-based program that serves youth who are pregnant for the first time and who are living in poverty. Our MHSA funding mandates we focus on recruiting the higher risk populations who have significant life challenges, such as foster children, those on probation, from stressed families, exposed to violence and with other issues that could compromise their health and future health of their first offspring. NFP <u>PREVENTS</u> mental disease by stopping women from drinking alcohol while pregnant, recognizing and intervening for developmental delays in young children, and encouraging young mothers cease illegal drug use and dangerous behaviors prior to the birth of their first child. NFP is proven effective in changing, for the better, the life course of families at risk. www.nursefamilypartnership.org</p> <p>The regulations appear to have been</p>			

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		<p>changed to eliminate the mandated spending on Prevention and Early Intervention (PEI) programs.</p> <p><u>Comment 30.01</u> I support the requirement that all counties continue to implement PEI programs for the following reason.</p> <p>As a Family and Youth Coordinator working within the public mental health system for over 15 years and as a parent of a child with serious mental illness, I strongly encourage the Commission to require early intervention and prevention programs in all counties. Both my personal and professional experiences with children and families with serious mental health issues, have supported the need for funding for outreach programs for families, providers, and others to recognize early signs of mental illness and to improve early access to services and programs for suicide prevention and to reduce stigma and discrimination. This component emphasizes programs that prevent mental illnesses from becoming severe and disabling, as well as improving timely access to services for underserved populations</p> <p><u>Comment 50.01</u> As a Family Partner working with families that required mental health services and as a parent of a child with mental illness, I strongly support the Commission to</p>			

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		<p>require early intervention and prevention programs in all counties. I have witnessed the two ends of families with early intervention and families without, and the results are enormously different. The early intervention makes a great impact in preventing severe outcomes and the support for the families help them learn how to navigate the system sooner causing less trauma to the children and decreasing the frustration on the parents. It's a win-win situation for the families and the mental health system in the long run.</p> <p><u>Comment 56.01</u> As a Family Partner working within the public mental health system and as a parent of a child with serious mental illness, I strongly encourage the Commission to require early intervention and prevention programs in all counties. Both my personal and professional experiences with children and families with serious mental health issues, have supported the need for funding for outreach programs for families, providers, and others to recognize early signs of mental illness and to improve early access to services and programs for suicide prevention and to reduce stigma and discrimination. This component emphasizes programs that prevent mental illnesses from becoming severe and disabling, as well as improving timely access to services for</p>			

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		<p>underserved populations. Wilma Flintstone, Santa Clara County, etc., etc.</p> <p><u>Comment 57.01</u> As a Parent Partner working within the public mental health system and as a parent of a child with serious mental illness, I strongly encourage the Commission to require early intervention and prevention programs in all counties. Both my personal and professional experiences with children and families with serious mental health issues, have supported the need for funding for outreach programs for families, providers, and others to recognize early signs of mental illness and to improve early access to services and programs for suicide prevention and to reduce stigma and discrimination. This component emphasizes programs that prevent mental illnesses from becoming severe and disabling, as well as improving timely access to services for underserved populations.</p> <p><u>Comment 61.01</u> As a Family Partner working within the public mental health system and as a family member with relatives who have serious mental health issues, I strongly encourage the Commission to require early intervention and prevention programs in all counties. Both my personal and professional experiences with children and families with serious</p>			

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		<p>mental health issues, have supported the need for funding for outreach programs for families, providers, and others to recognize early signs of mental illness and to improve early access to services and programs for suicide prevention and to reduce stigma and discrimination. This component emphasizes programs that prevent mental illnesses from becoming severe and disabling, as well as improving timely access to services for underserved populations. Please help and support our county communities. We are the voice of all the ones in need.</p> <p><u>Comment 64.01</u> Working within the public mental health system, I strongly encourage the Commission to require early intervention and prevention programs in all counties. My professional experiences working with children and families with serious mental health issues, have supported the need for funding for outreach programs for families, providers, and others to recognize early signs of mental illness and to improve early access to services and programs for suicide prevention and to reduce stigma and discrimination. This component emphasizes programs that prevent mental illnesses from becoming severe and disabling, as well as improving timely access to services for underserved populations, providing families the opportunity for better</p>			

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		<p>outcomes.</p> <p><u>Comment 66.01</u> As a Parent Partner working within the public mental health system and as a parent of a child with serious mental illness, I strongly encourage the Commission to require early intervention and prevention programs in all counties.</p> <p>Both my personal and professional experiences with children and families with serious mental health issues, have supported the need for <i>funding for outreach programs for families, providers, and others to recognize early signs of mental illness and to improve early access to services and programs for suicide prevention</i> and to reduce stigma and discrimination. This component emphasizes programs that prevent mental illnesses from becoming severe and disabling, as well as improving timely access to services for underserved populations.</p> <p><u>Comment 73.01</u> As a professional working within the public mental health system and as a parent of a child with emotional health challenges, I strongly encourage the Commission to require early intervention and prevention programs in all counties. Both my personal and professional experiences with children and families with serious mental health issues, have</p>			

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		<p>supported the need for funding for outreach programs for families, providers, and others to recognize early signs of mental illness and to improve early access to services and programs for suicide prevention and to reduce stigma and discrimination. This component emphasizes programs that prevent mental illnesses from becoming severe and disabling, as well as improving timely access to services for underserved populations.</p> <p><u>Comment H4.01</u> Good morning. I'm Sederia Lewis, and I'm here in support of the prevention and early intervention programs, as well. My concerns are that the programs be culturally competent in terms of meeting people where they're at.</p> <p>I, too, am a consumer and had no knowledge that I, too, was having difficulty with mental challenges. For twenty years, I was going to health professionals, but never understood what the challenges were -- getting medication, stop taking the medication, because I didn't understand.</p> <p>It wasn't until I started going to some peer-run programs that helped me understand and identify some of the challenges that I was identifying with -- that I didn't identify with. And, through that, I was able to get re-stabilized after</p>			

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		<p>having to retire at an early age. I've been retired since 1996, now, due to my mental health challenges, and I am still traumatized in terms of going back into the workforce.</p> <p>I do a lot of volunteer work in the community. I'm here today with the Client Stakeholder Project as a volunteer, and I just really think that the services need to be continued, primarily. Even in the peer-run organizations - I see a lot of peer-run organizations where people are relapsing in terms of their challenges and not being supported. So, I see that there's a need for that area to be supported, as well.</p> <p>I just wanted to say I support early intervention and people who don't necessarily look like they have a problem being supported, as well, because I wasn't supported in the ways that I needed to be supported, because I was always told, well, you're intelligent. But I was having all these issues and not really understanding what those issues were to deal with. Thank you all.</p> <p><u>Comment H5.01</u> Okay. I am here to represent the voice of parents, caregivers, and family members across the state. United Advocates for Children and Families has a diverse network of more than two thousand people that includes families</p>			

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		<p>raising children and youth with behavioral health issues, as well as parent partners and family advocates working as peer professionals in the mental health system in addition to consumer youth and transition-age youth.</p> <p>I'm here today to address the needs of those parents that are working and learning to care for their children, who feel they are fighting an uphill battle and need the support and resources for prevention as well as early intervention programs.</p> <p>Our network of parent partners is also working diligently in the system to help parents and families navigate the system and advocate for the needs of their children and youth.</p> <p>We recognize and support the implementation of these regulations as it pertains to prevention and early intervention, but we have a few recommendations based on the needs and the feedback that we've received.</p> <p>Our first recommendation is that you require prevention programs. The current regulations require counties to include at least one early intervention program, but only make prevention programs optional. This excludes entire populations that could be adequately and</p>			

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		<p>more appropriately identified and served.</p> <p>The lack of prevention programs do perpetuate a cycle of fail-first responses and does little to ensure that an at-risk population is identified in a timely manner. Prevention programs also demonstrate well-documented, positive outcomes for children and youth that extend through the education, juvenile justice, and child welfare systems.</p> <p><u>Comment H6.02</u> First, we'd like to strongly recommend that PEI regulations require counties to offer more prevention. You've heard that from many speakers.</p> <p><u>Comment H13.02</u> Second, we strongly recommend, as has been mentioned here by others, the recommendation that PEI regs require the counties to offer one or more prevention programs. The proposed regs require counties to administer at least one early intervention, but leaves prevention programs optional.</p> <p>Risk factors, such as adverse childhood experiences, exposure to trauma, drugs, poverty, and the experience of racism and social inequity are social determinants of health that disproportionately impacts communities of color and other underserved communities.</p>			

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		<p>Evidence-based prevention programs and policies are widely available for implementation. These programs can be found to reduce these risk factors mentioned, among others, and improve positive mental health, contribute to better physical health, and generate positive social and economic outcomes.</p> <p>We strongly feel that making these programs optional may adversely impact these at-risk populations that prevention programs are designed to serve. And, in the vein of needing to catch a condition before it becomes severe, prevention is critical. We would say a lack of prevention programs forces our communities to cycle in and out of care without ever having a chance to prevent it. Thank you.</p> <p><u>Comment H15.01</u> Good morning. This is Beatrice Lee. I'm the president of REMHDCO and have also been involved with MHSA from the very beginning in planning and working with Alameda County and Contra Costa County, implementing MHSA programs. And also, I am a member of the CMMC and also work extensively with the API Strategic Planning Workgroup. So, I'm very familiar with all the issues that have been addressed this morning.</p> <p>REMHDCO has prepared a letter</p>			

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		<p>outlining our recommendations, which is being handed out to you. And, as all of you heard and is our experience this past few weeks in working with many groups that have submitted letters, this is one issue that we're all "on the same page" with, we're all very supportive of, even though there might be other issues that we have not been "on the same page" with in the past.</p> <p>So, it was very clear that prevention and early intervention is a very, very important strategy component of MHSA. And, in my experience, this is the most important, in addition to innovations and the California Reducing Disparities Project, in really, truly transforming the system for vulnerable populations.</p> <p>And, in my experience working in Alameda County -- as Commissioner Aslami-Tamplen knows, Alameda County was really in the forefront in funding five different PEI strategies for underserved communities: one for Afghan, South Asian, Native American, and also the API/Latino groups. And that funding has enabled these communities to hire advocates to reach to communities that have never been reached before, because you hire someone from that community that can really engage and outreach that community.</p>			

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		<p>And, you know, though we had outlined many areas that do support the Act, one that does concern me that's been expressed already is that prevention is couched as being -- it's actually optional for the counties, and really should not.</p> <p>Prevention should -- really should be required of the counties to implement, because if you truly want to do upstream work, this is what we've been doing -- talking about in terms of wellness. You've got to do it early on and not when symptoms appear, and that is important, too.</p> <p>But, to reach the communities that we're talking about, early work, upstream work, is really important. So, I really want to urge the Commission to really look at that language change that we're recommending. Thank you.</p>			
No Specified Section	Commenter #26	<p><u>Comment 26.01</u></p> <p>This document is to provide written input to the Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) Program and Expenditure Plan revisions to the regulations. The proposed Plan and Regulations would benefit from increased emphasis on the prevention of mental disease and provision of scientifically sound prevention/intervention practices rooted in evidence demonstrating the benefit of</p>	Accept	Same changes suggested in response to Comment 60.02	1. Regarding request for more focus on prevention, see Response to 60.02.

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		<p>early prevention programs on reduced mental disease.</p> <p>Evidence-based programs that have been shown scientifically to improve a person's life-course functioning should be emphasized in the MHSA, and should be the ultimate goal of any MHSA funded program. The new regulations, and their limited focus on prevention during the prenatal period, infancy, and early childhood, will unfortunately reduce the funding support for early intervention programs such as perinatal home visiting. Consider the following:</p> <ol style="list-style-type: none"> 1. Early intervention research studies that support prenatal home visits to youth to provide support that includes mental health counseling have been shown to improve mother-child interactions, reduce child maltreatment, and enhance child development, such as a child's improved cognitive ability. 2. When at-risk, previously abused individuals begin parenting without acknowledgment of their own abuse history and how it can negatively impact their own parenting styles, they are more likely to perpetuate this cycle of violence. NFP nursing support, mentoring and training has been successful in assisting them in methods in which to end the cycle of abuse and employ safer and more nurturing parenting techniques beginning with their very first child. 			

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		<p>3. Prenatal care that includes mental health services and promotes relationship building and education has positive effects on pregnancy outcomes in terms of improving health promotion behaviors, lowering medical costs, reducing stress, decreasing the likelihood of delivering pre-term and low-birth weight babies (less than 2500 g), and promoting the psychological well-being of the mother that also positively affects the health of her baby.</p> <p>4. When mental health is recognized as one of the leading health indicators that is permanently intertwined in prenatal care, its improved effects that contribute to ensuring positive health outcomes for the mother and her infant is much greater than prenatal care that lacks such competencies.</p> <p>5. "Sensitive and responsive care-giving is a requirement for the healthy neuro-physiological, physical and psychological development of a child... care-giving behavior is related to later positive health and development outcomes in young children."</p> <p>6. Approximately 50% of mental diseases show up before the age of 14 years old.</p> <p>These facts call for greater attention to "primary" prevention of mental health diseases, and secondary prevention and focus on early intervention services in</p>			

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		<p>the MHSA regulations that can help to prevent developmentally delayed or compromised youth from having to enter the mental health system in the future. Decreased emphasis in these Regulations on the early years in the prevention, recognition and treatment of mental disease will impact the opportunity to prevent mental health disease thereby introducing the potential for increased mental health disease and greater intervention costs and costs to society.</p>			
No Specified Section	Commenter #31	<p><u>Comment 31.01</u> “ As a Family and Youth Advocate working within the public mental health system for the last 15-years and as a parent of a child, now adult, with serious mental illness, I strongly encourage the Commission to require Early Intervention and Prevention programs in all counties. Both my personal and professional experiences with children and families with serious mental health issues, have supported the need for funding for outreach programs for families, teachers, providers, caregivers and caretakers and others to recognize early signs of mental illness and to improve early access to services that will forestall long years of suffering before identification and treatment. PEI should always include programs for suicide prevention and reducing stigma and discrimination. This component emphasizes programs that</p>	<p>Accept: Requirement to include a Prevention Program</p> <p>Reject: Requirement to include a Stigma and Discrimination and Suicide Prevention Program</p>		<p>1. This comment did not specify a particular section but it seems to support the change for prevention programs from optional to mandatory. See response to Comment 60.02</p> <p>2. The comment also seems to advocate for mandatory stigma and discrimination reduction and suicide prevention. The proposed regulations require all PEI programs to be designed, promoted, and implemented in non-stigmatizing and non-discriminatory manner. In addition, counties also have the option to offer a Stigma and Discrimination Program. See response to Comment 42.01</p>

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		prevent mental illnesses from becoming severe and disabling, as well as improving timely access to services for underserved populations			
No Specified Section	Commenter #36	<p><u>Comment 36.01</u> Members of the CMMC join the Mental Health Services Oversight and Accountability Commission (MHSOAC) in its commitment for the effective implementation of PEI efforts statewide, particularly in underserved and under-represented communities. CMMC seeks a set of PEI regulations that more strongly accounts for the interests of the unserved and underserved stakeholder communities and the vital role of social determinants of health. Our input below is driven by the perspective that 'achievability' as a practical objective should not trump the potential for fundamental and substantive system transformation; PEI regulations can and should ensure that reporting and program requirements bring to the center every Californian from the margins.</p> <p><input type="checkbox"/> Firstly, we strongly recommend that PEI regulations require the County to offer one or more Prevention Programs.</p> <p><input type="checkbox"/> Secondly, some CMMC members participated in the PEI Work Group to draft initial regulations as presented in November 2013. While the process for subsequent revisions to the draft PEI</p>	Accept: Require a prevention program	Same changes as suggested in response to Comment 60.02	<ol style="list-style-type: none"> 1. This comment did not specify a particular section but it seems to support the change for prevention programs from optional to mandatory. See response to Comment 60.02 2. The MHSOAC will involve stakeholders in any changes to Proposed PEI Regulations through the regulatory process which requires a public process, including a 15-day public comment period.

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		<p>regulations did not violate any legal concerns, not engaging some of the original workgroup members during negotiation with County Behavioral Health Directors Association lacked transparency. With PEI being an extremely important MHSA strategy that can have a major impact in reducing disparities, ongoing stakeholder involvement is recommended at all stages of this process.</p> <p><input type="checkbox"/> Finally, we would support the proposed regulations pending modifications of specific subdivisions in Article 5 and Article 7, as described in our recommendations (See "Attachment").</p> <p>A genuine consideration of community input, including that of stakeholder groups as diverse as CMMC, is vital in establishing regulations that promote system transformation in furtherance of health equity. We look forward to deepening our collaboration in serving the needs of all Californians.</p>			
No Specified Section	Commenter #7	<p><u>Comment 7.02</u> Thank you. I do agree that the PEI regulations needed to be updated because prevention new to mental health. I liked the WHO 2012 risk and protective factors report was referenced, I'm using it and methodologies developed by CalOMS to generate</p>	No suggestion	No action	The comment does not include any proposed change to Proposed PEI Regulations

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		prevention measures as opposed to treatment measures. Many fields such as public health, education, health and social services have already figured out how to do this, as the activities and risk and protective factors are the same for any health and human services related sector.			
No Specified Section	Commenter #7	<u>Comment 7.03</u> I also notice that the interventions are listed in reverse order: usually they begin with promotion, universal, selected and then indicated.	No suggestion	No action	The comment does not include any proposed change to Proposed PEI Regulations
No Specified Section	Commenter #H2	<u>Comment H2</u> Good morning. My name is Steven Fazil. I've done a lot of outreach for mental illness. I've worked a couple of jobs where I went out into communities, went to churches, and tried to get people to even admit that they have a child that had mental illness or whatever, because it's -- it was -- one of -- I'm sixty years old and it's been kicked underneath the rugs for so long that people don't want to even admit that they have a child that has a problem or whatever. They blame it on a lot of other things. And then, a lot of people that are involved that have this illness end up trying to squash it by either drug abuse, whatever, trying to figure out self-medicating. And I think early prevention	No suggestion	No action	The comment does not include any proposed change to Proposed PEI Regulations

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		<p>is one of the best things they could do to stop it in the beginning, because, in our prisons, you have a lot of people who have mental illness because they did not diagnose.</p> <p>Nobody was there to tell them, hey, you got a problem, you know, this -- you can work this out like this. There's a procedure to do this. So -- and when you work with one person, you need to work with the whole family. You can't just work with that child and not help the rest of the people in that family, because it had to come from somewhere. Sometime, like she said, it was -- the other speaker said it was handed down, you know, whatever.</p> <p>Sometimes the things that families do to each other, like spanking - sometimes they say spare the rod and spoil the child, but sometimes they take it a little too far, and that could break -- push a person into depression, into a lot of different things -- bipolar, different things that happen.</p> <p>So, my recommendation is that I understand that -- I'm glad you guys are finally picking up the ball and trying to run with it and trying to do the right thing. But, early prevention and family -- you got to think about that. That's something that needs really to be addressed. Thank you.</p>			

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No section specified	Commenter #H3	<p>Comment H3 Hello. My name is Sally Zinman, and I'm the executive director of the California Association of Mental Health Peer Run Organizations, and part of the Client Stakeholder Project, which is a project that you sponsored.</p> <p>My concern is the -- identifying prevention, stigma and discrimination, and suicide prevention as something that counties "may" do instead of "shall" do. It seems, to me, to decrease the importance of those three elements. All of them are important, but I am specifically concerned about stigma and discrimination not being a mandate the counties have to do. Not being put in that level of "shall" instead of "may."</p> <p>I've been doing this a long time, almost forty years, and the more I look at it, the more I think that if we could crack the stigma and discrimination shell, that we would get at the bottom of most of the problems -- or many of the problems that people with mental disabilities face and address.</p> <p>I think our nation's and state's policy is being driven now, right this moment, currently, by stigma and discrimination, and especially the violence myth that we heard earlier. I think individuals are -- it's difficult for individuals to integrate back into -- individually, it affects us in terms</p>	<p>Reject: Require a Stigma-Discrimination Reduction Program (3725(a)) and a Suicide Prevention Program (3730(a))</p> <p>Accept: Require a Prevention Program</p>	<p>Retain existing language with no change: proposed regulation Sections 3725(a) and 3730(a)</p> <p>3720(a)</p> <p>See proposed changed language in Response to Comment 74.06</p>	<ol style="list-style-type: none"> 1. Require a Prevention Program: See Response to 60.02 2. Require a Stigma-Discrimination Reduction Program and a Suicide Prevention Program: In California, counties have the responsibility and the authority, with community stakeholders, to determine effective program approaches that are best suited for their local priorities in preventing mental illnesses from becoming severe and disabling and, for Prevention and Early Intervention Programs, to fulfill the outcomes specified in WIC 5840, one of which is suicide as a consequence of untreated mental illness. Counties need flexibility to determine whether a program to prevent suicide is a sufficiently high priority to fund as part of the overall PEI Program. See Response 1 to Comment 3.36, Response to Comment 39.04, and Response 6 to Comment 3.09I

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		<p>of our ability to integrate back into society.</p> <p>I'm sort of -- I'm very surprised to see it, because the MHSA law itself really emphasizes stigma and discrimination in the prevention and intervention part. I think it's mentioned twice when it talks about what prevention and early intervention should be.</p> <p>So, I would urge you to consider all of them: prevention, suicide prevention -- wait, it's prevention, suicide, and stigma and discrimination being a "shall" instead of a "may," but my specific emphasis is on stigma and discrimination. Thank you.</p>			
No section specified	Commenter #H14	<p><u>Comment H14.01</u> Thank you. Good morning. Fionna Lavelle with the California Family Resource Association. We're a statewide association representing hundreds of family support agencies, and we are an agency within the Child Abuse Prevention Center.</p> <p>I want to associate us with the comments of REMHDCO and the letter before you submitted by the MHSA partners, and in particular I just wanted to highlight sort of what our priority issues are, which really are about prevention and protecting funding streams for prevention,</p>			3.

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		<p>particularly in the context of reaching young people and their families.</p> <p>You know, we know from experience that, too often, families and individuals have to wait until there's a crisis before they have access to services. And we also know that the risk factors that are detailed in these regs disproportionately affect underserved communities, particularly racial and ethnic communities.</p> <p>And so, I want to talk about, you know, reinstating the focus on a required prevention program and dedicating funds specifically for children, youth, and families, not just because it's the right thing to do, but because, strategically, it's effective, it's working, and it's what we need to do with PEI dollars.</p> <p>The two modifications to the regulations that we feel are most important are maintaining the policy direction that's been in place up to this point of dedicating fifty-one percent of PEI funds toward children, youth, and families.</p> <p>We know that it's still the case that half of mental disorders begin to show up before age fourteen, and three-quarters before age twenty-four. So I think, if we want to achieve the prevention and early intervention goals that these regs are all about, it's very important to continue to</p>			

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		<p>require the focus on young people and their families.</p> <p>I also just want to say that, you know, in our experience, we represent a lot of agencies that have prevention-oriented services. And counties are faced with tough choices about what to do with their funding streams, and oftentimes, unfortunately, it's the case that prevention is on the "chopping block," and that's what we want to avoid by making sure that the regulations explicitly call out the importance of including at least one prevention program and including to focus on children, youth, and families.</p> <p>So, with that, I'll wrap up. Thank you.</p>			
No Specified Section	Commenter #H6	<p><u>Comment H6.01</u> Good morning. My name is Jim Gilmer. I'm here on behalf of the California MHSA Multicultural Coalition. And to sort of break up the monotony, because I know you are going to hear a lot of testimony this morning. I came up here from L.A. very early this morning, probably like Commissioner Van Horn. I'm not sure.</p> <p>But, I heard a song this morning. It's "Am I Wrong" by Nico and Vinz, and it's about a personal relationship where he says, am I wrong because people may see me the way I don't see myself, or am I wrong because I want to think outside</p>	Reject	Retain existing language with no change	MHSOAC staff appreciates the importance of the social determinants of health, including mental health in the context of preventing mental illnesses from becoming severe and disabling. This perspective is reflected in the Statement of Reasons that provides a rationale for the Proposed PEI Regulations. The importance of social determinants does not suggest any particular regulatory requirement. In California, counties have the responsibility and the authority, with community stakeholders, to determine effective program approaches that are best suited for their local priorities in preventing mental illnesses from becoming severe and disabling and to fulfill the outcomes specified in WIC 5840. To promote effective practices, support and technical assistance resource for counties are a necessary adjunct to these regulations.

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		<p>the box? Am I wrong? Well, if I'm wrong, I don't want to be right.</p> <p>The CMMC is in a relationship with the OAC. We're trying to strengthen that relationship, because we represent underserved and unserved racial and ethnic communities and communities with diverse sexual orientation. PEI is a major strategy and engine, in our opinion, to reduce disparities.</p> <p>Because of that impetus and the hope that we had when we first started out with MHSA back in 2006, even the Prop 63 days, when we all participated in getting signatures to bring services to our communities. We see PEI and these regulations as very, very critical to serving our ethnic, racial, and sexually diverse communities.</p> <p>We encourage that the regulations be adopted as follows. We have three major points. On a general policy level, if we want and you want to reduce disparities, we would like to include a heavy emphasis on social determinants of health.</p> <p>You can look globally -- World Health Organization, many other researchers have concluded that social determinants of health, when looked at integratively, will definitely reduce disparities because these issues lead to chronic mental</p>			

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Section #	Comment Author	Comment Summary	Response	Action	Rationale
		health disorders.			
No Specified Section	Commenter H#6	<u>Comment H6.03</u> Secondly, this whole process -- as a PEI Work Group member, we felt that there was a lack of transparency in how this was rolled out, selectively working with CMHDA and not including stakeholders and representatives from racial and ethnic communities. This is a very important strategy. We should be involved at all stages.	No suggestion	Retain existing language with no change	The comment does not include any proposed change to Proposed PEI Regulations
No Specified Section	Commenter #H10	<u>Comment H10.01</u> Hi. Good morning. Debbie Innes Gomberg with the Los Angeles County Department of Mental Health and co-chair of the MHSA Committee, and I wanted to say that Los Angeles County also submitted a letter. And counties are the implementers of programs. We're accountable to our stakeholders, and so the regulations need to be achievable, and I think with three things I'm going to mention they will be achievable. The first thing is flexibility around outreach and engagement. If a county already is providing outreach and engagement for PEI purposes through another component of the Mental Health Services Act, we believe that should be sufficient and not necessarily need to be funded through PEI.	Accept	See proposed changed language in response to Comment 4.01	See Response to Comments <u>Comment 4.01, 10.01, 11.01, 12.01, 16.01, 17.01, 22.01, 24.01, 27.01, 28.01, 37.02, 43.01, 46.01, 62.01, 69.01, 70.02, 72.02</u>

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Section #	Comment Author	Comment Summary	Response	Action	Rationale
No Specified Section	Commenter #H11	<p><u>Comment H11.02</u> Also agree with the importance of schools as a strategic place for prevention, and that support at early stages is the ideal place to disrupt onset. There are many studies on the effects of early stressors on brain development, so early disruption of these negative effects is truly vital. Thank you.</p>	No suggestion	Retain existing language with no change	The comment does not include any proposed change to Proposed PEI Regulations
No Specified Section	Commenter #H16	<p><u>Comment H16.01</u> I'm Darlene Prettyman. I want to speak to the issue of "underserved" as opposed to "inappropriately served." I think everywhere that the word "underserved" population is addressed, it should be "underserved/inappropriately served." I'd like to give you an example.</p> <p>Early intervention, prevention, is not dealing with some of our people that have been in the system for thirty years or so. Many of those people are placed in IMDs, board and care's many miles away from the county where they live. I travel that road all the time, because that's where my son is.</p> <p>It's a good location. I'm not complaining about that. I'm telling you, when I go there, I talk to the consumers that are there that haven't seen their family in three months. They can't afford the trip. They can't afford to be involved. This is an inappropriate service and it should be addressed.</p>	Reject	Retain existing language with no change	Regulations 9CCR 3200.300 include "inappropriately served" in the definition of "underserved."

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		<p>And I think each county should be required at least to have a Skype where family members could go and talk to their family member where it is so far away where they don't have that connection.</p> <p>I'll give you one for instance. I visit with the consumers when I go there. I know all of them. And I knew this one, Sam. He was a good friend of mine. He was six-foot three-inches, so every time I'd hug him, he'd have to bend way over.</p> <p>I went back and Sam wasn't there. And I said, where is Sam? Well, Sam had gotten into trouble -- some sort of trouble. I can't find him. He has no family member. He has nobody to talk for him. He is totally being inappropriately served.</p> <p>And we need to address that population. Not just the younger ones. Not just the ones that are -- in the -- have been in the system recently, but those who have been in the system for a long period of time. They're not getting some of the proper services. Thank you.</p>			
No Specified Section	Commenters #1, 14, 15, 18, 19, 20, 34, 40	<p><u>Comments 1.03, 14.02, 15.03, 18.02, 19.03, 20.02, 34.02, 40.01</u></p> <p>These comments were general and encouraged the Commission to accept the changes proposed by Mental Illness Policy Organization (Commenter #3) and Joy Torres (Commenter #8)</p>	Accept in part and reject in part as set forth throughout the document	See suggested changes throughout	See responses to Commenters #3 and #8 throughout the document.

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