

**Matrix of Public Comments with Staff's Recommended Responses to PEI Proposed Regulations
15-Day Public Comment Periods Phase I (9/9/14 – 9/26/14), Phase II (10/14/14 – 10/30/14), and Phase III (10/30/14 – 11/17/14)
Presented at December 18, 2014 MHSOAC Meeting**

15-day Notice from September 9 – September 26, 2014 (Phase I)					
Section #	Comment Author	Comment Summary	Response	Action	Rationale
3702(2)	Commenter #79	<p>Comment 79.01 Section 3702 (a) states: "<u>Strategy</u>" as used in the Prevention and Early Intervention regulations means a <u>planned</u> and specified method with a program intended to achieve a defined goal. Comment: The statement should clarify who's goal the <u>defined goal</u> is.</p> <ul style="list-style-type: none"> The <u>defined goal</u> should align with the values of the client—to include race, ethnicity, sexual orientation, gender identity and culture. One major concern for LGBTQ in not defining the goal this way is that it could open the door to conversion therapy techniques, which are still legal in California when treating clients/consumers over the age of 18. In addition, the LGBTQ Reducing Disparities Project research found that one of the top problems faced by LGBTQ respondents was that their mental health provider said negative things about their sexual orientation and/or their gender identity/expression. The <u>defined goal</u>, therefore, needs to specifically include sensitivity, awareness and affirmation of a person's sexual 	Reject	Retain existing language with no change	<p>The "defined goal" in the definition of "Strategy" as used in Section 3702(a) of Proposed PEI Regulations refers to the goals of the program as specified by the County.</p> <p>All PEI programs are required by Title 9, California Code of Regulations, §3320 to be "client-driven". Programs are also required to reflect cultural competence (Title 9, California Code of Regulations, §3320). These requirements are reiterated in Proposed PEI Regulation Section 3755(b)(3), which requires a County to include in the PEI Plan a brief description, with specific examples of how each program and/or strategy funded by Prevention and Early Intervention funds will reflect and be consistent with all Mental Health Services Act General Standards set forth in Title 9, California Code of Regulations, §3320. All PEI programs are required to be non-stigmatizing and non-discriminatory per Proposed Regulation Section 3735(a)(3). As a result of these existing Proposed PEI Regulation requirements, all PEI programs must be consistent with the client's (and, as applicable for children, the parent's) goals, values, and culture. The kinds of coercive practices the comment envisions are not legal under Proposed PEI Regulations, so additional language is not needed.</p>

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		orientation, gender identity and gender expression.			
3705	Commenter #3	<p><u>Comment 3.53</u> II. THERE IS NO AUTHORITY FOR MHSOAC'S PROPOSED SMALL-COUNTY EXEMPTION IN SECTION 3705</p> <p>MHSOAC proposes to modify section 3705 to exempt small counties (less than 200,000 in population) from offering Prevention programs that are otherwise required by MHSA. It does not appear from the public record that this exemption was requested by any county or by any public commenter. Instead, it appears to have been added at Staff's suggestion, based on Staff's speculation that, because of their small population, "it might not be as effective to dilute their efforts" by requiring small counties to provide both Early Intervention and Prevention programs (or combined programs).</p> <p>MIPO objects to this proposed modification. There is no provision for such exemption in MHSA, and MHSOAC's decision to add it is not based on any evidence in the public record, but apparently instead on Staff's speculation. MIPO submits that all counties, small included, could effectively</p>	Reject	Retain existing language with no change	<p>The exemption is legally permissible pursuant to the MHSOAC's authority to "implement" the PEI Component of the MHSA. It is also permissible to determine that a "small county" defined in the current MHSA regulations (Title 9 California Code of Regulations, Section 3200.260) with less than 200,000 in population should be exempt from the requirement because of their reduced population, resources, and infrastructure.</p> <p>The rationale for using the "small county" designation for the exemption is to be consistent with the current MHSA regulations that have used this standard when providing exemptions for other requirements. (See Title 9 California Code of Regulations, Sections 3620 and 3650.)</p> <p>The rationale for exempting small counties is that small counties have fewer PEI dollars to utilize compared to larger counties. Because all counties are required by the MHSA to offer at least one Early Intervention Program as well as to provide several other required programs and/or strategies, there is less money remaining to offer a Prevention Program, which is required by proposed PEI Regulations and permissible under the MHSA. Requiring smaller counties with fewer resources to offer a Prevention Program in addition to the MHSA-required programs and strategies could force a small county to dilute its efforts to the point of becoming less effective. The lack of a requirement for a small county to offer a Prevention Program obviously does not limit the County's flexibility to choose to offer one. Because of their small population, these counties</p>

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		<p>and efficiently offer both Prevention and Early Intervention programs if MHSOAC would properly define and limit those programs to ones that serve those whom MHSOAC enacted to help-the mentally ill and severely mentally ill-- rather than authorizing the creation of PEI programs based on "risk factors" that cover those who are not, and never will be ill.</p>			<p>need the flexibility to respond to local priorities with a more focused approach. Given limited resources, it is unwise to limit the County's flexibility in instances where the County might have insufficient MHSA PEI dollars to fulfill this additional requirement.</p>
3705 & 3720(a)	Commenter #84	<p><u>Comment 84.01</u> In that respect, we are highly concerned that the regulations propose exempting small counties from the requirement to provide a prevention program. The proposed amendment to Section 3705 and 3720 would add an exemption for small counties defined as less than 200,000 (Title 9 California Code of Regulations Section 3200.260)</p> <p>The statutory definition of "Small County" is one with a population of under 200,000, then approximately 30 out of 58 counties would be exempt from providing a Prevention Program.</p> <p>The total estimated population of these 30 counties is 2,046,12. This is greater than the population of Alaska, South Dakota, Delaware, Montana, Rhode Island, New Hampshire, Maine, Hawaii, Idaho, West Virginia, and Nebraska.</p>	Reject	Retain existing language with no change	<p><u>Small County exemption:</u> See response to comment 3.53 above on page 2.</p> <p><u>Time limit for Small County exemption:</u> There is no suggested time limit for the exemption because the situation of limited resources for a small county is unlikely to change without an accompanying change in population.</p> <p><u>Technical assistance for counties:</u> Support for counties including training and technical assistance is a critical adjunct to these Proposed PEI Regulations. The MHSOAC is committed to providing and supporting the provision of support to counties as a priority oversight and accountability strategy.</p>

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		<p>According to testimony at the MHSOAC September meeting, 8 counties defined as “small counties” have a prevention program currently running in the county.</p> <p>Of the 30 counties in the “small county” list, 11 have either a NAMI affiliate, a NAMI signature prevention program (In Our Own Voice) available to the county, or have a robust NAMI affiliate in an adjacent county. One county (Humboldt) already has NAMI affiliates providing “prevention” programs (IOOV, Parents and Teachers as Partners, Telling Our Story) at the direction of the county.</p> <p>There is no time limit on this exemption. There is no “technical assistance” mandated to assist with developing prevention programs in these small counties at some future date. Over 2 million people would be excluded from access to the promise of prevention programs.</p> <p>For the reasons stated previously, we strongly support the original language under Section 3705 and 3720 (a) The County shall offer at least one Prevention Program as defined in this section. This is the original language of the regulations and assists in implementing the overall purpose of the PEI Component which is to prevent</p>			

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		mental illness from becoming severe and disabling.			
3705(a)(3)	Commenter #83	<p>Comment 83.01 Section 3705. Prevention and Early Intervention Component General Requirements.</p> <ul style="list-style-type: none"> We strongly support the language under (a)(3) that “At least one Prevention program as defined in Section 3720”. 	Accept	Retain existing language with no change as requested in comment.	The rationale for the modified text that the comment supports and that is the subject of the 15-day Notice is set forth in the Matrix of Public Comment presented at the August 28, 2014 MHOSAC meeting.
3705(a)(3)(A)	Commenter #42	<p>Comment 42.02 CAMHPRO is very concerned that the proposed PEI Regulations exempt small counties from being required to offer a Prevention Program (Section 3705 (a) (3) A.) We feel sure there is an alternate way of supporting the value of prevention as well as honoring the special hardships of small counties.</p> <p>One of the transformative aspects of the MHSA is its inclusion and valuing of prevention as an essential mental health service. Prevention services “prevent” unnecessary personal suffering of mental distress as well as save countless dollars in direct clinical mental health services as well as crisis interventions. The long term positive personal outcomes and cost effectiveness is proven. Not to require a prevention service in every County flies in the face of an intent of the MHSA, to</p>	Reject	Retain existing language with no change	<p><u>Small County exemption:</u> See response to comment 3.53 above on page 2.</p> <p><u>Simplifying evaluation reporting requirements:</u> Evaluation and reporting requirements in Proposed PEI Regulations are limited and fairly simple. The MHOSAC is committed to providing and supporting the provision of support to counties, including but not limited to training and technical assistance, for counties to assist with implementing new PEI regulations including reporting requirements. Simplifying or eliminating evaluation reporting requirements does not address the issue of small counties’ limited program resources, which could lead to too much dispersion of effort in too many directions without flexibility to decide whether or not to offer a Prevention Program, which is not required by the MHSA. See responses to comment 33.02 on page 39 of the Matrix of Public Comments presented at the October 23, 2014 MHOSAC meeting and the responses to comments 82.01 (below on page 7), 84.01 (above on page 3), and 4.11 (below on page 34).</p>

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		<p>reduce the long term suffering of individuals and their families.</p> <p>In our observation, small counties are in fact providing some of the most innovative prevention services in the State. We do not believe that small counties are adverse to doing prevention services. We suggest that they are adverse to doing the reporting and documentation that comes along with doing the services. Small counties do not have the resources to do the kind of evaluation and documentation that is often required.</p> <p>The problem appears to be the reporting, not the provision of the prevention service. We recommend that small counties be allowed accommodations in reporting requirements rather than exempt them from providing the prevention services.</p> <p>CAMHPRO wants to honor the needs of small counties as well as the value of prevention services. We strongly suggest making reporting accommodations for small counties, reducing reporting requirements or developing alternate and simpler reporting methods for small counties.</p>			

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3705(a)(3)(A)	Commenter #75	<p><u>Comment 75.01</u> 1. MHSOAC provided substantial evidence that counties are running prevention programs and early intervention programs; so why not mandate all counties to have these programs.</p>	Reject	Retain existing language with no change	Proposed PEI Regulations provide an exemption for small counties because of their smaller populations and fewer resources, which place a greater burden on local decision-making to discern and act on local priorities and avoid diluting efforts. Providing the exemption gives the small counties the flexibility to decide whether to offer a Prevention Program, which is permitted and not mandated by the MHSA. See responses to comments 3.53 (above on page 2), 42.02 (above on page 5), 82.01 (below on page 7), and 84.01 (above on page 3).
3705(a)(3)(A)	Commenter #82	<p><u>Comment 82.01</u> We wish to oppose the proposed exemption of at least one preventative program for "small counties". Our county is, in fact, within the small county category and we feel strongly that if the County is not mandated, individuals in Mendocino County will not have access to preventative programs.</p> <p>We are hoping that the committee will reconsider their decision on exempting the smaller communities which need the same programs afforded to the larger communities. Individuals suffering from mental illness, whether in a small community or larger community, need equal services.</p> <p>Preventative programs are just that, preventative. Altering or preventing a more dramatic cycle of mental illness saves money, not to mention needed help to the individual at a critical time.</p>	Reject	Retain existing language with no change	The lack of a requirement for a small county does not preclude the County from offering a Prevention Program. It simply retains that decision at the local level, which is currently the case under the PEI Guidelines issued by the Department of Mental Health in 2008. Community members who want to prioritize County PEI funds for prevention need to advocate at the local level for this priority. See responses to comments 3.53 (above on page 2), 42.02 (above on page 5), 75.01 (above on page 7), and 84.01 (above on page 3) and response to comment H6.01 on page 147 of the Matrix of Public Comment presented at the August 28, 2014 MHSOAC meeting,

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		<p>Mendocino County has had prevention programs in the past which have had very positive effects on the participants. We feel that as a small community we would be penalized and would have decreased services in a community that is presently struggling with the treatment and care of our population suffering with mental illness.</p>			
3705(a)(3)(A)	Commenter #83	<p><u>Comment 83.02</u> <u>Section 3705. Prevention and Early Intervention</u> <u>Component General Requirements.</u> However, we oppose the inclusion of the next sentence <i>(A) Small counties are excluded from the requirement to offer a Prevention Program.</i> and ask that it be deleted.</p> <p>Although the number of consumers and families from underserved racial and ethnic communities may be small in these counties, we believe it all the more likely that they do not have access to culturally appropriate services and experience disparities in treatment.</p> <p>In addition, if the definition of “Small County” is one with a population of under 200,000, then <i>approximately 30 out of 58</i> counties would be exempt from providing a Prevention Program. Since there is no time limit in this</p>	Reject	Retain existing language with no change	<p>All PEI programs are required to include strategies to Improve Timely Access to Services for Underserved Populations, to be implemented in ways that are non-stigmatizing and non-discriminatory, and to demonstrate Cultural Competence consistent with MHA General Standards. (See Proposed PEI Regulations Section 3735(a)(3).) Serving the needs of diverse racial and ethnic communities is not limited to Prevention Programs. A county might decide to prioritize the needs of diverse racial and ethnic communities who have early onset of a mental illness, or to prioritize various access strategies for diverse communities.</p> <p>Proposed PEI Regulations prioritize local decision-making for counties with population under 200,000 about how to best meet the needs of people, including underserved racial and ethnic communities, who are at risk of or have early onset of a mental illness. See responses to comments 3.53(above on page 2), 42.02(above on page 5), 75.01(above on page 7), 82.01(above on page 7), and 84.01(above on page 3).</p>

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		<p>exemption, we believe this adds up to too many people - regardless of race or ethnicity - who could lack access to a Prevention Program.</p>			
3705(b)	Commenter #83	<p>Comment 83.03 3705.(b) The County may include in its Prevention and Early Intervention Component:</p> <p>Under this section, the sentences should probably be renumbered. More importantly, however, we suggest that language be added to make it clear that in addition to the two programs listed, these two programs could also be offered as a stand-alone program (as opposed to just a strategy):</p> <p>(3) One or more programs that help create Access and Linkage to Treatment as defined in Section 3735.</p> <p>(4) One or more programs whose focus is to Improve Timely Access to Mental Health Services for Individuals and/or Families from Underserved Populations as described in Section 3735.</p>	Accept in part/concept	Retain existing language with no change	<p>The MHSOAC at the August 28, 2014 voted to modify the Proposed PEI Regulations to make it clear that both Access to Treatment and Improving Timely Access to Services for Underserved Populations can be stand-alone programs. See Proposed Regulation Section 3735(a)(1)(B) and (a)(2)(C) which were the subject of a 15-day Notice.</p> <p>The subsections will be re-numbered.</p>

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3706(b) (sic)	Commenter #81	<p><u>Comment 81.01</u> The current MHSOAC document titled, <i>Prevention and Early Intervention Programs Initial Statement of Reasons</i>, emphasizes the importance of providing prevention and early intervention services to children, youth, and families. As stated in this MHSOAC document, an estimated 75-80% of children and youth who need mental health treatment don't receive it. (Kataoka S, et al. (2002). In addition, an estimated 40-85% of children entering the foster care system have significant mental health problems. Foster children with mental health problems are less likely to be reunified with their families or adopted. Foster children's emotional and behavioral problems also make them more susceptible to negative consequences such as expulsion from school or involvement with the juvenile justice system" (MHSOAC Prevention/Early Intervention Plan, May 2013)</p> <p><u>Recommendation:</u> I respectfully request that the MHSOAC vote to support the inclusion a new section (3706 (b)) to the proposed new PEI regulations that would require "at least 51% of the Prevention and Early Intervention Fund to be used to serve individuals who are 25 years or younger."</p>	Accept	Retain existing language with no change as requested in comment.	The MHSOAC at the September 30, 2014 meeting voted to make the changes suggested by the comment. That change was the subject of a 15-day Notice.

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3510.010(a)(5) (sic) 3560.010 is correct section	Commenter #80	<p>Comment 80.06 Recommendation D: Hathaway-Sycamores supports Section 3510.010 (a)(5) (sic) which expands reporting categories of race and ethnicity. We recommend that the OAC divide the age category of transition age youth, (a)(5)(iii) to those 16-17 and those 18-25 to better determine which services are being provided to children vs. young adults.</p>	Reject	Retain existing language with no change	<p>This comment is outside the scope of the 15-day Notice because the text dealing with the age category was not modified in the proposed regulations associated with the 15-day Notice in which this comment was submitted nor any other 15-day Notices. However, see response below.</p> <p>The category Transition-Age Youth is already defined in the MHSA regulations (Title 9 California Code of Regulations Section 3200.280) as youth from 16 to 25 years of age. Proposed PEI Regulations are consistent with this definition to promote uniformity of reporting on use and impact of MHSA funds.</p>
3710	Commenter #3	<p>Comment 3.51 B. Making “Early Intervention” Mandatory Does Not Comply with the Statutory Requirement to Provide PEI Programs for the Severely Mentally Ill.</p> <p>MHSOAC argues it has complied with the statutory mandate for relapse prevention programs by making its Early Intervention programs mandatory in Section 3710.6 MHSOAC is incorrect. In fact, its proposed Section 3710 incorporates relapse prevention only for individuals who do not need it and are not entitled to it, because they are not even mentally ill.</p> <p>Here is the relevant language in the modified version of MHSOAC's proposed Section 3710 (with the underscoring and interlineations reflecting MHSOAC's proposed</p>	Reject	Retain existing language with no change	<p>This comment repeats the argument made during the 45-day comment period. The MHSOAC has previously responded to this argument explaining its legal interpretation of the MHSA as it relates to the PEI component. See below.</p> <p><u>Use of PEI funds for individuals with a severe and disabling mental illness:</u> The purpose of the MHSA PEI component is to prevent mental illnesses from becoming severe and disabling (WIC §5840(a)), not to serve individuals who already have a severe and disabling mental illness except for Access and Linkage to Treatment and as a possible target population for a Prevention Program to prevent relapse for individuals in recovery from a severe mental illness. See responses to comments 3.13 and 3.25 on pages 29 and 9 of the Matrix of Public Comments presented at the August 28, 2014 MHSOAC meeting and responses to comment 3.47 on page 26 of the Matrix of Public Comments presented at the September 30, 2014 MHSOAC meeting.</p>

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		<p>modifications, and the italics reflecting emphasis added):</p> <p>Section 3710. Early Intervention Program.</p> <p>(a) The County shall offer at least one Early Intervention program as defined in this section.</p> <p>(b) "Early Intervention program" means treatment and other services and interventions, <u>including relapse prevention, to address and promote recovery and related functional outcomes for a mental illness early in its emergence . . .</u></p> <p>(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>(e) Early Intervention program may include efforts to prevent relapse in an individual with early onset of a mental illness.</p> <p>MHSOAC ignored MIPO' s request for a separate Early Intervention program for</p>			<p><u>Reducing the duration of untreated mental illness:</u> See response to comment 3.33 on page 9 of the Matrix of Public Comments presented at the September 30, 2014 MHSOAC meeting.</p> <p><u>Quickly regaining productive lives:</u> A key purpose of the PEI component is to intervene early in the onset of a mental illness to help people quickly regain productive lives. For that reason, among others, Proposed PEI Regulations require all counties to offer an Early Intervention Program, which includes relapse prevention for people experiencing a mental illness early in its emergence. The intention is to prevent this mental illness from becoming severe and disabling. See responses to comment 3.09 on page 1 of the Matrix of Public Comments presented at the August 28, 2014 MHSOAC meeting and to comment 8.20 on page 21 of the Matrix of Public Comment presented at the September 30, 2014 MHSOAC meeting.</p> <p><u>Relapse Prevention for Individuals in Recovery from a Severe Mental Illness:</u> These individuals can be the focus of a Prevention Program. See responses to comments 3.09 and 8.35 on pages 1 and 31 of the Matrix of Public Comments presented at the August 28, 2014 MHOSAC meeting; response to comment 3.31 on page 1 of the Matrix of Public Comments presented at the September 30, 2014 MHSOAC meeting; and response to comment 3.03 on page 1 of the Matrix of Public Comments presented at the October 23, 2014 MHSOAC meeting.</p>

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		<p>the severely mentally ill. Instead, MHSOAC has limited its Early Intervention programs to helping those who have a mental illness "early in its emergence." These individuals obviously are not severely mentally ill, and according to MHSOAC, do not even need a mental illness diagnosis. Individuals who are early in onset of a mental illness do not need a relapse program aimed at "reducing the duration of untreated severe mental illnesses," because they do not have, and likely never will have, "untreated severe mental illness." Further, they are not, and likely never will be, disabled. Thus, they do not need assistance in "regaining productive lives." In fact, if early intervention works, those "early in emergence" will never experience "untreated severe mental illness," or loss of "productive lives." That, indeed, is the whole point of this kind of intervention. But because of the statutory mandate contained in WIC section 5840(c), MHSOAC's regulation must require programs that "reduce the duration of untreated severe mental illness" and assist those individuals in "quickly regaining productive lives." As MIPO has previously noted, it is vitally important and literally life-saving to intervene early and/ or prevent a relapse into severe mental illness, so that those so afflicted</p>			

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		<p>do not descend into homelessness, local mental wards, jail, or death.</p> <p>In response to comments on its initial draft of Section 3710, MHSOAC denied that those who are severely mentally ill are entitled to receive the assistance of PEI programs. What the staff's responses say, essentially, is this: let the county welfare system (referred to by MHSOAC as "CSS") take care of the severely mentally ill. But this shows a lack of understanding of the statute that MHSOAC is supposed to be enforcing. It not only ignores the statute's literal language, which makes these programs a mandatory part of PEI, but also ignores a central purpose of PEI: to keep people out of the county welfare system by preventing disability.</p> <p>Many California citizens with severe mental illness diagnoses have either been pushed off county welfare or never qualified for it, because they are stable enough to hold jobs. To choose a very public example, Ellyn Saks, a medically-stable, schizophrenic law professor at USC, does not currently qualify for California welfare benefits. Individuals who have left CSS are also constantly at risk of returning. They need relapse prevention/ early intervention services to keep them stable and off welfare rolls. Many other severely mentally ill</p>			

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		<p>individuals have never been part of CSS because their families insure and care for them privately, to avoid the substandard care often offered by county systems.</p> <p>Because insurance is now more widely available, the numbers of severely mentally ill individuals who operate outside of CSS will increase as Affordable Care becomes the norm. However, when loved ones relapse, families fragment and the untreated severely mentally ill end up in the welfare system if they are lucky, and homeless, in mental hospitals, in prisons, or dead if they are not. Yet MHSOAC persists in ignoring them, and treating the statutory language that addresses them as if it did not exist.</p> <p>In sum, though individuals in CSS should certainly be allowed to participate in relapse prevention programs, PEI also includes people who are no longer part of CSS or were never part of CSS. This includes not just those in onset of a severe mental illness, but also those who are already severely mentally ill, in danger of relapse into "untreated severe mental illness," and in need of programs to assist them, when it happens, in "quickly regaining productive lives." WIC § 5840(c).</p>			

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3710 & 3720	Commenter #3	<p><u>Comment 3.49</u> I. MHSOAC'S PROPOSED MODIFICATIONS TO SECTIONS 3710 AND 3720 CONTINUE TO IGNORE CRITICAL STATUTORY LIMITATIONS AND MANDATES</p> <p>Though it proposed some modifications in response to MIPO' s initial comments, MHSOAC continues to ignore critical statutory limitations and mandates in its proposed definitions of "Early Intervention" and "Prevention" programs set forth in sections 3710 and 3720. In fact, MHSOAC continues to ignore the very individuals that the Mental Health Services Act (MHSA) was enacted to help: the severely mentally ill. These shortcomings in MHSOAC's proposed modifications are discussed below.</p>	No specific action suggested	N/A	N/A
3710(c)(1)	Commenter #4	<p><u>Comment 4.09</u> California counties appreciate the opportunity to work with the Mental Health Services Oversight and Accountability Commission (MHSOAC) to assure that the PEI regulations enable counties to provide an array of prevention and early intervention services. To that end, the definition of "serious mental illness" in section 3710(c)(1) of the proposed PEI regulations is too narrowly defined -- as only within</p>	Accept	Amend 3710(c)(1) as follows: For purpose of this section, "serious mental illness or emotional disturbance with psychotic features" means, schizophrenia spectrum and other psychotic disorders including schizophrenia, other psychotic disorders, <u>disorders with psychotic features</u> , and schizotypal (personality) disorder, They are defined by	<u>Recommended Change:</u> Staff suggests a slight addition to the current language, which is from the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM) definition of schizophrenia spectrum and other psychotic disorders to include "other disorders with psychotic features". The original definition from the DSM does not include disorders with psychotic features, such as bipolar or major depressive disorders with psychotic feature. Individuals with early onset of these disorders can also benefit from the four-year time limit for an Early

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		<p>the confines of specific psychotic disorders. The definition should be broadened to include mental disorders where psychotic features are present, giving counties the opportunity to demonstrate greater impact in successfully treating psychotic symptomatology earlier in the course of the illness. Generally, evidence-based, promising and community-defined practices targeting psychotic symptoms that are longer in duration are preferable to brief (and less effective) treatments, which often result in the need for higher acuity services-generally funded by Mental Health Services Act (MHSA) Community Services and Supports.</p>		<p>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.</p>	<p>Intervention Program, so staff recommends expanding the definition as suggested by the comment.</p>
3710(c)(1)	Commenter #4	<p><u>Comment 4.10</u> Current Proposed Language:</p> <p>Section 3710. Early Intervention Program.</p> <p>(a) The County shall offer at least one Early Intervention program as defined in this section.</p> <p>(b) "Early Intervention program" means treatment and other services and interventions, including relapse prevention, to address and promote recovery and related functional outcomes for a mental illness early in its emergence, including the applicable</p>	Accept in concept.	Change existing language as described in response to comment 4.09 above.	See response to comment 4.09 above on page 16. The suggested changed language is consistent with the recommendation in comment 4.10 but is slightly broader, including any disorder with psychotic features, including but not limited to bipolar and related disorders and depressive disorders.

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		<p>negative outcomes listed in Welfare and Institutions Code Section 5840, subdivision (d) that may result from untreated mental illness.</p> <p>(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>(1) For purpose of this section, "serious mental illness or emotional disturbance with psychotic features" 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.</p> <p>CBHDA Recommendation:</p> <p>Revise Section 371 O(c)(1) as follows:</p>			

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		<p>For purpose of this section, "serious mental illness or emotional disturbance with psychotic features" means any diagnosis in the currently recognized Diagnostic and Statistical Manual's Schizophrenia Spectrum and Other Psychotic Disorders section in addition to the diagnoses in the Bipolar and Related Disorders and Depressive Disorders sections when psychotic features are present.</p>			
3715 & 3735	Commenter #7	<p><u>Comment 7.05</u> In looking at the proposed language, the Outreach and Early Intervention strategies seem like they would be the same strategy, as the outreach services would be needed to make the early intervention program feasible. The Prevention program is clearly distinguishable from these two other services. So, in my mind, you are really only talking about two programs. Another way to look at this is using the Institute of Medicine's spectrum: Prevention = Universal and Selective; Outreach and Early Intervention = Indicated. For example, mental health services provided through the CalWORKs programs can be Selective because the behaviors these people exhibit and circumstances they are experiencing put them at risk of developing a mental illness. Some of</p>	Reject	Retain existing language with no change	<p>The comment is outside the scope of the 15-day Notice because the text that is commented upon was not modified. However, please see response below:</p> <p>The term "outreach" in the proposed section refers to engaging with, teaching, and learning from people who can recognize and respond to early signs and symptoms. (See definition in §3715(b).) It has a different focus than the common use of the term "outreach" as a process of encouraging individuals to participate in a service or program.</p> <p>Outreach to Potential Responders is one of the PEI component's priorities that aim to increase timely access to needed mental health services; the others are Access to Treatment, Improving Timely Access to Services for Underserved Populations, and Stigma and Discrimination Reduction. These are distinct from Prevention Programs and Early Intervention Programs, which intend outcomes for specific individuals.</p>

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		these people may actually be manifesting early signs of mental illness and then be referred for treatment, which would move them through the Indicated category and potentially treatment.			
3720	Commenter #3	<p>Comment 3.52 C. The Proposed Definition of “Risk Factors for Mental Illness” as Contained in Section 3720 is Unnecessary, Confusing, and a Violation of Statute</p> <p>The Commission accepted an oral comment requesting that the definition of "risk factors for mental illness" in Section 3720 be expanded to include risks based on "losses." Previously, Staff had rejected this proposed change because "[l]oss is a broad, [sic] concept and a universal human experience. Allowable risk factors for Prevention Programs require greater than average risk, beyond universal experiences." Despite Staff's position, the Commission apparently insisted on the change. In the version of the proposed regulation attached to MHSOAC's Fifteen Day Notice, the following language was added to the examples of risk factors: "traumatic loss (e.g. complicated, multiple, prolonged, severe)."</p>	Reject	Retain existing language with no change	<p><u>Loss</u>: While it is true that loss, in itself, is not a risk factor for mental illness, repeated, traumatic, and complicated loss can be a risk factor for a number of serious mental illnesses and also for negative consequences associated with serious mental illness, including suicide. This is more frequently the case when the loss is comorbid with other factors, such as alcohol or other substance dependence, significant trauma, or a family history of mental illness or suicide.</p> <p>The suggested new definition of “risk factors” is outside the scope of the 15-day notice and need not be responded to. However, please see the response below:</p> <p>The list of risk factors suggested by the comment conceptualizes risk factors considerably more narrowly than the conception of risk factors documented by the mental health literature. Based on the limited list of risk factors proposed by the comment, trauma would not be considered a risk factor for a serious mental illness, which by definition would eliminate Post-Traumatic Stress Disorder (PTSD) as a serious mental illness. Research documents that PTSD is a common co-morbid disease in many severe mental illnesses, which is frequently overlooked in mental health settings (Mauser et al, 1998).</p> <p>Risk factors are not necessarily causal in isolation, independent from other risk factors, but often co-occur.</p>

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		<p>The definition of "risk factors for mental illness" as set forth in Section 3720 should be eliminated, not expanded. "Risk factors for mental illness" are legally irrelevant, because PEI programs are supposed to be directed at people who are already mentally ill, not those who are at risk of becoming mentally ill. "Losses" may make us sad, and some of us depressed, and an even smaller number of us clinically depressed. But it is only the last, smallest group that is even arguably within the purview of MHSA, which requires a "mental illness" diagnosis. Like "adverse childhood experiences," "family conflict," "prolonged isolation," and most of the other "risk factors" listed in Section 3720, this new "risk factor" is also present in many individuals who are perfectly sane and will remain so for the rest of their lives.</p> <p>MIPO has already argued that Section 3720, in its entirety, is contrary to statute. However, assuming "risk factors" are appropriate to address, the definition should read as follows:</p> <p>(c) "Risk factors for <u>severe</u> mental illness" means conditions or experiences that <u>evidence-based research shows</u> are associated with a higher than average risk of developing a potentially serious <u>severe</u> mental</p>			<p>Risk factors are certainly not excluded because some people who experience the condition do not develop a severe mental illness. To the contrary, a central goal of the MHSA's PEI component is to prevent the development of or negative consequences of severe mental illness; intervening at the point of elevated risk is a demonstrated effective way to accomplish this goal. See response to comment 60.02 on page 17 of the Matrix of Public Comment presented at the August 28, 2014 MHSOAC meeting.</p>

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		<p>illness. Kinds of risk factors include, but are not limited to, biological including family history and neurological, 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 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>The "risk factors" in proposed Section 3720 are certainly what they purport to be, i.e., risk factors for common conditions that affect a significant percentage of the population at large. However, these "risk factors" have no proven causal relationship with severe mental illness, which is heavily genetic. Attacking "risk factors" in members of the general public to stave off severe mental illness assumes correlation is causation, and thus confuses cause and effect. The fact is, severely mentally ill individuals frequently experience job loss, family problems, and so forth,</p>			

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		<p>because of their severe illnesses. Addressing "risk factors for mental illness" among the public at large will never prevent "severe mental illness" because it ignores the biological bases of these diseases.</p> <p>Including and expanding a "risk factors for mental illness" definition also violates the "clarity" standard in the Administrative Procedure Act and applicable OAL guidelines. The public comment contained in the rulemaking record demonstrates the public has been misled by the "risk factors" definition, despite the language in subsection (e)(1) purporting to narrow Section 3720 to individuals "who are at greater risk than average of developing a potentially serious mental illness." Counties that have funded happiness-making programs like gardening, dance, yoga, hip hop carwashes, homework help, horseback riding and the like for people who are not and never will be mentally ill, will be able to continue these programs under the guise that they are addressing "risk factors for mental illness." These programs are beyond the purview of MHSA.</p> <p>MHSOAC has repeatedly acknowledged that it intends this result. Its responses</p>			

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		<p>to public comment demonstrate its intention to direct funds to "prevent mental illness," which is an impossible undertaking and one that Proposition 63/MHSA was carefully drafted to proscribe. Here are specific examples:</p> <p><i>Comment:</i> "I would like to suggest that the PEI regulations include a focus on primary prevention of mental illness " [Staff's Responses, pp. 121-122, Comment 10.8]</p> <p><i>Staff response:</i> "Accept." [Id. at p. 121]</p> <p><i>Comment:</i> "The proposed Plan and Regulations would benefit from increased emphasis on the prevention of mental disease ... 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 " [Staff's Responses, pp. 136-137, Commenter # 26]</p> <p><i>Staff response:</i> Accept [I d. at p. 136]</p> <p><i>Staff comment:</i> "One way of preventing mental illness from becoming severe and disabling is to intervene at the point of risk. Research referenced in the Initial Statement of Reasons documents that</p>			

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		<p>this is a sound practice that can either <i>prevent the mental illness from occurring</i> or at least can prevent the devastating consequences <i>if one develops</i>. [Staff's Responses. p.18 (emphasis added)]</p> <p><i>Commenter #3 (MIPO):</i> MHSOAC has no statutory authority to address "risk factors for mental illness."</p> <p><i>Staff response:</i> "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 for individuals and/ or groups at greater than average risk of <i>a mental illness</i> In these instances, any benefits to individuals who are not at greater than average risk for developing a potentially serious mental illness are <i>beneficial by-products of the program but not the allowable MHSA purpose</i> <i>Prevention programs intervene at the point of risk, to prevent a mental illness from developing</i> " [Staff's Responses, p. 45, #27 (emphasis added)]</p> <p>In sum, the "risk factors for mental illness" definition is legally irrelevant, confusing and an encouragement to continued waste and misallocation of funds that should be helping people who are already sick- waste that MHSOAC seems determined to encourage.</p>			

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		<p>Californians did not vote to tax themselves to fund these so-called "beneficial by-products" that MHSOAC has spent millions supporting. Eliminating, or at the very least, modifying the "risk factors" definition to include only risk factors for severe mental illness, is necessary to get the PEI program back into compliance with statute.</p>			
3720	Commenter #7	<p><u>Comment 7.07</u> I do like the rest of the description of the prevention services; it is actually describing the upstream approach needed to prevent manifestation of serious mental illness. You might consider looking at the CalOMS definitions, as substance abuse services has already clearly defined prevention and early intervention activities.</p>	Reject	Retain existing language with no change	<p>The suggestion is outside the scope of the 15-day Notice and need not be responded to. However, please see the response below:</p> <p>The California Outcome Measurement Service for Prevention (CalOMS Pv) is a web-based data collection system for primary prevention services and activity data funded with Substance Abuse Prevention and Treatment block grant dollars through the Policy and Prevention Branch of the California Department of Healthcare Services. As an integrated treatment and prevention outcomes measurement system, it has great applicability to the urgent need for an integrated outcomes measurement system that includes mental health outcomes related to risk of, experience of, and recovery from mental illness. Definitions of prevention in use by CalOMS rely on the Institute of Medicine definition of Prevention, and also feature SAMHSA's five steps to effective and sustainable prevention. However, there is no specific dimension of the CalOMS approach that staff can identify that is specifically applicable to proposed PEI Regulations.</p>

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3720	Commenter #83	<p><u>Comment 83.04</u> <u>Section 3720. Prevention Program.</u></p> <ul style="list-style-type: none"> For the reasons stated previously, we strongly support the language under (a) The County shall offer at least one Prevention Program as defined in this section. 	Accept	Retain existing language with no change as requested in comment.	The rationale for the change supported by the comment and the subject of the 15-day Notice is set forth in the Matrix of Public Comments presented at the August 28, 2014 MHSOAC meeting.
3720(a)	Commenter #80	<p><u>Comment 80.07</u> <u>3. Protection of Prevention Programs:</u> 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), we recommend 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.</p>	Accept	Retain existing language with no change	The MHSOAC at the August 28, 2014 meeting voted to modify Section 3720(a) to make the change suggested by the comment. As such, the proposed modification subject of the 15-day Notice makes the changes suggested by the comment.
3720(a) & (d)	Commenter #3	<p><u>Comment 3.50</u> <u>A. MHSOAC's Proposed Modifications Continue to Disregard the Statutory Mandate for Prevention and Early Intervention Programs for the Severely Mentally Ill.</u></p>	Reject	Retain existing language with no change	<u>Relapse Prevention as a Focus of a Prevention Program:</u> The comment repeats arguments made during the 45-day public comment period. The comment defines prevention more narrowly than how it is defined in the MHSA and in the proposed PEI Regulations. The Commission's legal interpretation of

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		<p>To summarize briefly from MIPO's previous comments, MHSA's Prevention and Early Intervention ("PEI") provisions contain two important mandates. The first is to prevent "mental illnesses" from becoming "severe and disabling," and to address severe mental illnesses in both children and adults "as early in the onset of these conditions as practicable." Second, PEI funds are also supposed to be used to provide early intervention in/prevention of relapses for those individuals who already have a severe mental illness. As MIPO previously documented, MHSOAC's misguided "policies" and pseudoregulations have resulted to date in millions of dollars in PEI funds being spent on programs that had little or nothing to do with helping those who had an existing mental illness, let alone a severe mental illness.</p> <p>While MHSOAC has proposed several modifications in response to MIPO's earlier comments, it has changed nothing of substance. Statutory language that reserves PEI funding for people who are actually sick is still being ignored or misquoted. And, MHSOAC's regulations continue to make discretionary what the statute imposes as a mandate for PEI programs.</p> <p>Here, first, is the statutory mandate, quoted in relevant part from WIC section</p>			<p>this issue is set forth in the Matrix of Public Comments presented at the August 28, 2014 MHSOAC meeting.</p> <p>The proposed regulations define prevention to include services for individuals who have a range of risk factors for a serious mental illness in addition to the comment's focus on individuals in recovery who are at risk of relapse. While relapse prevention for individuals in recovery from a severe mental illness is an allowable focus of a Prevention Program, the specific priority focus for a Prevention Program is determined by each county through its community planning process as is required by WIC §5848(a).</p> <p>See responses to comments 3.09, 3.06, 3.21, and 8.35 on pages 1, 5, 49, and 31 of the Matrix of Public Comments presented at the August 28, 2014 MHSOAC meeting.</p> <p>Early intervention program which is a required program includes "relapse prevention." See proposed Section 3710(b).</p>

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		<p>5840 (with emphasis supplied):</p> <p>(a) The State Department of Mental Health shall establish a program designed to prevent mental illnesses from becoming severe and disabling</p> <p>*****</p> <p>(c) 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>And here is the current modified version of MHSOAC's proposed Regulation 3720, quoted in relevant part (with underlining and strikeouts reflecting the proposed modifications):</p> <p>Section 3720. Prevention Program.</p> <p>(a) The County may <u>shall</u> offer one or more Prevention Programs as defined in this section</p> <p>*****</p> <p>(d) Prevention program services may include relapse prevention for individuals in recovery from a serious mental illness.</p>			

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		<p>MHSOAC is correct in modifying subsection (a) of its proposed regulation to make Prevention programs mandatory. However, the regulation as modified remains deficient because the relapse programs for the severely mentally ill are not mandatory components of the Prevention programs as required by WIC section 5840(c). As it did in subsection (a), MHSOAC should change the "may" to "shall" in subsection (d) to bring its proposed regulation into compliance with the statute.</p>			
3720(d)	Commenter #7	<p><u>Comment 7.06</u> I'm curious as to why relapse prevention was put in the prevention component; this has historically been a treatment service. This is for people who have mental illness, but the symptoms and disability are in remission. The illness is still present, but in remission.</p>	No specific action requested	N/A	<p>This comment is outside the scope of the 15-day Notice because the text was not modified in the proposed regulations associated with the 15-day Notice in which this comment was submit nor any other 15-day Notices. However, please see the response below:</p> <p>Relapse prevention is an inherent and necessary part of an Early Intervention Program. Relapse prevention for people in recovery can also be the focus of a Prevention Program, since people with a previous mental illness are among those who at risk of developing a mental illness “based on individual risk or membership in a group or population with greater than average risk of a serious mental illness.” The relapse that is part of the PEI component is in addition to relapse that is also an inherent part treatment for a serious mental illness in the CSS component, as pointed out in the comment. See response to comments 3.03 and 3.05 on page1 and page 7 of the Matrix of Public Comments presented at the October 23, 2014 MHSOAC meeting.</p>

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3725	Commenter #77	<p><u>Comment 77.01</u> I am not sure how effective the Statewide Anti- Stigma Campaign is and how you intend to measure the attitude changes that this social media campaign is I am assume designed to change. What I do know is that people are still dying on the streets as I observe people looking right through or not at all at folks who are serious and persistently mentally (SPMI) and homeless.</p>	No specific action requested	N/A	<p>This comment is outside the scope of the 15-day Notice because the text was not modified in the proposed regulations associated with the 15-day Notice in which this comment was submitted nor any other 15-day Notices. However, please see the response below:</p> <p>The Statewide Anti-Stigma campaign being implemented by CalMHSA is not within the scope of these regulations because it is a limited-time project and is expected to be completed by the time the regulations are implemented. However, the statewide Stigma and Discrimination Reduction program includes a comprehensive evaluation, results of which should be available about the same time PEI Regulations are implemented. This project is expected to generate tools and resources that will benefit counties as they determine effective program approaches and construct evaluations for their Stigma and Discrimination Reduction Programs.</p> <p>As the comment points out, stigma and discrimination related to mental illness is a serious and persistent problem. Proposed PEI Regulations require each county that chooses to offer a Stigma and Discrimination Reduction Program to specify the specific attitude, knowledge, and/or behavior that it intends to change and measure progress toward that intended outcome using appropriate indicators. Staff reviewed the literature regarding measurement of stigma and discrimination reduction, including recommendations from the CalMHSA statewide project, and determined that the state of measurement is not yet sufficiently clear to recommend specific indicators or measures. See responses to comments 8.29 and 8.53 on pages 16 and 46 of the Matrix of Public</p>

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					Comments presented at the October 23, 2014 MHSOAC meeting.
3725(b)(1)	Commenter #79	<p><u>Comment 79.02</u> Section 3725 (b) (1) states: <u>...efforts to combat multiple stigmas that have been shown to discourage individuals from seeking mental health services</u></p> <ul style="list-style-type: none"> • The research produced by the CA LGBTQ Reducing Disparities Project found that one of the top problems reported by LGBTQ individuals when seeking services was the mental health provider made negative comments about their sexual orientation or gender identity. LGBTQ individual also reported that one of the top barriers to seeking mental health services was concern that the mental health provider would not be supportive of their LGBTQ identity or behavior. It is also important to note that among the top barriers to seeking services was the concern that the mental health provider would mistreat them due to their race or ethnicity. • I therefore recommend the following language be included to clarify this addition: <ul style="list-style-type: none"> ○ <u>...efforts to combat multiple stigmas that have been shown to discourage individuals from seeking mental health services including, but not limited to,</u> 	Reject	Retain existing language with no change	Proposed PEI Regulations require all PEI programs to be “designed, implemented, and promoted using Strategies that are Non-Stigmatizing and Non-Discriminatory” (§3735(a)(3)). This language is purposefully broad and is intended to prohibit all forms of stigmatizing and discriminatory practices, including the significant examples provided by the comment. The language in (§3735(a)(3)) is reinforced by a non-exclusionary list of examples, which includes 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 orientation and also promoting positive attitudes and understanding of recovery among mental health providers. It is not possible or necessary to try to address in regulations all possible prohibited stigmatizing and discriminatory behaviors and practices that this required strategy prohibits or all positive welcoming behavior and practices that the required strategy is intended to promote.

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		<p>provider-based stigma and discrimination due to the client's actual or perceived sexual orientation, gender identity, race or ethnicity.</p>			
3735(a)(1)(B)	Commenter #83	<p>Comment 83.05 Section 3735. Prevention and Early Intervention Strategies.</p> <ul style="list-style-type: none"> We support the additional language proposed under (a)(1)(B) <u>In addition to offering the required Access and Linkage to Treatment strategy, the County may also offer Increase Access and Linkage to Treatment as a program.</u> 	Accept	Retain existing language with no change as requested in comment.	The rationale for the modified text that the comment supports and that is the subject of the 15-day Notice is set forth in the Matrix of Public Comment presented at the August 28, 2014 MHOSAC meeting.
3735(a)(2)(C)	Commenter #83	<p>Comment 83.06 Section 3735. Prevention and Early Intervention Strategies.</p> <p>We also support the additional language proposed under (a)(2)(C) <u>In addition to offering the required Improve Timely Access to Services for Underserved Populations strategy, the County may also offer Improve Timely Access to Services for Underserved Populations as a program.</u></p>	Accept	Retain existing language with no change as requested in comment.	The rationale for the modified text that the comment supports and that is the subject of the 15-day Notice is set forth in the Matrix of Public Comment presented at the August 28, 2014 MHOSAC meeting.
3750(g)(3)(A) & (h)(3)(A) & (B)	Commenter #80	<p>Comment 80.05 Recommendation C: Strengthen language in Section 3750 to accept consumer/family member report of onset of symptoms - subsection (g)(3)(A), or indicators of risk - (h)(3)(A) and (B) when other data sources (such as medical record) are unavailable. Add language to</p>	Reject	Retain existing language with no change	This comment is outside the scope of the 15-day Notice because the text was not modified in the proposed regulations associated with the 15-day Notice in which this comment was submitted; however the text was modified and was the subject of a subsequent 15-day Notice. The commenter did not submit a comment during the subsequent 15-day Notice period. Despite

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		these sections which recognize cultural specific terms which describe mental health symptoms and risk factors.			<p>the comment being outside the scope of both 15-day Notices please see the response below:</p> <p><u>Onset of symptoms:</u> The MHSOAC at the October 23, 2014 meeting modified the text of Section 3750(g)(3)(A) and (h)(3)(A) and (B) by deleting the measurements that require information regarding the “onset of symptoms” which is the subject of this comment. As such, the suggestion to accept consumer/family member report of onset of symptoms when other data is unavailable is no longer relevant.</p> <p><u>Cultural specific terms:</u> Current language in Proposed PEI Regulations require all PEI Programs and Strategies to utilized practices that have demonstrated their effectiveness for the intended populations and to demonstrate application of the MHSA-wide cultural competency General Standard, both of which would require the recognition, encouragement, and acceptance of culturally specific and relevant terms to describe symptoms of a mental illness, as suggested by the comment.</p>
No Specified Section	Commenter #4	<p><u>Comment 4.11</u> As regulations are developed to guide and shape behavioral health service delivery, it is critical that the MHSOAC and the counties (that are responsible for effectively delivering behavioral health services) work together so that the PEI regulations maximize the public benefit, assure best practices in behavioral health care, and honor the voters' intent.</p>	No specific action suggested	N/A	MHSOAC staff are strongly in agreement that support, including training and technical assistance, for counties is essential, both to provide access to information and resources related to effective practices that are likely to bring about intended MHSA PEI outcomes that are applicable to the specific Program or Strategy, and also to support implementation of new evaluation and reporting requirements. See response to comment 84.01 (above on page 3).
No Specified Section	Commenter #7	<p><u>Comment 7.08</u></p>	No specific action suggested	N/A	N/A

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		It will be hard to break through the culture of the treatment focus that has been established over the past few decades. In addition, prevention really provides the opportunity to collaborate with our partner agencies, as all of the risk and protective factors are the same for all of us.:-)			
No Specified Section	Commenter #75	<u>Comment 75.02</u> 2. Regulations made based on Financial Regulations which can and will change without MHSOAC's permission. This will create more problems and allow other counties to either be included or excluded from having to run prevention programs and early intervention programs.	No specific action suggested	N/A	N/A
No Specified Section	Commenter #76	<u>Comment 76.01</u> Keep the spirit of MHSA Prevention and Early Intervention language written into the contracts as written in original MHSA legislation. Currently there is broad (90%) lack of treatment and services for people living with serious mental illness. This crisis in mental health care has had tragic and costly consequences in our society, including many suicides and appallingly high numbers of people with serious mental illness who are homeless, in jails and prisons, hospitalized, or seeking crisis care in emergency rooms.	No specific action suggested	N/A	N/A

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		<p>Support keeping these contracts as originally designed for MHSA. With increasing and frequent school shootings, is vital that mental illness is recognized and treated at early stages and not as retroactive disease after a catastrophic incident. Society also needs to be spared the huge expense of institutional and correctional treatment.</p>			
No Specified Section	Commenter #77	<p><u>Comment 77.02</u> Our Jail as you know have become the de-facto mental health facility in California. Instead of using precious dollars on some project that the jury is out on its effectiveness. Why not use dollars to intervene, prevent folks from dying or getting killed on our streets by providing more direct services that use a combination of clinical and peer support models. Why not educate more provider and specifically providers who work in unlicensed board and cares how to improve their services and provide financial incentive for folks to work toward providing higher levels of care and to become licensed.</p> <p>Why not use some of the money to work with operators of these facilities including Institutes for Mental Diseases to provide training and education on how to work with residents to develop active, productive residential councils.</p>	Reject	Retain existing language with no change	<p>Many of the suggested approaches could be funded as PEI programs, depending on the specific intended outcomes and target populations. Proposed PEI Regulations require all PEI programs and strategies to use approaches that have demonstrated their effectiveness to bring about the intended MHSA PEI outcomes for the intended population. Counties have discretion, through the local community planning process, to determine the specific priorities and the best approaches to meet those priorities. See response to comment 3.25 on page 9 of the Matrix of Public Comments presented at the August 28, 2014 MHSOAC meeting.</p>

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		<p>Why not consider funding County Chaplaincy programs if folks have determine that spiritual health is a necessary part of recovery. Each County would have dedicated people or contract these services out to provide spiritual training and education on a variety of service models that are documented and proven effective. My last comment is fund each county to provide effective family reunification partnerships between consumers and family members and other stakeholders to broaden the understanding and possibly prevent homelessness, jails and other forms of institutionalization. Thanks for your consideration.</p>			
No Specified Section	Commenter #78	<p><u>Comment 78.01</u> While the last MHSOAC Commission meeting held on August 25, 2014 provided the opportunity for the public comment regarding Sections 3705 - 3735 as well as the addition of Sections 3701 and 3702, we would like to respectfully request a change in the way that public comment is conducted at future meetings on this subject.</p> <p>We are truly grateful as stakeholders to be able to have meaningful impact during this process. We feel, however, that the structure used during the August 25th meeting does not allow adequate</p>	No specific action requested	N/A	<p>The suggestion is outside the scope of the 15-day Notice and need not be responded to. However, please see the response below:</p> <p>It is not reasonable nor feasible to have the Commission during its regularly scheduled meeting vote on each individual section. The proposed regulations discussed at the August 28, 2014 MHSOAC meeting had been the subject of a 45-day comment period and a hearing held on July 24, 2014. At the August meeting the Commission agendaed only a third of the total proposed sections to give more time to discuss each of the sections. In compliance with the Bagley-Keene Open Meeting Act the Commission heard public comment prior to discussion and vote on proposed changes to the regulations. In addition, any</p>

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		<p>opportunity for public comment on all applicable proposed changes to the regulations. While many of us generally approve of the majority of the language in the regulations, there are many that feel there are still small changes to be made to language and other items within. During the last meeting, the public was given a very brief time limit, making it difficult or impossible to address all of the proposed changes.</p> <p>In addition, we feel that the process used is not conducive for public comment, as many of those present were very confused regarding how and what could be commented on, as well as when it was appropriate to address support or opposition. In order to address these issues and allow the public comment period to truly reflect the needs of the stakeholders involved, we are recommending the following changes to the format of the upcoming MHSOAC meeting:</p> <p>We encourage the MHSOAC to approve each section individually, rather than in a single motion as was done at the August 25th meeting, with public comment allowed before each motion is voted on. We feel this modification would ensure that stakeholders will have a sufficient opportunity for public comment</p>			<p>changes that the Commission voted upon at the August meeting were the subject of a subsequent 15-day public comment period.</p>

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		regarding any and all proposed changes.			
No Specified Section	Commenter #78	<p>Comment 78.02 Should the MHSOAC wish to continue using a single motion process, we would like to request that sections of the regulations on which the commission has previously received comment or suggestions for change be considered separately, and only those sections on which there has been no previous comment be included in the single motion. This process will allow members of the public to comment on those sections on which they have previously registered concern.</p>	No specific action requested	N/A	See response to comment 78.01 above on page 37.
No Specified Section	Commenter #78	<p>Comment 78.03 Regardless, we especially request that there is separate discussion – that is, opportunity for public comment - for each of the following sections: 35.10.010(a)(i); 3560.010(b)(5)(A) – 3560.010(b)(5)(H); 3740(a)(1),(2),(3); 3740(3); 3750(g)(3)(a); 3750(h)(3)(A) and (B); and 3755(c)(3)(C). These are sections that were submitted for comment in writing by Community Stakeholders and we believe it is important for the Commissioners to hear our comments on these.</p>	No specific action requested	N/A	See response to comment 78.01 above on page 37.

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No Specified Section	Commenter #78	<p><u>Comment 78.04</u> While we recognize and are sensitive to the collective desire to see these regulations developed and implemented in a timely manner, we believe that it would be a mistake to rush this process in order to “have it completed.” We encourage and welcome discussion on these recommendations and truly hope that this process can be modified in such a way that the meaningful and necessary feedback of all stakeholders involved is heard and accounted for in a way that is open, equitable, and easy to understand.</p>	No specific action requested	N/A	See response to comment 78.01 above on page 37.
No Specified Section	Commenter #80	<p><u>Comment 80.01</u> 1. Targeting Services to Children and Youth: The proposed regulation remove the mandate that a minimum of 51% of PEI funds be allocated to target children, youth, and families.</p> <p>The current MHSOAC Prevention and Early Intervention Programs Initial Statement of Reasons emphasizes the importance of providing prevention and early intervention services to children, youth, and families. As stated in this MHSOAC document, an estimated 75-80% of children and youth who need mental health treatment don't receive it. Widely accepted statistics demonstrate that half of all lifetime cases of diagnosable mental illnesses begin by</p>	Accept	Retain existing language with no change	The MHSOAC at the September 30, 2014 meeting voted to modify the proposed regulations to make the change suggested by the comment. See proposed Section 3706(b). As such, the proposed modification subject of the 15-day Notice makes the changes suggested by the comment.

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		<p>age 14, and three- fourths by age 24. Therefore, the preservation of funds for children and youth is critical and necessary to ensure effective prevention efforts for children and their family members.</p> <p>The MHSAspecified purpose for PEI programs is to prevent mental illnesses from becoming severe and disabling (Welfare and Institutions Code Section 5840, subdivision (a)). Specific provisions of the MHSAs require counties to: Emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness: suicide, incarcerations, school failure or drop-out, prolonged suffering, unemployment, homelessness, and removal of children from their homes.</p> <p>Recommendation: Hathaway-Sycamores strongly supports the original mandate to allocate a minimum of 51% of PEI funds to target children, youth and families and recommends that this mandate be retained.</p>			
No Specified Section	Commenter #80	<p>Comment 80.02 2. Outcomes and Evaluations: Hathaway-Sycamores supports the efforts for data collection and program evaluation of PEI projects throughout California. However, the proposed</p>	No specific action suggested	N/A	This comment is outside the scope of the 15-day Notice because the text was not modified in the proposed regulations associated with the 15-day Notice in which this comment was submit nor any other 15-day Notices. However, please see the response below:

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		regulations fall short of describing the link between gathering data and program improvement. Evaluation efforts should facilitate consistent statewide reporting of data and demonstrate effective processes for service delivery and improvement in functioning for consumers.			As emphasized in the Statement of Reasons regarding the Proposed PEI Regulations, a key purpose of all included evaluation requirements is quality improvement at both local and state levels. Another key purpose is to communicate the outcomes of the use of MHSA funds to a wide range of interested audiences (legislators, individuals at risk of and with mental illness and their family members, the general public, service providers, members of underserved communities, etc.).
No Specified Section	Commenter #80	Comment 80.03 Recommendation A: MHSOAC should consider data collection processes which align with current efforts made by counties as well as processes under development at DHCS (including the EPSDT Performance Outcome System Project, Katie A v. Bonta mandated Accountability, Communication, and Oversight - ACO, and proposed DSS Continuum of Care Reform evaluations). By leveraging these other efforts we can ensure that funding is not diverted from PEI programs to created duplicative data systems.	No specific action suggested	N/A	This comment is outside the scope of the 15-day Notice because the text was not modified in the proposed regulations associated with the 15-day Notice in which this comment was submitted nor any other 15-day Notices. However, please see the response below: See responses to comment 35.02 on page 41 of the Matrix of Public Comment presented to at the October 23, 2014 MHSOAC meeting.
No Specified Section	Commenter #80	Comment 80.04 Recommendation B: MHSOAC should provide clarity regarding what qualifies as good outcomes, how they will be measured, how the criteria will be set, and what decisions would be made based on the data received.	No specific action suggested	N/A	See response to comment 80.03 above on page 42.

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3510.010	Commenter #4	<p><u>Comment 4.12</u> 1) Section 3510.010. Prevention and Early Intervention Annual Revenue and Expenditure Report.</p> <p>At a time when federal and state care systems are integrating services, the proposed section 3510.010 of the PEI regulations represents siloed, duplicative reporting. For example, the proposal requires counties to track expenditures and characterize “programs” using a methodology inconsistent with Department of Health Care Services (DHCS) reporting forms, program implementation, and the tracking mechanisms established in electronic health records or information technology systems.</p> <p>California Welfare and Institutions Code §5899(a) reads: “The State Department of Health Care Services, in consultation with the Mental Health Services Oversight and Accountability Commission and the California Mental Health Directors Association, shall develop and administer instructions for the Annual Mental Health Services Act Revenue and Expenditure Report.” The proposed regulations ignore existing statutory language regarding DHCS’ role in developing Annual Revenue and Expenditure Reports guidance, while demanding county reporting on revenues and expenditures beyond MHSA’s</p>	Reject	Retain existing language with no change	<p>This comment is outside the scope of the 15-day Notice because the text was not modified in the proposed regulations associated with the 15-day Notice in which this comment was submitted nor any other 15-day Notices. However, please see the response below:</p> <p>MHSOAC is working in close collaboration with DHCS to ensure consistency in reporting requirements for the Annual Revenue and Expenditure Report. Staff from DHCS and MHSOAC are currently collaborating on the Instructions for the Annual Revenue and Expenditure Report for Fiscal Year 2012/13. The Regulations apply to the Annual Revenue and Expenditure Reports starting Fiscal Year 2015/16. There will be no separate, duplicative, or contradictory reporting requirements for the Annual Revenue and Expenditure Report.</p> <p>WIC §5846(a) requires the MHSOAC to develop regulations for PEI “programs and expenditures” and as such, the MHSOAC has the authority and the responsibility to ensure that minimum standards such as fiscal reporting at the program level in categories that are consistent with the MHSA are included. In addition, WIC§5846(b) requires that “any regulations adopted by the department [DHCS] pursuant to Section 5898 shall be consistent with the commission’s regulations.”</p> <p>It is impossible for the legislature, general public, or other stakeholders to understand and assess the use of public MHSA PEI funds without County fiscal reporting at the program level. Without strengthened</p>

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		<p>purview which are already subject to existing federal and state oversight.</p> <p><i>CBHDA Recommendation: Revise section 3510.010 to reflect that county Annual Revenue and Expenditure Reports accepted by DHCS will be considered by the MHSOAC as compliant with its PEI regulations. PEI regulations regarding Annual Revenue and Expenditure Reports must align with DHCS guidance on these reports and not create a new and separate reporting standard that is duplicative and inconsistent with DHCS. CBHDA understands MHSOAC's need for pertinent Prevention and Early Intervention information, but respectfully urges MHSOAC to work with DHCS so that county Revenue and Expenditure Reports and other reporting use a single methodology.</i></p>			<p>fiscal reporting requirements, it is not possible to address the significant concerns expressed in the August 2013 State Auditor's Report charge that "a strong monitoring process and strong requirements help ensure that taxpayer funds are appropriately spent" (p. 24) and that "neither the desk audit nor the MHSA-related questions evaluated whether all counties had consistently followed MHSA requirements and spent taxpayer funds appropriately" (p. 26). Nor is it possible to assess the validity of concerns expressed in the press and by some members of the public that PEI funds are being misused and to provide accurate information.</p> <p>See response to comments 4.04, 10.04, et al. on page 58 of the Matrix of Public Comments presented at the October 23, 2014 MHSOAC meeting; to comments 4.05, 10.05, et al., comment 8.20, and comment 38.04 on pages 17, 21, and 20 of the Matrix of Public Comments presented at the September 30, 2014 MHSOAC meeting.</p>
3510.010	Commenter #85	<p><u>Comment 85.01</u> My question is there any way to add that report also be submitted to the Local Mental Health Board especially the First part</p> <p><u>Section 3510.010. Prevention and Early Intervention Annual Revenue and Expenditure Report.</u> <u>(a) As part of the Mental Health Services Act Annual Revenue and Expenditure Report the County shall report the following:</u> (1) The total funding source dollar amounts expended during the reporting period,</p>	Accept	<p>Change existing language as indicated:</p> <p>5810.010 new subdivision (b)</p> <p><u>(b)The County shall within 30 days of submitting to the state the Annual Revenue and Expenditure Report:</u> <u>(1) post a copy on its web site;</u> <u>and</u> <u>(2) provide a copy to its local Mental Health Board</u></p>	<p><u>Recommended Change:</u> Add language to specify that County shall make Annual Revenue and Expenditure Report available to the public and to local Mental Health Board.</p> <p>Given the important role of the local Mental Health Board to conduct a public hearing and review the adopted plan or update and make recommendations to the county mental health department for revision (WIC §5848(b)), it makes sense that access to the Annual Revenue and Expenditure Report would be a crucial resource. It also makes sense, given the local approval of PEI programs and expenditures (WIC §5847(a)), that providing public access to the Annual Revenue and Expenditure Report would provide</p>

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		<p>This would greatly help the local board to Guarantee a better outcome. When I ask my county about their expenditures, They reply we will get back to us (the board), but never do or give us a partial answer, but not to the question asked. Since in my county the mental health Department gets the large amount of MHSA funds for their programs compared to the community partners that get a significantly less as noted in the MHSA update 2014 to 2017. So if the boards are aware of their departments expenditures, they could better utilize the MHSA dollars.</p> <p>I want to clarify a of part the e-mail I sent Since in my county the mental health Department gets the large amount of MHSA funds for their programs compared to the community partners that get a significantly less as noted in the MHSA update 2014 to 2017</p> <p>It should be Since in my county the mental health Department gets the large amount of MHSA funds for their programs per clients that have less clients they are serving. If you compared it to the community partners that get a significantly less per clients and they serve more clients and basically serve the same propose as noted in the MHSA update 2014 to 2017. Some Some Community partners need more funding to expand their services and help with the expense. I hope that is more clear of what I meant to say.</p>			<p>essential information for local decision-making, oversight, and the ongoing meaningful involvement required by the MHSA (WIC §5848(a)).</p>

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3703	Commenter #3	<p><u>Comment 3.55</u> II. MIPO'S COMMENTS ON PROPOSED NEW REGULATION SECTION 3703</p> <p>MHSOAC is proposing a new regulation section 3703 defining "mental illness" as follows:</p> <p><u>Section 3703. Definition of Mental Illness.</u></p> <p>(a) "Mental illness" as used in the Prevention and Early Intervention regulations means, a syndrome characterized by clinically significant disturbance in an individual's cognitive, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental illness is usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental illness. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental illness unless the deviance or conflict results from a dysfunction in the individual, as described above.</p> <p>As discussed below, MIPO objects to this proposed definition because it is inconsistent</p>	Agree in part	<p>Change existing language as indicated: 3703 (a) "Mental illness" as used in the Prevention and Early Intervention regulations means, a syndrome characterized by clinically significant disturbance in an individual's cognitive, <u>cognition</u>, emotion regulation, or behavior that reflects a dysfunction in the psychological <u>or</u> biological, or developmental processes underlying mental functioning. Mental illness is usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental illness. Socially deviant <u>variant</u> behavior (e.g. political, religious, or sexual) and conflicts that are primarily between the individual and society are</p>	<p><u>Recommended change:</u> Remove reference to "developmental"; specify that mental illness includes emotional disturbance for individuals under the age of 18; add language to specify exclusions in the definition of emotional disturbance for children and adolescents under the age of 18 for consistency with definition of serious emotional disturbance in 5600.3; and replace the term "deviance" with "variance" because the term is pejorative.</p> <p>(1)The comment misquotes WIC §5600.3 as limiting serious mental illnesses to specific disorders, instead, §5600.3 states that serious mental illnesses "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."</p> <p>(2) The comment's suggestion that the definition of "mental illness" should be limited to disorders that can become "severe mental illness" is untenable because there is no consensus or certainty in the field about which mental disorders have the potential to become severe and disabling (Parabiaghi et al, 2006). To the contrary, most mental illnesses have the potential to become severe and disabling and level of severity, duration of symptoms, and functional impairment are all critical element of assessment and diagnosis of most mental disorders.</p> <p>(3) The conclusion drawn by the comment that voter intent was to treat "mental illness" and "severe mental illness" as virtually indistinguishable is not supported by the ballot materials. If, as the comment states, both advocates and opponents of Prop. 63 treated "mental illness" and "severe mental illness"</p>

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		<p>with the MHSA and with voter intent in passing Prop. 63. It also violates the APA's clarity standard.</p> <p>A. "Mental Illness" Under The MHSA Is Limited To Disorders That Can Worsen Into "Severe Mental Illness."</p> <p>Unlike "severe mental illness," the term "mental illness" is not specifically defined in the MHSA. The statute does provide guidance, however, as to what it means. The MHSA's language specifies that "mental illness" is a disabling but treatable condition which, left untreated, can lead to severe consequences, including suicide, homelessness, school failure, and jail. This guidance is evident in the introductory provisions of the MHSA:</p> <p>Untreated <i>mental illness</i> 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 <i>mental illness</i> 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</p>		<p>not mental illness unless the deviance <u>variance</u> or conflict results from a dysfunction in the individual, as described above.</p> <p>(b) <u>The definition in subdivision (a) includes emotional disturbance in a child or adolescent under the age of 18, other than a primary substance use disorder or developmental disorder.</u></p>	<p>as virtually indistinguishable, it does not follow that their intention was to focus only on severe mental illness; it is equally plausible to conclude that the focus on mental illness was broad. However, it is abundantly clear both from the ballot arguments and from the language in the MHSA that a key goal of the MHSA is to prevent the devastating and disabling consequences of mental illness. That is why the PEI component states that its overall goal is to "prevent mental illnesses from becoming severe and disabling" (WIC §5840(a)), language which is entirely consistent with the ballot measure language quoted.</p> <p>The ballot language also specifically states that the goal of the MHSA is not only to respond to severe mental illnesses that have already developed, but also to prevent mental illnesses from developing where possible: "It will help children avoid mental illness, or cope with its effects." This ballot language is consistent with the inclusion of Prevention Programs that intervene at the point of risk in addition to Early Intervention Programs, Suicide Prevention Programs, and the various approaches that broadly intend to facilitate the earliest possible access to needed mental health services to avoid the devastating consequences of untreated mental illness.</p> <p>The primary relevance of this definition to proposed PEI regulations is to define broadly the consequences that the PEI component as a whole intends to prevent.</p> <p>See response to comment 3.54 below on page 58.</p>

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		<p>enforcement, including juvenile justice, jail and prison costs.</p> <p align="center">*****</p> <p>(e) With effective treatment and support, recovery from <i>mental illness</i> is feasible for most people.</p> <p>MHSA, Findings and Declarations, Sec. 2(c) and (e). It is also evident in the MHSA's operative provisions:</p> <p>The program shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness:</p> <ul style="list-style-type: none"> (1) Suicide. (2) Incarcerations. (3) School failure or dropout. (4) Unemployment. (5) Prolonged suffering. (6) Homelessness. (7) Removal of children from their homes <p>WIC § 5840(d).</p> <p>There is also important guidance in the definitions and descriptions of "severe mental illness" in WIC section 5600.3, which are incorporated by reference in several operative provisions of the MHSA. Because the MHSA PEI provisions require action to "prevent mental illnesses from becoming severe and disabling" (WIC § 5840(a)), "mental illness" should be limited to disorders that can become "severe mental illness," as</p>			

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		<p>statutorily-defined. Section 5600.3 incorporates specific diagnoses viewed by the public and professionals as "mental illnesses," <i>i.e.</i>, psychotic and severe mood (affective) disorders. It also specifically excludes diagnoses that are <i>not</i> viewed as "mental illnesses."</p> <p>Disorders specifically included in section 5600.3 for adults (over 18 years old) are as follows:</p> <p>"[S]chizophrenia, bipolar disorder, post-traumatic stress disorder, as well as major affective disorders or other severely disabling mental disorders."</p> <p align="center">*****</p> <p>"Adults or older adults who require or are at risk of requiring acute psychiatric inpatient care, residential treatment, or outpatient crisis intervention because of a mental disorder with symptoms of psychosis, suicidality, or violence."</p> <p>WIC § 5600.3(b)(2) and (c). Diagnoses specifically excluded in section 5600.3 for adults are as follow:</p> <p>"[A] substance use disorder or developmental disorder or acquired traumatic brain injury pursuant to subdivision (a) of Section 4354 unless that person also has a serious mental disorder as defined in paragraph (2)."</p>			

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		<p>WIC § 5600.3(b)(3)(A). Disorders specifically included in section 5600.3 for children and adolescents are as follows:</p> <p>"[A] mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders ... which results in behavior inappropriate to the child's age according to expected developmental norms. Members of this target population shall meet one or more of the following criteria:</p> <p>(A) As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:</p> <p>(i) The child is at risk of removal from home or has already been removed from the home.</p> <p>(ii) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.</p> <p>(B) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder."</p>			

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		<p>Disorders specifically excluded in section 5600.3 for children and adolescents:</p> <p>"[A] primary substance use disorder or developmental disorder."</p> <p>WIC § 5600.3(a)(2).</p> <p>To summarize, we deduce from section 5600.3 that "mental illnesses" may worsen to become severe psychotic disorders or mood disorders, including "schizophrenia, bipolar disorder, post-traumatic stress disorder, as well as major affective disorders or other severely disabling mental disorders," with particular emphasis on disorders that place an adult or child at risk of violence, suicide, or homelessness/ ejection from the home. Section 5600.3's definitions also specifically exclude developmental disorders (such as mental retardation), which typically affect the brain permanently and do not improve with treatment. Finally, both the child and adult definitions exclude substance abuse disorders (drug and alcohol abuse), unless it co-occurs with a severe mental illness. All of this is generally in accordance with the general public understanding of mental illness.</p> <p>An examination of ballot materials to discern voter intent is also relevant here. <i>See, e.g., Westly v. Board of Administration</i> (2003) 105 Cal.App.4th 1095. The ballot materials reveal that both advocates and opponents of Prop.</p>			

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		<p>63 treated "mental illness" and "severe mental illness" as virtually indistinguishable, <i>i.e.</i>, "mental illness" was assumed to incorporate only severely disabling conditions that are amenable to treatment. Here are excerpts from the ballot materials for and against Prop. 63:</p> <p>Proposition 63 also provides prevention services to help children, adults, and seniors get care <i>before a mental illness</i> becomes disabling <i>Mental illness</i> does not have to be disabling. With proper care, children can return to a normal life and enjoy success in school. Adults and seniors can regain their dignity and find productive work. ... One in three people who are homeless are on the streets only because of <i>untreated mental illness</i>. Our prisons and jails are full of thousands of people <i>with mental illnesses</i> who would not be there if they had been offered treatment. ... It's heartbreaking to watch children fall into <i>mental illness</i>. They struggle in school, unable to focus on learning. Left untreated, many withdraw from teachers, friends, and family. Finding it difficult to "fit in" at school, many drop out. <i>All of these consequences are preventable</i>. Proposition 63 provides for early intervention and badly needed services. It will help children avoid <i>mental illness</i>, or cope with its effects, and get back on track to learning.</p> <p align="center">*****</p>			

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		<p>We must get the <i>mentally ill</i> off the streets and get them the treatment they need. For too long, those who suffer have been left without hope and without help. We agree!</p> <p style="text-align: center;">*****</p> <p>Treating <i>mental illness</i> doesn't just mean helping individuals. It means better schools and businesses, and safer communities. Successful treatment keeps adults healthy, employed, and self-sufficient. It helps children stay and succeed in school. Police can focus on crime, instead of <i>untreated mental illness</i> After decades of neglecting <i>mental illness</i>, California began an experimental, community-based mental health program five years ago The program has been studied extensively. (See www.AB34.org.) The results show that three times more people found employment than had worked previously. Those enrolled had a 66% reduction in hospital days, and an 81% reduction in jail days.</p> <p>In sum, the ballot materials treat "mental illness" and "severe mental illness" as virtually indistinguishable. In fact, the ballot materials treat the Adult Systems of Care (AB 34), for which eligibility is based on "severe mental illness" as defined in section 5600.3, as a program that addresses "mental illness," rather than "severe mental illness." This, again, is in accordance with the public's ordinary understanding of "mental illness."</p>			

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		<p>MHSOAC repeatedly concedes that its regulations should only address conditions that have the potential to become "severe." Yet, as discussed below, its proposed definition of "mental illness" not only incorporates disorders specifically excluded in section 5600.3, but also a vast array of minor disorders that the public would never consider "mental illness," and that will never worsen into a "mental illness." The proposed definition is, therefore, a change in statute rather than an interpretation, and beyond MHSOAC's authority. Further, this change creates ambiguity and confusion where none existed before. As such, it violates the APA's "clarity" standard. See Govt. Code § 11349(d).</p> <p>B. MHSOAC's Definition Of "Mental Illness" Includes Sleep Disorders, Drug Abuse, And Other Disorders That Are Not And Never Will Become Severe Mental Illness.</p> <p>MHSOAC's proposed definition of "mental illness" simply takes the term "mental disorder" used in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), and substitutes "illness" in place of "disorder." By doing this, MHSOAC has expanded "mental illness" to include a vast array of "disorders," including mental retardation, drug and alcohol abuse and other disorders specifically excluded from WIC section 5600.3- disorders</p>			

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		<p>that are not considered "mental illnesses" and that never will become "severe mental illnesses."</p> <p>The DSM groups disorders that have similar constellations of symptoms. Those that are generally considered "mental illnesses" include the specific diagnoses referenced in WIC section 5600.3: either mood disorders (including bipolar, depressive or anxiety disorders), or psychotic disorders, such as schizophrenia. But DSM' s "mental disorders" also include numerous disorders that no one would define as mental illness: <i>e.g.</i>, mental retardation and other developmental disabilities, stuttering and other communication disorders, sleep disorders, elimination (bowel) disorders, a variety of substance abuse and addictive disorders, and sexual dysfunctions, to name just a few. Many of these "disorders" - <i>e.g.</i>, developmental disabilities and substance abuse - are specifically excluded from the definitions in WIC section 5600.3. And none of them will worsen into "severe mental illness," which is the condition that the PEI provisions were designed to prevent. When sleep disorders worsen, people get sleepier. When drug and alcohol abuse disorders worsen, people abuse more drugs and alcohol, and so forth. All of these conditions fall outside the purview of the MHSA.</p> <p>MHSOAC's proposed definition is thus drastically overbroad because no one –</p>			

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		<p>particularly not the vast majority of voters - would consider the enumerated "disorders" to be "mental illnesses." MHSOAC should define "mental illness" as it is commonly understood, to include the diagnoses with constellations of symptoms that can worsen into "severe mental illness," <i>i.e.</i>, the DSM mood disorders (including depressive and anxiety disorders) and psychotic disorders. For example, Depressive Disorder NOS can worsen into Major Depressive Disorder, single or recurrent. An individual diagnosed with Bipolar II, which is fairly common, even among high-functioning people, is always at risk of a Bipolar I diagnosis, a far more severe and disabling illness. A victim of trauma with an Anxiety Disorder is at risk of a diagnosis of PTSD, a more severe disorder on the spectrum that is specifically included in WIC section 5600.3</p> <p>If MHSOAC believes this approach is unduly restrictive, it should be required to follow the template used in section 5600.3: after stating the obvious diagnoses in its definition of "mental illness," it could allow counties to justify inclusion of other DSM diagnoses based on the risk of severe disability, <i>i.e.</i>, the specific markers for "severe mental illness" enumerated in WIC section 5840(d). MHSOAC should also follow the example of section 5600.3 by referencing "the most recent edition" of the DSM or its future equivalent, rather than simply incorporating language from the current DSM V.</p>			

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		<p>Psychiatrists are presently drafting a proposed replacement for the DSM that will be more grounded in genetics and neurobiology. MHSOAC's regulations should be drafted to move with the science, thus fulfilling the statutory requirement that it "revise the program elements ... to reflect what is learned about the most effective prevention and intervention programs." WIC § 5840(e).</p> <p>C. MHSOAC's Proposed Definition Of "Mental Illness" Is Confusing And An Invitation To Further Misuse Of Funds.</p> <p>Apart from being drastically overbroad, MHSOAC's proposed definition of "mental illness" is extremely confusing, particularly to people with professional backgrounds. Mental health professionals will assume that all forms of developmental disabilities, substance abuse, sexual disorders, sleep disorders, elimination disorders, and other conditions that no voter would characterize as "mental illness," are nonetheless included in the definition.</p> <p>At best, the definition reduces clarity instead of creating it. At worst, the definition will allow MHSOAC to continue the practice that began under its pseudoregulations of misusing funds intended for the severely mentally ill, to underwrite programs that have nothing to do with preventing "mental illness" from becoming "severe mental illness." On this</p>			

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		additional ground, MHSOAC's proposed definition should be rejected.			
3704	Commenter #3	<p>Comment 3.54 I. MIPO'S COMMENTS ON PROPOSED NEW REGULATION SECTION 3704</p> <p>MHSOAC is proposing a new regulation 3704 defining "serious mental illness" and "severe mental illness," as follows:</p> <p>Section 3704. Definition of Serious Mental Illness and Severe Mental Illness</p> <p>(a) "Serious mental illness" and "severe mental illness" as used in the Prevention and Early Intervention regulations means, a mental illness 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 or indefinite period of time. These mental illnesses 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.</p> <p>As discussed below, MIPO objects to MHSOAC' s proposed definition because it is not consistent with the way in which those</p>	Agree in part	<p>Change existing language as indicated: 3704</p> <p>(a)"Serious mental illness" and "severe mental illness" as used in the Prevention and Early Intervention regulations means, a mental illness that is severe in degree and persistent in duration, which may cause behavioral functioning which <u>that</u> 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 or indefinite period of time. These mental illnesses 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. <u>(b)The definition in subdivision (a) includes, for individuals under the age of 18, serious emotional disturbance, which is defined as a mental disorder as</u></p>	<p><u>Recommended change:</u> Include in the definition of serious mental illness the 5600.3 definition of serious emotional disturbance for children and adolescents under the age of 18.</p> <p>There are two primary contexts for serious (or severe) mental illness with regard to Proposed PEI Regulations. The first is the serious mental illness and consequences of serious mental illness that the PEI component is intended to prevent (WIC §5840(a)), which include but are not limited to those listed in WIC §5600.3. The second is the MHSA requirement to provide access and linkage to medically necessary care provided by county mental health programs for children with severe mental illness (WIC §5840(b)(2)) which is related to the requirement to reduce the duration of untreated mental illness (5840(c)).</p> <p>The purpose of WIC §5600.3 is to define target populations and priority eligibility for the use of funds deposited in the mental health account of the local health and welfare trust fund. For the PEI component, the relevant part of §5600.3 is the definition of serious mental illness, which includes the definition of serious emotional disturbance for children and youth. Staff has suggested incorporating the §5600.3 definition of serious emotional disturbance into the definition of serious mental illness to make the definition applicable to all ages.</p> <p>The criteria in §5600.3, cited in the comment are too narrow for defining the scope of potential disabilities</p>

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		<p>terms are defined and used in the Mental Health Services Act (MHSA).</p> <p>A. MHSOAC's Proposed Regulation Section 3704 Is Not Consistent With The Definition Of "Severe Mental Illness" As Used In The MHSA's Operative Provisions.</p> <p>None of MHSA's operative provisions use the term "serious mental illness." Instead, they consistently use the term "severe mental illness" (or a variation thereof). See, e.g., WIC §§ 5840(b)(2), 5872.2, and 5813.5. In each provision in which the term is used, it is defined by reference to a pre-existing provision of the Welfare & Institutions Code: section 5600.3.2 The best example of this appears in WIC section 5840(b)(2), where it references programs for "children <i>with severe mental illness, as defined in Section 5600.3</i>, and for adults and seniors <i>with severe mental illness, as defined in Section 5600.3</i>" (emphasis supplied).</p> <p>WIC section 5600.3 itself does not use the term "severe mental illness." Instead, it refers to "seriously emotionally disabled children or adolescents" and to "adults and older adults who have a serious mental disorder." It reads in relevant part as follows:</p> <p>(a) (1) Seriously emotionally disturbed children or adolescents. (2) For the purposes of this part, "seriously emotionally disturbed</p>		<p><u>identified in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms.</u></p>	<p>as a consequence of untreated mental illness that the PEI component intends to prevent.</p> <p>The disabling consequences of serious mental illness that §5600.3 includes in its eligibility criteria are precisely the kinds of disabling consequences (severe functional impairments, threat of decompensation, long history of untreated mental illness) that the MHSA PEI component intends to prevent, but the PEI component intends to prevent a range of other disabilities, including but not limited to those specified in WIC §5840(d). The list in §5600.3 is not particularly relevant for the PEI requirement to provide Access and Linkage to Treatment as early in onset as possible, ideally before any of those disabilities occur. It is therefore not necessary to include in the PEI component definition of "serious mental illness" the enumerated negative consequences that serve as eligibility priorities for §5600.3. See response to comment 3.55 above on page 46.</p>

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		<p>children or adolescents" means minors under the age of 18 years who have a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. Members of this target population shall meet one or more of the following criteria:</p> <p>(A) As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:</p> <p>(i) The child is at risk of removal from home or has already been removed from the home.</p> <p>(ii) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.</p> <p>(B) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.</p> <p>(C) The child meets special education eligibility requirements under Chapter 26.5</p>			

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		<p>(commencing with Section 7570) of Division 7 of Title 1 of the Government Code.</p> <p>(b) (1) Adults and older adults who have a serious mental disorder.</p> <p>(2) For the purposes of this part, “serious mental disorder” means 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 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 section shall not be construed to exclude persons with a serious mental disorder and a diagnosis of substance abuse, developmental disability, or other physical or mental disorder.</p> <p>(3) Members of this target population shall meet all of the following criteria:</p> <p>(A) The person has a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental</p>			

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		<p>Disorders, other than a substance use disorder or developmental disorder or acquired traumatic brain injury pursuant to subdivision (a) of Section 4354 unless that person also has a serious mental disorder as defined in paragraph (2).</p> <p>(B) (i) As a result of the mental disorder, the person has substantial functional impairments or symptoms, or a psychiatric history demonstrating that without treatment there is an imminent risk of decompensation to having substantial impairments or symptoms.</p> <p>(ii) For the purposes of this part, “functional impairment” means being substantially impaired as the result of a mental disorder in independent living, social relationships, vocational skills, or physical condition.</p> <p>(C) As a result of a mental functional impairment and circumstances, the person is likely to become so disabled as to require public assistance, services, or entitlements.</p> <p align="center">*****</p> <p>(c) Adults or older adults who require or are at risk of requiring acute psychiatric inpatient care, residential treatment, or outpatient crisis intervention because of a mental disorder with symptoms of psychosis, suicidality, or violence.</p>			

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		<p>WIC § 5600.3 (a)-(c).</p> <p>MHSOAC's definition in proposed section 3704 contains part but not all of the defining language contained in section 5600.3. While section 5600.3 is detailed and complex, California counties - the entities who must administer the PEI provisions – already work with it daily in disbursing funds from their mental health accounts. Because the MHSA specifically incorporates section 5600.3 as its definition of “severe mental illness” in several of its operative provisions, MHSOAC should not use an incomplete definition in its proposed PEI regulation. Instead, MHSOAC's definition of “severe mental illness” in proposed regulation 3704 should simply reference and incorporate the relevant language contained in section 5600.3(a)-(c).</p> <p>C. MHSOAC’s Proposed Definition Of “Severe Mental Illness” Ignores The Distinction Between Children And Adults As Contained In WIC Section 5600.3.</p> <p>Because it incorporates WIC section 5600.3, the MHSA's definition of “severe mental illness” distinguishes between children and adults, whereas MHSOAC's proposed regulation 3704 does not. MHSOAC lacks the statutory authority to ignore this important distinction in its regulations, and to ignore the definition as it pertains to children.</p>			

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		<p>Although MHSOC has included in proposed regulation 3704 part of section 5600.3's definition of serious mental disorders in adults, it has ignored important limitations and qualifications that exist in the statute. For example, MHSOAC's proposed definition eliminates the qualification that "[t]he person has a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a substance use disorder or developmental disorder or acquired traumatic brain injury pursuant to subdivision (a) of Section 4354 unless that person also has a serious mental disorder as defined in paragraph (2)." WIC § 5600.3(b)(3)(A). MHSOAC's proposed definition also eliminates the requirement that "[a]s a result of the mental disorder, the person has substantial functional impairments or symptoms, or a psychiatric history demonstrating that without treatment there is an imminent risk of decompensation to having substantial impairments or symptoms." WIC § 5600.3(b)(3)(B)(i). This is not an interpretation of the statute, but a material and drastic change.</p> <p>Under California's Administrative Procedures Act (APA), no regulation can be valid or effective "unless consistent and not in conflict with the statute." Govt. Code § 11342.2. Here, MHSOAC's proposed regulation section 3704 is not consistent with the MHSA's definition of "severe mental illness" (nor is it</p>			

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		<p>consistent with the MHSA's use of "serious mental illness" in its introductory provisions). For these reasons, section 3704 should be modified to eliminate the reference to "serious mental illness," and to replace the existing definition of "severe mental illness" by incorporating all of the relevant language contained in WIC section 5600.3(a)-(c). For clarity, MHSOAC should have two subsections in regulation 3704, one which covers "severe mental illness" in adults as defined in section 5600.3, and one which covers "severe mental illness" in children, as defined in section 5600.3.</p>			
3706	Commenter #3	<p><u>Comment 3.56</u> III. MIPO'S COMMENTS ON PROPOSED NEW REGULATION SECTION 3706</p> <p>MHSOAC proposes a new regulation section 3706 that it labels "General Requirements for Services." As discussed below, MIPO objects to several of the subsections in this proposed new regulation because they lack any statutory basis and will promote the continued misuse of PEI funds.</p> <p>A. MHSOAC Is Without Statutory Authority To Require That 51% Of PEI Funds Be Spent On Programs For Persons 25 Years Old Or Younger</p> <p>MHSOAC proposes in section 3706(b) that "at least 51% of the Prevention and Early Intervention Fund shall be used to serve</p>	Reject	Retain existing language with no change	<p><u>51% or more of PEI funds for programs serving children and youth:</u> The fact that most mental disorders begin in children or youth and are frequently neither diagnosed nor treated is a key reason to prioritize use of PEI funds for this purpose. See response to comment 60.03 on page 60 of the Matrix of Public Comment presented to the MHSOAC on September 30, 2014 meeting.</p> <p><u>Bullying as a risk factor for potentially serious mental illness:</u> Children who bully and those who are bullied experience significant short-term and long-term negative mental health and other consequences that frequently extend into adulthood. This shared impact includes an elevated tendency toward depression, suicidal thought and attempts, substance abuse, and reactive aggression. Children who are bullied are approximately twice as likely as others to be depressed later in life and are at increased risk for anxiety (including generalized anxiety disorder, agoraphobia, and panic disorder), attention-deficit</p>

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		<p>individuals who are 25 years old or younger." This is a continuation of a practice that MHSOAC first adopted in its pseudo-regulations. The problem is, MHSOAC lacks statutory authority for imposing this arbitrary restriction. The MHSOAC does not authorize or sanction a minimum 51% allocation of PEI funds to children and young adults. Indeed, as to PEI programs, children are only mentioned in the "access and linkage" provision (WIC § 5840(b)(2)), and in two out of the seven "negative outcomes" for untreated mental illness identified in section 5840(d)- school failure or drop-out, and removal of children from their homes. WIC § 5840(d)(3) and (7).</p> <p>By setting an arbitrary division of funds, MHSOAC fails to acknowledge that, for example, the average age of onset in women of the most feared of all severe mental illnesses – schizophrenia - is 25 to 35. It also ignores the fact that the median age for onset of bipolar disorder is 25, and for major depressive disorders is 32. At the other end of the spectrum, it ignores that pre-adolescent children are rarely diagnosed with a severe mental illness, yet nevertheless mandates the expenditure of program funds for that age group. MIPO acknowledges there are thousands of mentally ill and severely mentally ill children, generally adolescents, in California. They include the children of MIPO's members. But qualification for PEI funds should not depend on age. The</p>			<p>hyperactivity disorder, post-traumatic stress disorder, dissociative symptoms, personality disorders, and eating disorders. Being bullied lowers self-esteem and increases school absenteeism and academic problems, psychosomatic and physical health problems, sleep issue, and physical injury. Significant associations between bullying and negative mental health outcomes are found even after controlling for other major childhood risk factors. Children and adolescents who both bully and are bullied have the most serious risk of mental and behavioral problems, including agoraphobia, panic disorder, and suicidality. The mental health consequences of bullying can be differentiated from the fact that having certain mental disorders is a risk factor for bullying and being bullied.</p> <p>With effective screening, it is possible to identify these children as early as first grade. Research documents that ecological approaches are among the most effective. Like all PEI programs, counties must use practices that have demonstrated their effectiveness to bring about MHSOAC PEI outcomes for individuals at risk of or with early onset of a mental disorder.</p> <p><u>Inclusion of parents and family members in Prevention Programs:</u> Prevention programs often are strengthened by including, eliciting the perspectives of, and supporting parents and other family members. Many evidence-based prevention approaches for young children at risk of mental illness work jointly with the parent or serve parents as an adjunct to direct intervention with the child. Because context is so important to children's mental health, engaging other family members, as well as,</p>

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		<p>statutory requisite is instead "mental illness" or a "severe mental illness." This is what MHSOAC needs to focus on, which its regulations to date have ignored.</p> <p>B. Allocating 51% Of PEI Funds To Children And Young Adults Under 25 Will Perpetuate The Wasteful Practices of the Past.</p> <p>The proposed 51% allocation for children and young adults will perpetuate past funding abuses. For example, according to its own statistics, MHSOAC is spending 23.3% of PEI funds on anti-bullying programs in schools. These programs, addressed to all school children, have nothing to do with preventing "mental illness" from becoming "severe mental illness," particularly since severe mental illness is rarely diagnosed in young children.</p> <p>MHSOAC has no doubt devoted an enormous amount of PEI funding to anti-bullying because one of its staff members and one of its commissioners have published articles that treat bullying as "an urgent public health issue." Despite this alarmist label, few of the mental "health" issues associated with bullying in these articles amount to an actual diagnosis of mental illness, and none amount to a "severe mental illness," with the arguable exception of antisocial personality disorder, which is likely a cause and not an effect of bullying.</p>			<p>in some instances, school personnel, child welfare staff, primary care providers, and juvenile justice service providers can also be beneficial. See response to comments 3.12 and 3.15 on pages 36 and 38 of the Matrix of Public Comments presented at the August 28, 2014 MHSOAC meeting.</p> <p><u>Individuals at risk of a potentially severe mental illness:</u> See responses to comments 60.02 and 8.35 on pages 17 and 31 of the Matrix of Public Comment presented at the August 28, 2014 MHSOAC meeting.</p> <p><u>Leaving out individuals who are mentally ill:</u> The comment confuses the MHSA requirement to include services that assist people in quickly regaining productive lives (WIC §5840(c)) with an imagined mandate that MHSA PEI programs be limited to people who have already lost productive lives through mental illness. "Includes" does not mean "limited to." The PEI component is not intended to fund and proposed PEI Regulations do not permit use of PEI fund, for individuals who are already seriously mentally ill, except for the MHSA provision to link individuals across the lifespan to treatment in the CSS or other systems, which is a required strategy for all PEI programs, and for the option for a Prevention Program to focus on relapse prevention for individuals in recovery from a mental illness. See response to comments 3.03 on page 1 of the Matrix of Public Comments presented at the October 23, 2014 MHSOAC meeting and comments 3.13, and 3.25 on pages 29 and 9 of the Matrix of Public Comment presented at the August 28, 2014 MHSOAC meeting.</p>

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		<p>Furthermore, data shows these anti-bullying programs are not effective, even at stopping bullying, and may actually make it worse. But MHSOAC continues to ignore this data and continues to spend-and will continue to spend-tens of millions of dollars funding such programs under their proposed "universal prevention" and "community standard" regulations. The 51% allocation to children and young adults will ensure that this waste of funds continues. Meanwhile, despite a statutory mandate, severely mentally ill people are committing suicide, going to jail, being pushed out of jobs and homes, and otherwise suffering the consequences of severe mental illness for lack of relapse prevention/ early intervention programs that MHSOAC refuses to fund.</p> <p>MIPO acknowledges that bullying is a bad thing - one of many bad things in this world that the MHSA was never expected or intended to address. Even assuming that anti-bullying and similar programs aimed at the general public help some children avoid depression, it is still a misuse of funds to underwrite such programs. As MIPO explained in its previous comments, the MHSA PEI provisions were never intended to prevent "mental illness," but instead to keep diagnosed "mental illnesses" from becoming "severe mental illnesses" as statutorily defined. It is contrary to the MHSA to allocate PEI funds to prevent "mental illness." It is also</p>			<p>The comment misstates the law and the facts in stating that the proposed regulations divert funds intended by the voters for the sickest people and use them instead on people who are not sick and do not even need help. Reading the MHSA as a whole clearly shows that it was intended to provide a continuum of services and that PEI is one spectrum of those services. For example, the Act requires Counties to provide services under each of the components of the Act. (See WIC §5847(b).) In addition, the funding distribution as set forth in WIC 5892(a) clearly shows that the largest portion of the Mental Health Services Fund (MHSF) goes to programs to treat individuals with severe mental illness: WIC §5892(a)(5) requires 80% of MHSF that is distributed to counties be used for services to individuals with severe mental illness. WIC §5892(a)(3) requires 20% of the MHSF distributed to the counties be used for prevention and early intervention programs per 5840. The voters understood and intended that the services provided under PEI would be focused on a population other than those who are already severely mentally ill.</p> <p>Programs intended to benefit the general public or individuals neither at risk of nor with early onset of a mental illness are not allowable under Proposed PEI Regulations. See response to comment 3.23_on page 45 of the Matrix of Public Comment presented to the August 28, 2014 MHSOAC meeting.</p> <p><u>Mandated family therapy:</u> Clearly there is no mandate for a County to offer a family therapy program and no option for a County to offer a family therapy program for the general public unless there were evidence that such an approach would bring</p>

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		<p>irrational to mandate that 51% of PEI funds be spent on children, when young adults over 25 and older adults comprise the bulk of the mentally ill and severely mentally ill in need of PEI programs. MIPO respectfully submits that this proposed regulation will simply perpetuate the existing waste of PEI funds.</p> <p>C. MHSOAC Has No Authority To Ignore Statutory Mandates In Order To Fund Parenting Programs for the General Public.</p> <p>MIPO also objects to proposed subsections (c) through (e) of section 3706, which should be stricken entirely as contrary to statute. These proposed subsections allow all counties to fulfill their PEI obligations by creating programs for parents and caregivers of youth who are merely "at risk" of mental illness. In subsections (d) and (e), small counties are pressured to fulfill their obligations in this manner. Proposed section 3706 reads as follows:</p> <p>Section 3706. General Requirements for Services.</p> <p>(a) The County shall serve all ages in one or more programs of the Prevention and Early Intervention Component.</p> <p>(b) At least 51 percent of the Prevention and Early Intervention Fund shall be used to</p>			<p>about MHSA mental health and related outcomes for individuals at greater than average risk of a mental illness or with early onset of a mental illness, in order to prevent mental illness from becoming severe and disabling.</p> <p><u>Small County Opt-Out:</u> See responses to comments 84.02 (below on page 76), 88.01 (below on page 76), 88.02 (below on page 83), and 88.03 (below on page 84).</p> <p><u>Leaving out adults and senior adults with a mental illness:</u> The comment ignores the requirement in Proposed PEI Regulations for counties to serve all age groups, with an opt-out option for counties with population below 200,000, and the requirement to offer an Early Intervention Program for individuals with early onset of a mental illness. See responses to comment 60.03 on page 60 of the Matrix of Public Comment presented at the September 30, 2014MHSOAC meeting and comment 3.03 on page 1 of the Matrix of Public Comment presented at the October 23, 2014 MHSOAC meeting.</p>

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		<p>serve individuals who are 25 years old or younger.</p> <p>(c) Programs that serve parents, caregivers, or family members with the goal of addressing MHSA outcomes for children or youth at risk of or with early onset of a mental illness can be counted as meeting the requirements in (a) and (b) above.</p> <p>(d) A Small County may opt out of the requirements in (a) and/ or (b) above if:</p> <p>(1) The Small County obtains a declaration from the Board of Supervisors that the County cannot meet the requirements because of specified local conditions.</p> <p>(e) A Small County that opts out of the requirements in (a) and/ or (b) shall include in its Three-year Program and Expenditure Plan and/ or Annual Update documentation describing the rationale for the County's decision and how the County ensured meaningfully stakeholder involvement in the decision to opt out.</p> <p>As discussed below, MHSAOAC is without legal authority to ignore the mandates in the PEI provisions and substitute its own funding preferences. In so doing, it has stood the statute on its head, diverting funds intended by the voters for the sickest people and using them instead on people who are not sick and do not even need help.</p>			

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		<p>1. The MHSA's PEI Provisions Do Not Limit Programs to Children and Do Not Authorize Programs for Parents and Caregivers.</p> <p>Nothing in the MHSA's PEI provisions address family / caregiver therapy. To the contrary, the PEI provisions only authorize "[o]utreach to families, employers, primary care health care providers, and others to recognize the early signs of potentially severe and disabling mental illnesses," WIC § 5840(b)(1). Arguably, then, family therapy should never be paid for with PEI money. The voters only authorized family/ caregiver education, not family/ caregiver therapy.</p> <p>MIPO, however, believes that programs for the caregivers of those who are mentally ill and severely mentally ill are permissible if they fit into either of the two statutory mandates under WIC section 5840(c) requiring programs for mentally ill and severely mentally ill adults and children. Those mandates are as follows:</p> <p>The program <i>shall</i> include mental health services similar to those provided under other programs effective in preventing mental illnesses from becoming severe, and <i>shall also</i> include components similar to programs that have been successful in reducing the duration of untreated severe</p>			

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		<p>mental illnesses and assisting people in quickly regaining productive lives.</p> <p>WIC § 5840(c) (emphasis supplied). MIPO's previous comments have endorsed evidence-based family therapy programs as helpful preventions/ early interventions for mentally ill and severely mentally ill individuals. Serving their families simultaneously serves them.</p> <p>Proposed regulation 3706(c) authorizes something very different: it allows counties to completely ignore the mandates as long as they are providing programs for families "with the goal of addressing MHSA outcomes" for people who are (1) under the age of 25, and (2) "at risk of" a mental illness. Note that no one involved needs a mental illness diagnosis. Note also that such programs can substitute entirely for PEI programs that serve the mentally ill and severely mentally ill directly. Finally, note that the proposed regulation allows counties to entirely ignore mentally ill and severely mentally ill adults and seniors, and all mentally ill/ severely mentally ill people without families. This is contrary to the statute in at least the following ways:</p> <ul style="list-style-type: none"> Proposed section 3706(c) creates another exemption from the statutory mandates, this one applicable to all counties at their option. It is an exemption because the statute mandates PEI programs that address <i>severe</i> mental illness, i.e., 			

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		<p>programs "effective in preventing mental illnesses from becoming <i>severe</i>" and "successful in reducing the duration of untreated <i>severe</i> mental illnesses and assisting people in quickly regaining productive lives." WIC § 5840(c) (emphasis supplied). Family therapy for the general public may improve family mental "health," but it will not prevent severe mental illnesses, which are biological brain disorders. Family therapy would not have prevented the illnesses of MIPO members' severely mentally ill children (whose siblings are perfectly sane), nor is it sufficient protection against worsening symptoms/relapses. Direct programs for mentally ill and severely mentally ill individuals (including family therapy where appropriate) are what is mandated and needed.</p> <ul style="list-style-type: none"> • Proposed section 3706(c) further invites counties to ignore all adult and senior mentally ill and severely mentally ill people entirely, no matter how desperate their need. Instead, the counties can choose to serve only people under 25, thereby ignoring the vast majority of the mentally ill and severely mentally ill. Nothing in MHSA suggests this is even remotely appropriate. • Proposed section 3706(c) also invites counties to completely ignore the vast majority of individuals the PEI provision was drafted to help, including the sickest of the sick, in favor of people who need 			

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		<p>the least help. Many mentally ill and severely mentally ill individuals – including children and young adults - are homeless or without families/ caregivers willing to undergo therapy with them. These individuals will not receive PEI services under this proposed regulation, no matter how badly they need them. Instead, proposed 3706(c) allows counties to provide services to "at risk" youth who have well-intended, involved families willing to participate in group therapy. Youth without families, or with families that refuse therapy, will get no help at all.</p> <p>Each of these defects is sufficient in itself to require rejection of the proposed regulation. Collectively, they demonstrate a complete reversal of everything that the MHSA stands for, and result in a diversion of PEI funds away from the desperately needy and in favor of people who are not covered by the statute and do not even need assistance.</p> <p>MIPO could find no support or even explanation in the record for proposed subsection (c). MHSAOAC staff apparently created it in response to a comment that requested a 51% allocation to children generally. But as written, it would permit a 100% allocation to family therapy. The extensive discussion in the staff comments of allocating 51% to youths fails to mention that proposed subsection (c) can trump this allocation completely. Anyone who reads the</p>			

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		<p>staff explanation without careful examination of the underlying regulation would naturally presume that 49% of PEI funds remain available for general programs for adults and seniors under section 3706(a) and (b). But that is not the case, as counties can meet their requirements under subsection (a) by offering the therapy programs under subsection (c).</p> <p>2. Pressuring Small Counties to Follow MHSOAC Funding Choices Undermines MHSOAC's Rationale for a Small County Exemption.</p> <p>In proposed subsections (d) and (e) of proposed section 3706, MHSOAC has apparently shifted its stance on small counties, which were formerly granted a wholesale exemption from PEI requirements based on the claim- unsupported in the record - that they needed "greater flexibility." While under proposed subsection (d), small counties must follow an extensive process to prove they need an exemption, MHSOAC has given them an easy way out through proposed subsection (c): like large counties, they can comply with PEI requirements by establishing a family therapy program for youth who are not mentally ill.</p> <p>MIPO's objection to subsection (c), discussed above, applies equally to small counties and will not be reiterated. Neither will we reiterate our argument that MHSOAC has no power to</p>			

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		<p>create exemptions from statutory mandates, particularly when there is no evidence they are needed. What should be noted, however, is that pressuring small counties into creating family therapy programs for youth who are not mentally ill is completely inconsistent with MHSOAC's rationale for unilaterally proposing a small county exemption: its contention that these counties need "flexibility." Small counties - indeed all counties - may justifiably regard these family therapy programs as an utter waste of money that is desperately needed for other legitimate uses, e.g., for severely mentally ill adults. Yet MHSOAC has made this option easy, and flexibility difficult. Again, the record reflects no rationale for applying subsection (c) to small counties, because the staff rationale, drafted for the Commissioners, does not even acknowledge that the subsection (c) exists.</p> <p>For all of the reasons set forth above, proposed regulation section 3706 should not be adopted as written.</p>			
3706	Commenters #84, 88	<p><u>Comment 84.02, 88.01</u> In that respect, we are highly concerned over language changes to Section 3706. General Requirements for Services, currently under the 15 day review process for the MHSOAC.</p> <p>This section details that Counties shall <u>“(a) serve all ages in one or more programs of the Prevention and Early Intervention Component”</u> and <u>“(b) At least 51 percent of</u></p>	Reject	Retain existing language with no change.	<p><u>The opt-out option for the requirement to spend at least 51% of PEI funds on individuals who are age 25 or younger and to serve all ages for counties with population under 200,000:</u> The proposed regulation intends to balance the need for greater flexibility for small counties to respond to local priorities with limited PEI funds with the need to ensure that the County does not decide to opt out without due consideration and analysis, in meaningful partnership with stakeholders.</p>

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		<p><u>the Prevention and Early Intervention Fund shall be used to serve individuals who are 25 years old or younger”.</u></p> <p>Language of the section has been modified to now read as follows: <u>“(d) A Small County may opt out of the requirements in (a) and/or (b) above if:</u></p> <p><u>(1) The Small County obtains a declaration from the Board of Supervisors that the County cannot meet the requirements because of specified local conditions.</u></p> <p><u>(e) A Small County that opts out of the requirements in (a) and/or (b) shall include in its Three-year Program and Expenditure Plan and/or Annual Update documentation describing the rationale for the County’s decision and how the County ensured meaningfully stakeholder involvement in the decision to opt out.</u></p> <p>We respectfully submit that an “opt out” system, without safeguards to maintain oversight and provide accountability, runs counter to both the spirit and the letter of law that was established with Proposition 63.</p> <p>Specifically, “opt out” claims from the Counties should provide the opportunity for a review process by the MHSOAC that substantiates each County’s claim. This could be accomplished by modifying the text to read as follows:</p>			<p>It is critical to avoid inadvertently requiring counties to serve a broader range of populations than is feasible. Counties with higher than average (18-19%) of population over age 65 include Inyo, Tuolumne, Calaveras, Amador, Sierra, and Plumas, all of which have a total population under 200,000. Counties with the highest statewide proportion of individuals over the age of 65 who are below 200% of the poverty level include Imperial, Kings, Mariposa, Yuba, Modoc, Siskiyou, and Del Norte, again all with populations under 200,000. These are examples of counties that could benefit from the option to prioritize PEI services for older adults, potentially limiting their capacity to utilize 51% of their PEI funds for programs for individuals under the age of 25. Counties with more funds by definition have greater flexibility to provide more programs that serve a greater range of individuals. However, this decision should not be automatic but should be addressed specifically in the Annual Update or Three-Year Plan and specifically approved by the Board of Supervisors.</p> <p>The Legislature in 2011 amended the MHSA to move PEI plan approvals from the MHSOAC to the County Board of Supervisors. Since approval of the County’s use of PEI funds rests with the Board of Supervisors, not at the state level, it makes sense for the County to provide documentation to the Board of Supervisors. The meetings of the Board of Supervisors are open to the public and provides for local community input. In addition, the proposed regulation requires the documentation to be included in the County’s Three-Year Program and Expenditure Plan and/or Annual Update both of which require local review and public hearing under</p>

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		<p>“(f) The MHSOAC reserves the right of review and approval of documentation describing the rationale and verification of meaningful stakeholder involvement.”</p> <p>This addresses our two fundamental concerns:</p> <p>1) With the current language, there is no oversight to determine whether the rationale presented by the Counties is supported by the facts. By allowing the Counties to exempt themselves simply through documentation that is not reviewed, the MHSOAC is not providing accountability either for the County or for the MHSA.</p> <p>2) Counties should be held to some standard in their effort to demonstrate meaningful stakeholder involvement. Meaningful stakeholder involvement is a core concept of the MHSA, and the MHSOAC is clearly responsible for setting such standards. Should a small county decide to “opt-out” without adhering to the concept of meaningful stakeholder involvement, what will happen?</p> <p>While we acknowledge the challenges faced within small counties, we remain most concerned about staying true to the heart of Proposition 63. In our opinion, the Proposition is grounded in the values of support and respect for clients and family members,</p>			<p>the MHSA. This local review and public hearing provides the opportunity for local community members and stakeholders to provide local oversight and accountability and planning. See response to comment 60.03 on page 60 of the Matrix of Public Comment presented at the September 30, 2014 MHSOAC meeting, and response to comments 88.02 and 88.03 below on pages 83 and 84.</p>

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		<p>caregivers and parents. State oversight is imperative in the accountability of the counties to spend the tax dollars for this Proposition as it is intended.</p> <p>For the reasons stated previously, we strongly oppose the proposed language under Section 3706, currently under 15-day review. Regulatory language should support both the practical realities of mental health services and the redemptive promise of the law.</p>			
3706(b)	Commenters #35, 87, 90	<p>Comments 35.05, 87.01, 90.01 1. Targeting Services to Children and Youth: The proposed regulation include the requirement that a minimum of 51% of PEI funds be allocated to target children, youth, and families.</p> <p>The current <i>MHSOAC Prevention and Early Intervention Programs Initial Statement of Reasons</i> emphasizes the importance of providing prevention and early intervention services to children, youth, and families. Widely accepted statistics demonstrate that half of all lifetime cases of diagnosable mental illnesses begin by age 14, and three-fourths by age 24. As stated in the MHSOAC document, moreover, an estimated 75-80% of children and youth who need mental health treatment don't receive it. (Kataoka S, et al. [2002]. Unmet need for mental health care among U.S. children: Variation by ethnicity and insurance status. <i>American Journal of</i></p>	Accept	Retain existing language with no change as requested in comment.	The rationale for the modified text that the comment supports and that is the subject of the 15-day Notice is set forth in the Matrix of Public Comments presented at the September 30, 2014 MHSOAC meeting.

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		<p><i>Psychiatry</i> 159(9), 1548-1555.) The preservation of MHSA PEI funds for children and youth, therefore, is critical and necessary to ensure effective prevention efforts for the early onset of mental illness.</p> <p>The MHSA-specified purpose for PEI programs is to prevent mental illnesses from becoming severe and disabling (Welfare and Institutions Code Section 5840, subdivision (a)). Specific provisions of the MHSA require counties to: Emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness: suicide, incarcerations, school failure or drop-out, prolonged suffering, unemployment, homelessness, and removal of children from their homes. Requiring that 51% of the funding be allocated to children, youth and families will contribute to the reduction of these negative outcomes.</p> <p>Recommendation: We strongly support the proposed requirement to allocate a minimum of 51% of PEI funds to target children, youth and families and recommends that this language be retained.</p>			
3706(b)	Commenter #86	<p><u>Comment 86.01</u> Targeting Services to Children and Youth: The proposed regulation include the requirement that a minimum of 51% of PEI funds be allocated to target children, youth, and families.</p>	Accept	Retain existing language with no change as requested in comment.	The rationale for the modified text that the comment supports and that is the subject of the 15-day Notice is set forth in the Matrix of Public Comments presented at the September 30, 2014 MHSOAC meeting.

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		<p>The current <i>MHSOAC Prevention and Early Intervention Programs Initial Statement of Reasons</i> emphasizes the importance of providing prevention and early intervention services to children, youth, and families. The preservation of MHSOAC PEI funds for children and youth, therefore, is critical and necessary to ensure effective prevention efforts for the early onset of mental illness. The MHSOAC-specified purpose for PEI programs is to prevent mental illnesses from becoming severe and disabling (Welfare and Institutions Code Section 5840, subdivision (a)).</p> <p>Recommendation: United Parents strongly supports the proposed requirement to allocate a minimum of 51% of PEI funds to target children, youth and families and recommends that this language be retained.</p>			
3706(b) & (d)(1)	Commenter #4	<p>Comment 4.13 2) Section 3706. General Requirements for Services.</p> <p>The MHSOAC's proposal to earmark more than half of local PEI funding is at odds with the fundamental aim of the MHSOAC and AB 1467 to give County Boards of Supervisors, local Mental Health Boards, and other community stakeholders flexibility to meet the needs of local communities.</p> <p>While the proposed regulations attempt to give additional flexibility to small counties, the</p>	Reject	Retain existing language with no change	See response to comments 84.02 and 88.01 above on page 3.

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		<p>way counties must document this process is redundant. If a county includes a rationale in its Three-year Program and Expenditure Plan or Annual Update, by definition its Board of Supervisors has endorsed and adopted a plan documenting local needs. Since all counties are required to provide a Program and Expenditure Plan or Annual Update, an established process already exists by which the counties assess their needs and obtain Board of Supervisors' approval. Accordingly, this section will only impede counties from meeting local needs.</p> <p><i>CBHDA Recommendation: Delete provision 3706 (b) "At least 51 percent of the Prevention and Early Intervention Fund shall be used to serve individuals who are 25 years old or younger."</i></p> <p><i>CBHDA Recommendation: Delete provision (d) (1) of Section 3706 "The Small County obtains a declaration from the Board of Supervisors that the County cannot meet the requirements because of specified local conditions."</i></p>			
3706(d) & (e)	Commenter #35, 87, 90	<p><u>Comment 35.06, 87.02, 90.02</u> 2. Small County "opt-out" (3706 d and e): The proposed language requires that all counties allocate a minimum of 51% of PEI funding to prevention and early intervention programs targeting children, youth, and families. Small counties may be exempted</p>	Accept	Retain existing language with no change as requested by the comment.	The rationale for the modified text that the comment supports and that is the subject of the 15-day Notice is set forth in the Matrix of Public Comments presented at the September 30, 2014 MHSOAC meeting.

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		<p>from this requirement if they provide a rationale for an exemption which has been vetted with their local stakeholders and approved by their board of supervisors.</p> <p>We support the OAC's efforts to address the need for state wideness of regulations while honoring each county's stakeholder process for identifying their unique needs. The proposed language contained in 3706 (d) and (e) provides small counties with a mechanism for using their current stakeholder involvement process and approval from their board of supervisors to opt out of the proposed requirement to allocate a minimum of 51% of PEI funds to programs which target children, youth, and families. These two processes – i.e., stakeholder involvement and board of supervisors' approval - are essential to assuring that over 50% of California counties cannot simply ignore the 51% requirement.</p> <p>Recommendation: We support the proposed language in 3706 (d) and (e).</p>			
3706(d) & (e)	Commenter #88	<p>Comment 88.02 Comment 2. Should a small county decide to "opt-out" without adhering to the concept of meaningful stakeholder involvement, what will happen? Current language fails to provide for stakeholder appeal of "opt out" declarations in the event of significant disagreement at the County level. The language proposed above, while helpful in such a circumstance, relies on</p>	Reject	Retain existing language with no change	Pursuant to the MHSA, approval of a County's Three-Year Program and Expenditure Plan and Annual Update is vested with the County Board of Supervisors, not with the MHSOAC. The required community planning process applies to a small county's decision about whether or not it makes sense and is possible, given local resources and priorities, to serve all ages with PEI funds and to invest at least 51% of PEI funds to serve individuals

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		<p>informal mechanisms to trigger a review of an “opt out” declaration by MHSOAC. Therefore I propose the addition of the following language in order to ensure stakeholder access to the MHSOAC:</p> <p>“(g) Stakeholders shall have the right to appeal a County “opt out” declaration to the MHSOAC. On receipt of an appeal, MHSOAC shall determine the validity of the appeal and, if required, undertake a review of the “opt out” declaration as described in section (f).”</p>			<p>under the age of 25. As long as the County complies with the relevant statutes and regulations in making the decision to opt out, the state does not have the authority to second guess the local decision that is lawfully made. See response to comments 84.02 and 88.01 above on page 76 and 88.03 below on page 84.</p>
3706(e)	Commenter #35	<p>Comment 35.04 I think there is a typo in 3706 (e). Shouldn't it be “meaningful” stakeholder involvement and not “meaningfully” stakeholder involvement? One of my members pointed that out.</p>	Accept	<p>Change existing language as indicated: meaningfully stakeholder involvement</p>	All typos will be corrected in the final version of Proposed PEI Regulations.
3706(e)	Commenter #88	<p>Comment 88.03 Comment 3. There is no provision in current language for periodic review of “opt out” declarations. Under the current language a County could “opt out” once and never again revisit the issue. At the minimum I believe “opt out” declarations should be renewed every three years.</p> <p>I recommend that the following language be added:</p> <p>“(e) (1) Opt out declarations must be renewed by the County every three years or at the time that the County submits a Three Year Program and Expenditure Plan.”</p>	Reject	Retain existing language with no change	<p>The MHSA mandates a community planning process for each Annual Update and Three-Year Program and Expenditure Plan, the requirements for which are specified. This planning process requires participation by defined representative stakeholders, a 30-day review with the opportunity for comments by the public, a hearing convened by the local Mental Health Board, and approval by the County Board of Supervisors. The decision to opt out of the requirement to serve all ages with PEI funds and to reserve at least 51% of funds for children and youth will be subject to participation and review in the same manner as all other elements of the Three-Year Plan or Annual Update.</p> <p>Further, the MHSA requires the County to “demonstrate a partnership with constituents and</p>

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					<p>stakeholders throughout the process that includes meaningful stakeholder involvement on mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation, and budget allocations” (WIC §5848(a)), which would include review of decisions regarding whether to opt out based on evolving local conditions and priorities. No additional language is required to ensure that stakeholders contribute meaningfully to the initial decision and annual review of the decision.</p>
3706(e)	Commenter #88	<p><u>Comment 88.04</u> Comment 4: 3706 (e) typo correction</p> <p>A Small County that opts out of the requirements ... how the County ensured meaningfully stakeholder involvement in the decision to opt out.</p> <p>Correction:</p> <p>A Small County that opts out of the requirements ... and how the County ensured meaningfully stakeholder involvement in the decision to opt out.</p>	Accept	See response to comment 35.04 above	See response to comment 35.04 above on page 84.
3755 (c)(2)(A)	Commenter #4	<p><u>Comment 4.14</u> 3) Section 3755. Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update.</p> <p>Section 3755 (c)(2) reads, “Identification of the target population for the intended mental health outcomes including: (A) Demographics including, but not limited to, age,</p>	Reject	Retain existing language except for the changes listed in response to comment 79.03 below.	Section 3755(c)(2)(A) does not require reporting. This provision merely requires the County to list the programs’ intended target population. As such, whether the County has a data field in the Electronic Health Records is not relevant to this provision. See response to comment 79.03 (below on page 86).

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		<p>race/ethnicity, gender, and if relevant, primary language spoken, military status, and <u>sexual orientation</u>.</p> <p>CBHDA Recommendation: Most counties do not have a data field for sexual orientation and should only report it if they have a data field in their Electronic Health Records (EHRs) to track it. This should be an optional report category.</p>			
3755(c)(2)(A)	Commenter #79	<p>Comment 79.03 Section 3755 (c) (2) (A) on page 4:</p> <ul style="list-style-type: none"> I agree and support the inclusion of "gender identity" alongside the term "gender." Any program targeted to a particular gender should also include participants whose gender identity may not match their assigned or presumed gender. I agree and support the use of the terms "sexual orientation" and "gender identity," in place of the terms "lesbian, gay bisexual, transgender, and/or questioning identification." The terms "sexual orientation" and "gender identity" are more inclusive and culturally sensitive. Due to the enormous disparities that LGBTQ people face in the public mental health system (as documented in the California LGBTQ Reducing Disparities 	Accept	<p>Change existing language as indicated:</p> <p>(1) 3755(c)(2)(C): Identification of the target population for the intended mental health outcomes <u>the specific program</u> including but not limited to:</p> <p>(C) <u>Demographics relevant to the intended target population for the specific program</u>, including but not limited to age, race/ethnicity, gender or gender identity, and if relevant, sexual orientation, primary language used, <u>and</u> military status.</p>	<p><u>Recommended Changes:</u></p> <p>(1) <u>3755(c)</u>: Delete the phrase, "and if relevant". (2) <u>3735(a)</u>: Replace "sexual preference" with "sexual orientation" to be consistent with the other provisions in the proposed regulations.</p> <p><u>Target Population for a PEI Program:</u> Proposed PEI regulations differentiate between reporting requirements, which require Counties to report data and disaggregate data by sexual orientation, from designation of a program's intended target populations, which might or might not include a focus on sexual orientation or any of the other demographic categories listed in 3755(c)(1)(A), all of which are intended to be examples.</p> <p>Therefore, the "and if relevant" applies to all of the listed examples of demographic information. A program might focus on children in a particular school who have early onset of an anxiety disorder, without reference to race, sexual orientation, or any other particular factor. It is essential to record who is served based on demographics but not necessarily to define a target population based on</p>

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		<p>Report: <i>First, Do No Harm</i>), I strongly urge "sexual orientation" be placed with the groups listed <i>before</i> "and if relevant." For the same reasons the regulations call out race & ethnicity as relevant to this section, as well as in many other sections (e.g. disparities, cultural sensitivity, cultural competence, etc.), sexual orientation and gender identity need to be included. To maintain consistency throughout the regulations, and to recognize that LGBTQ populations are a disparity group, I strongly urge the terms "sexual orientation and gender identity" be included where ever the terms "race & ethnicity" are also included.</p>		<p>(2) 3735(a)(3)(B)Non-stigmatizing and Non-Discriminatory approaches include, but are not limited to, using positive, factual messages and approaches with a focus on recovery, wellness, and resilience; use of culturally appropriate language, practices, 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 <u>preference orientation</u>; 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>demographics. The County needs the flexibility to define the target population as it actually applies to the program. The definition of the target population is fundamentally different from required reporting categories, which serve both a local and state purpose and which require consistent categories, definitions, timeframes, etc.</p>
3755(c)(5)(A) & (B)	Commenter #4	<p><u>Comment 4.15</u> 4) Section 3755. Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update.</p>	Accept in part	<p>Revise existing language as indicated: 3755(c)(5)(A):</p>	<p><u>Recommended Change:</u> Add suggested language regarding the basis for documenting fidelity of implementation of an evidence-based, promising practice, community-based, and practice-based standards.</p>

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		<p>Counties endorse the adoption of evidence-based and promising practices and support assuring that programs are implemented as intended, including assuring fidelity—either through developer-required approaches (where they exist) or a county's defined requirements. CBHDA recommends changes to Section 3755 (a) and (b) to allow for appropriately documented and justified adaptations to both evidence-based and promising practices.</p> <p>CBHDA Recommendation: Revise language in Section 3755 (5) (a) and (b) as follows: (5) Specify how the Early Intervention program is likely to reduce the relevant Mental Health Services Act negative outcomes as referenced in Welfare and Institutions Code Section 5840, subdivision (d) by providing the following information:</p> <p>(A) If the County used the evidence-based standard or promising practice standard to determine the program's effectiveness as referenced in Section 3740, subdivisions (a)(1) and (a)(2), provide a brief description of or reference to the relevant evidence applicable to the specific intended outcome, explain how the practice's effectiveness has been demonstrated for the intended population, and explain how the County will ensure fidelity to the practice <u>according to the practice model and program design in</u></p>		<p>If the County used the evidence-based standard or promising practice standard to determine the program's effectiveness as referenced in Section 3740, subdivisions (a)(1) and (a)(2), provide a brief description of or reference to the relevant evidence applicable to the specific intended outcome, explain how the practice's effectiveness has been demonstrated for the intended population, and explain how the County will ensure fidelity to the practice <u>according to the practice model and program design in</u> implementing the program.</p> <p>3755(c)(5)(B): If the County used the community and/or practice-based standard to determine the program's effectiveness as referenced in Section 3740, subdivision (a)(3), describe the evidence that the approach is likely to bring about applicable Mental Health Services Act outcomes for the intended population(s) and explain how the County will ensure fidelity to the practice <u>according to the</u></p>	<p>The suggested change is consistent with how fidelity to an evidence-based practice is generally demonstrated in the mental health field and is therefore a useful addition to proposed PEI Regulations.</p> <p>Reject the “appropriately documented and justified adaptations” language because it is too vague to be applied to regulations. There is no basis to determine what constitutes “appropriate documentation and justification.” Adaptations of practices either must be justified based on one of the allowable standards of evidence or are appropriate areas of focus for an Innovative Project within the Innovation component in order to develop the necessary evidence.</p>

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		<p><i><u>implementing the program which may include appropriately documented and justified adaptations.</u></i></p> <p><i>(B) If the County used the community and/or practice-based standard to determine the program's effectiveness as referenced in Section 3740, subdivision (a)(3), describe the evidence that the approach is likely to bring about applicable Mental Health Services Act outcomes for the intended population(s) and explain how the County will ensure fidelity to the practice in implementing the program according to the practice model and program design which may include appropriately documented and justified adaptations.</i></p>		<p><u>practice model and program design</u> in implementing the program.</p>	
3755(k)(1)	Commenter #79	<p><u>Comment 79.04</u> Section 3755 (k) (1) on page 9:</p> <ul style="list-style-type: none"> The text states: "Estimated number of children, adults, and seniors to be served..." This may be an oversight, but these age groupings are not completely consistent with MHSA age groupings. I believe it should read "children, transition-age-youth, adults, and older adults." 	Reject	Retain existing language with no change	The language is consistent with the MHSA requirement in WIC §5847(e).
No Specified Section	Commenter #52	<p><u>Comment 52.03</u> This language seems to imply that the counties can spend it how they see fit within the coded guidelines. Which implies that a lot</p>	No specific action suggested	N/A	There is no action requested or question posed in the comment; however, there seems to be a misunderstanding regarding funding for programs for children and families. Proposed section 3706(b) requires Counties to use at least 51% of the PEI

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		of the money will go to adults and a lot less will be used for children and families.			funds on programs to serve individuals who are 25 year old or younger.
No Specified Section	Commenter #76	<p><u>Comment 76.02</u> Keep MHSA Legislative Language Original:</p> <p>Keep the spirit and intent of MHSA contract language- Prevention and Early Intervention, Innovation, as written in original MHSA legislation. Currently there is broad (90%) lack of treatment and services for people living with serious mental illness. This crisis in mental health care has tragic and costly consequences in our society, including many suicides and appallingly high numbers of people with serious mental illness who are homeless, in jails and prisons, hospitalized, or seeking crisis care in emergency rooms.</p> <p>The California State Audit and others have documented MHSA funds are not reaching the most seriously ill: Principal parties set out to generate those success story statistics by serving only FIVE PERCENT of public mental health clients--and ONLY NEW CLIENTS in NEW PROGRAMS. The calculated purpose of excluding all underserved clients in the existing system was to generate those deceptive statistics. They are irrelevant and a cruel insult to consumers and their families and friends suffering the tragedy of untreated serious mental illnesses, and the despair leading to increased suicides and incarceration. State employees, lobbyists, oversight commissioners agreed that they</p>	No specific action suggested	N/A	We are unable to reasonably determine what the comment is requesting in relations to the proposed modifications to the regulations.

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		<p>would get better "performance data" by serving new clients in new programs.</p> <p>Support keeping these contracts as originally designed for MHSA. With increasing and frequent school shootings, is vital that mental illness is recognized and treated at early stages and not as retroactive disease after a catastrophic incident. Society also needs to be spared the huge expense of institutional and correctional treatment.</p>			
No Specified Section	Commenter #76	<p>Comment 76.03 The following additional comments on PEI Reg proposals were submitted by a group, early in 2014. There was not regulatory process, or inadequate-evidenced by the drafted, signed letter.</p> <p>The rewriting of original PEI language represents co-opting of the original MHSA Initiative as well as repeated lack of stakeholder inclusion, process from OAC Commission on policy decisions.</p> <p>Then, and now, there was no or inadequate stakeholder notification.</p> <p>----- Richard Van Horn - OAC Commission Chairman David Pating, MD - Vice Chair Mental Health Services Oversight and Accountability Commission December 4,2013</p>	No specific action suggested	N/A	We are unable to reasonably determine what the comment is requesting in relations to the proposed modifications to the regulations that are the subject of the 15-day Notices. The comment contains a copy of a December 4, 2013 letter sent to the MHSOAC. The letter predates the rulemaking process and is not relevant to the regulations that are the subject of the 15-day Notice.

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		<p>1300 - Street, Suite 1000 Sacramento, CA 95814</p> <p>Dear Mr. Van Horn and Dr. Pating:</p> <p>The Community Partners who have signed this letter respectfully request that we and other community stakeholders be included in any future meetings to address the concerns raised by the California Mental Health Directors Association (CMIIDA) regarding proposed changes to the Prevention and Early Intervention (PEI) regulations being developed by the Mental Health Services Oversight and Accountability Commission(MHSOAC).</p> <p>The CMHDA letter dated November 2A,20L3 that proposed significant changes to the draft PEI regulations was not available for review by any community partners prior to the MHSOAC meeting on November 2I,2013. We realize that there is a tight timeline to finalize the PEI regulations, but this meeting was the second time that major proposed amendments to the draft regulations were shared with Community Partners without any prior notice.</p> <p>We appreciate that the MHSOAC conducted an open and inclusive process to initially develop the draft PEI and Innovations regulations. We hope that in the spirit of the MHSA – promoting collaboration between government and community partners,</p>			

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		<p>transparency, and "doing business differently" - that the MHSOAC will include representatives of major community stakeholders as well as CMIIDA in any future discussions before adopting any of the changes proposed in their letter.</p> <p>Sincerely, 8-"fi*--J** Beatrice Lee President of the Racial &Ethnic Mental Health Disparities Coalition</p> <p>RustyE Selix Executive Director of Mental Health America of California</p> <p>Ruben Cantu Program Director of California Pan Ethnic Health Network</p> <p>Caliph Assagai Legislation *a poUtic Policy Director ofNAMI California 8*liffirsociation of Mental Health Peer Run organizations</p> <p>cc: Robert Oakes Executive Director of the California Mental Health Directors Association.</p>			
No Specified Section	Commenter #89	<p><u>Comment 89.01</u> I have been communicating with Patricia and want to endorse all her comments.</p>	No specific action suggested	N/A	Our review of the comments received during the 15-day Notice indicates that commenter #88 is the only commenter named "Patricia." Please see responses to comments 88.01 through 88.07 above on pages 77, 83, 84, and 85.

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Section #	Comment Author	Comment Summary	Response	Action	Rationale
3560.010(b)(3)(C)-(E)	Commenter #92	<p>Comment 92.01 I am addressing Section 3560.010; subdivision 3. C.D.E.</p> <p>These regulations propose that PEI programs track and report: C. Number of individuals who followed through on the referral and engaged in treatment, defined as the number of individuals who participated at least once in the program to which they were referred. D. Duration of untreated mental illness ... E. Average interval between the referral and engagement in treatment, defined as participating at least once in the treatment to which referred.</p> <p>I understand the need to gather data and to track outcomes of services provided. We all want to know if our community members are benefiting from having PEI services available. We need additional guidance to determine if we are to gather this information from those we see as part of the Prevention aspect of PEI.</p> <p>First: Please be clear that we are being asked to track referrals to Mental Health Services. Or perhaps this may include drug/alcohol services and / or physical health referrals? Does this include the outreach level of connecting the community to services? For example: how will we track a community member who was given a brochure on a mental health services program at a resource fair? Would we ask all community members to sign a release of information to confirm contact with the MH program? Will we need to ask anyone we give a brochure to supply us with their contact information?</p> <p>The numbers of community members that the PEI programs come in contact with and provide resources and referrals to as</p>	Reject	Retain existing language with no change	<p><u>3560.010(b)(3)(C), Tracking the result of referrals to treatment for individuals with severe mental illness:</u> The reporting requirements under (b)(3)(C) through (E) are limited to the services described in proposed regulation section 3735(a)(1)(A): “Access and Linkage to Treatment.” As such, the reporting requirement is limited to referrals to treatment for individuals with a severe mental illness as defined in 5600.3 and who are referred to “medically necessary treatment” delivered through the CSS component or some other treatment source. Such access and linkage to treatment is a specific MHSA requirement for the PEI component (WIC §5840(b)(2)) and is a required strategy in Proposed PEI Regulations for all PEI programs (§3735(a)(1)), as well as an option for a stand-alone program (§3735(a)(1)(B)). The requirement does not apply to referrals to drug or alcohol treatment, to physical health referrals, or to referrals for other needed services or supports.</p> <p>The requirement to provide links to treatment for anyone with a severe mental illness is consistent with <i>PEI Guidelines</i> developed by the former Department of Mental Health currently in place for all PEI programs: “Programs</p>

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		<p>a part of prevention in our communities will be a daunting task to track and manage. In addition I am concerned that those who have been reluctant to seek help but are now being encouraged will find that having to provide contact information and / or signing a release of information at their first encounter may find this a barrier to seeking services.</p> <p>Second: “Duration of untreated mental illness” is an elusive and varying term and timeframe. Even self report may be unreliable and dependent upon the mental stability of the adult seeking services or the caregiver for minor children. I am hoping that there is further guidance on whom we are to ask this information. Again – is this to be done at community outreach events? In addition – we (or someone) must first discern if a mental illness exists. Part of the PEI guidelines is to prevent mental illness so there will be many that we serve that are not at a level of having a diagnosed mental illness</p> <p>Third: I would also ask for guidelines regarding what would be an acceptable number of attempts to contact the member of the community ? In my experience the population that we work with are transient and have, at best, intermittent phone service.</p> <p>Please consider: Is this level of tracking in line with the intent of PEI to provides resources to the community, to intervene early in the hopes of preventing a mental illness and to reduce barriers to seeking services.</p> <p>It would be helpful if there were clearer parameters regarding whom we are to ask for contact information, releases of information, evaluate for mental illness, and evaluate how long this mental illness has gone untreated; how many attempted contacts to community members inquiring about follow through for engagement in services is considered sufficient due diligence.</p>			<p>link individual participants who are perceived to need assessment or extended treatment for mental illness or emotional disturbance to County Mental Health, the primary care provider or another appropriate mental health services provider” (pp. 8-9). For every PEI program, the County, according to existing <i>PEI Guidelines</i>, is now required to explain how the program will provide “linkages to County mental health” (<i>PEI Guidelines</i>, Enclosure 3, Question 5, p. 10).</p> <p>The regulation requirement adds nothing to the current requirement that all PEI programs have a responsible method to link individuals who may have a severe mental illness to appropriate assessment and treatment. The requirement does not apply to people who give no indication of having a severe mental illness, including the many who are handed informational brochures. The requirement does not imply that everyone in a PEI-funded program needs to be assessed, asked to sign releases of information or fill out paperwork, or tracked.</p> <p>Assuming the counties are now meeting this requirement, they can continue whatever mechanism(s) they currently have in place to identify individuals who may have a serious mental illness that requires assessment and treatment</p>

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					<p>beyond PEI and to link them to treatment.</p> <p>The only provisions that are new in Proposed PEI Regulations regarding Access and Linkage to Treatment are the option to offer a stand-alone program for this purpose and the requirement to report the outcomes of referrals to treatment for individuals with severe mental illness.</p> <p>The requirement to measure and report how many individuals followed through on the referral to the point of engaging at least once in the treatment to which referred and to report the interval between referral and engagement requires following through on the referral to ensure its success, which is a basic ethical practice. Since the treatment to which the individual is referred is not part of the PEI component, reporting the outcome of referrals necessarily involves coordination with the treatment provider.</p> <p>It seems probable that the percentage of individuals who engage in the broad range of PEI activities who already have a severe mental illness that requires treatment beyond early intervention is very small; however, the actual number is unknown because no one is measuring the extent to which individuals with severe mental illness are identified through PEI programs or the result of these referrals.</p>

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					<p>To summarize: Access and Linkage to Treatment for individuals with a severe mental illness is a requirement of the MHSa and a requirement of all current PEI programs. Reporting the outcome of the MHSa mandate to link individuals with severe mental illness to treatment, which is already a PEI requirement, is the most fundamental possible evaluation requirement and a basic step toward accountability for outcomes.</p> <p><u>3560.010(b)(3)(D) and 3750(f)(3), Measuring the duration of untreated mental illness:</u> The Commission at the October 23, 2014 meeting voted to delete the proposed method to measure duration of untreated mental illness set forth in 3750(f)(3)(A). That action is the subject of this 15-day Notice. The Commission at the October 23rd meeting also voted to consider other approaches to measure this critical MHSa goal (WIC §5840(c)). Any subsequent method will be the subject of a 15-day Notice for public comment.</p> <p>The method originally proposed in 3750(f)(3)(A), now deleted, only applied to individuals with severe mental illness who were referred to treatment in the CSS systems or other treatment beyond early intervention.</p> <p>Whatever method is devised to measure duration of untreated mental illness will</p>

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					<p>have no application to the many individuals whom PEI programs serve who do not have a severe mental illness, including individuals with higher than average risk of a mental illness (Prevention Programs) or individuals who participate in the various access strategies mandated by the MHSA for PEI (Outreach for Increasing Recognition of Early Signs of Mental Illness, Improving Timely Access to Services for Underserved Populations, and Stigma and Discrimination Reduction Programs) or in a Suicide Prevention Program that does not focus on intended outcomes for specific individuals.</p> <p>Although measuring the duration of untreated mental illness only would apply to a subset of individuals served by PEI programs, it is useful to remember that the goal of all PEI programs is to prevent mental illness from becoming severe and disabling. One important way to do this is to identify as early in onset as possible individuals who already have a mental illness and to support them to receive treatment as early in onset as possible. This is a key MHSA goal that is stated within the PEI component and that necessarily requires a bridge to and partnership with the CSS component.</p>

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					<p><u>3560.010(b)(3)(C) and (E):Following up on referrals:</u> Following up to ensure that the individual referred actually received assessment and any necessary treatment could be with the treatment provider and does not necessarily require follow up with the individuals referred. The specific parameters of the relationship and communication between the PEI referring process and the treatment source will necessarily vary among counties. This kind of flexibility is built into the structure of Proposed PEI Regulations. See response to comment 91.01 below on page 100.</p>
3560.010(b)(3)(D)	Commenter #91	<p><u>Comment 91.01</u> In the above subject regulations, in section 3560.010 (3)(D), would you please explain what is to be reported. The regulation reads: “Duration of untreated mental illness as defined in Section 3750, subdivision (f)(3)(A). We went to the referenced section (3750) and were left with no better understanding. Are Counties expected to report on the duration that a client may have gone without mental health treatment for a diagnosis that they did not themselves make, and may not have knowledge of until the client becomes a County client? If so, how is the County to determine when and if a mental illness diagnosis was given?</p> <p>Would you please explain the intent of this regulation and the expectations from the County. The way it is currently worded is very vague.</p>	Reject	Retain existing language with no change	<p>As stated in the response to comment 92.01 above, the Commission has deleted the specific measure of duration of untreated mental illness and is considering options. The intention is to provide a simple, flexible measure that is methodologically sound and feasible for counties. Any measure of the duration of untreated mental illness as the result of a PEI referral to treatment necessarily involves both the referring entity (PEI) and the treatment entity. The specific mechanism of this communication and reporting is intended to be flexible to support the great variation among counties.</p>

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3560.010(b)(3)(E) & (4)(E)	Commenter #88	<p><u>Comment 88.06</u> Section 3560.010</p> <p>Annual Prevention and Early Intervention Program and Evaluation Report.</p> <p>b. (3) (E) and b. (4) (E)</p> <p>These sections use the same language and call for the counties to report the average interval between referral and start of treatment. Statistically speaking, the average (as a measure of central tendency) does not stand on its own. To have an accurate and complete picture of the data you would usually also need to know the standard deviation. Without the standard deviation you cannot know if the distribution is balanced. If it is not balanced then the average may not be the best measure to accurately describe the data.</p> <p>Since I assume this data may be used to compare county performance over time and/or to compare counties directly it is very important to know the standard deviation. Without the standard deviation you cannot know whether you are comparing apples to apples and you cannot make statistical adjustments for differences between counties which might allow you to draw statistically valid conclusions about those differences. For example two counties could each have an average interval of 25 days. But the standard deviation for one is 5 and the standard deviation for the second is 15. For the first county, most referrals entered treatment 20 to 30 days from referral. For the second county most referrals entered treatment 10 to 40 days from referral. As you can see there is much greater variation in the second county than the first but their average is the same.</p>	Accept in part	<p>Change existing language as indicated</p> <p>3560.010(b)(3)(E): Average Interval between the referral and <u>participation engagement</u> in treatment, defined as participating at least once in the treatment to which referred <u>and standard deviation</u>.</p> <p><u>3560.010(b)(4)(E):</u> Average Interval between the referral and <u>participation engagement</u> in services, defined as participating at least once in the services to which referred <u>and standard deviation</u>.</p>	<p><u>Recommended Change:</u> The comment is correct that the average is not sufficient information without the standard deviation, which measures the variability of data. Simple tools are available to assist counties to measure and report the standard deviation.</p> <p>The interval between referral and engagement in services is the only outcome measure of timeliness for Improving Timely Access to Services for Underserved Populations included in proposed PEI Regulations, so it is very important.</p>

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		<p>It may be that the second county actually gets most people into treatment within 10-15 days but that it has a number of outliers at more than 40 days that caused the standard deviation to be so large. When counties report their data they should also be reporting the methods they used and these kinds of data artefacts so that their results can be interpreted more accurately.</p> <p>Proposed language:</p> <p>The County shall report the following information annually as part of the Annual Update of Three Year Program and Expenditure Plan. The report shall including the following information for the reporting period:</p> <p>b. (3) For each Access and Linkage to Treatment Strategy or Program the County shall provide report: (E) Average interval between the referral and engagement in treatment, defined as participating at least once in the treatment to which referred. <u>Standard statistical analysis methods shall be used and reported. Additional measures such as standard deviation shall be provided as required.</u></p> <p>b. (4) For each Improve Timely Access to Services for Underserved Populations Strategy or Program the County shall provide report: (E) Average interval between the referral and engagement in treatment, defined as participating at least once in the treatment to which referred. <u>Standard statistical analysis methods shall be used and reported. Additional measures such as standard deviation shall be provided as required.</u></p>			

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3560.010(b)(5)	Commenter #88	<p><u>Comment 88.07</u> Section 3560.010</p> <p>Annual Prevention and Early Intervention Program and Evaluation Report</p> <p>3560.010 b. (5)</p> <p>I suggest you also collect data <u>on marital status and housing status</u>. We know that marital status can have protective effects on mental health. And it is self-evident that housing status can have a dramatic effect on consumer mental health status. Housing status could also serve as a marker for recovery among the homeless mentally ill.</p> <p>The housing status categories I have listed are HUD housing categories already being collected by Counties for other populations.</p> <p><u>J. Marital Status:</u> (i) <u>Married/Domestic Partner</u> (ii) <u>Separated</u> (iii) <u>Divorced/Ended Domestic Partnership</u> (iv) <u>Single</u> (v) <u>Declined to state</u></p> <p><u>K. Housing Status:</u> (i) <u>Stably housed</u> (ii) <u>At Risk of Homelessness</u> (iii) <u>In Imminent Danger of Homelessness</u> (iv) <u>Homeless</u> (v) <u>Other</u> (vi) <u>Declined to state</u></p>	Reject	Retain existing language with no change	While it is true that both housing status and marital status can have protective effects on mental health, this is also the case for a wide range of other protective factors. There is no sufficient purpose to require all counties to report these data for all programs. These and other protective factors might be relevant to specific PEI programs. For example, an Early Intervention Program that intends to prevent homelessness as a consequence of untreated mental illness would certainly measure housing status in addition to direct mental health outcomes.

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3560.010(b)(5)(B) – (D)	Commenter #71	<p>Comment 71.04</p> <p>In general, I believe that this expanded set of demographic categories, while definitely needed, has inadvertently created large gaps and ambiguities of category, not only creating awkwardness and, perhaps, inappropriateness of available selections, but also creating inconsistent data collection due to uncertainty of proper category.</p> <p>The category of Middle Eastern is particularly vague – especially in the context of what is <u>not</u> listed with regard to surrounding areas. There is a “culture world” stretching from Sahara/Morocco to Central Asia/Afghanistan (with resonance beyond). This “world” is often thought of as Islamic but in fact includes other religions as well. You have nothing for this world other than “African” (for N. Africa?), “Middle Eastern” and “Other”. I have suggested a broad category of “N. African/Middle Eastern/SW Asian” that would take in Morocco, Libya, Turkey, Saudi Arabia and Afghanistan and everything in between. This is just my personal suggestion and experts in the area(s) should be consulted.</p> <p>In this scenario “African” would become “Sub-Saharan African”.</p> <p>The list here of E. Asian countries is extensive but not so much for SE Asia – Myanmar, Thailand, etc. are left out as prominent non-state groups such as Hmong. I would propose “Other SE Asian” to cover this. Again, consult.</p> <p>The lack of a South Asian category has been fixed, but I suggest removing the term “Asian Indian” as insensitive to Pakistanis.</p> <p>“More than one” race/ethnicity should include directions to check this <u>and</u> report all that apply.</p>	Reject	Retain existing language with no change	<p>Since the regulations determine the categories in which counties report program data and disaggregate outcomes, it is essential that proposed PEI Regulations designate reporting categories for demographics. Decisions about inclusion or exclusion of a particular ethnic group cannot be made on a case-by-case basis but must be based on agreed-upon criteria. The current criteria are inclusion in at least one Federal reporting requirement and a populations in California above 100,000 according to 2010 census data. See responses to comments 93.01 and 95.01 below on pages 105 and 107.</p>

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		<p>This list is very much <u>not</u> fully cooked. I would suggest that the Commission form a workgroup of experts and interested parties along the lines of that addressing the “Duration of untreated mental illness” section.</p> <p>Another problem is that their list will inevitably change – so it will always be a work in progress. Given this, perhaps it is better to not have the list in regs at all. A process for setting up the list and changing it could be in regs – with a defined authority for making changes. Alternately, regs could have standards for inclusion (federal recognition could be one) along the lines of threshold languages used in (D).</p>			
3560.010(b)(5)(B) – (D)	Commenter #95	<p><u>Comment 95.01</u> Section 3560.010 (b)(5)(B)(C)(D)</p> <p>The following is the response of the OAC staff when asked how the categories in these sections were constructed:</p> <p>RE: Ques. re: Prop PEI regulations:</p> <p>Good morning,</p> <p>I forwarded your question to the appropriate staff and received the response below. Please let me know if you would like your previous comments and questions to be a part of public record.</p> <p>Response to your question: The answer is that the sections are not based on any state codes or act. The race and ethnicity codes are based on the following standard: This subcategory is included in at least one Federal reporting requirement and has a populations in California above 100,000 according to 2010 census data. We</p>	Reject	Retain existing language with no change	<p><u>Race and ethnicity demographic reporting categories:</u> The comment is incorrect in its assertion that MHSOAC staff did not consult with research regarding appropriate reporting of demographic categories or that the selected categories were based on political considerations. Research revealed that there is no consensus about what categories to include or exclude.</p> <p>Staff’s approach to designating racial and ethnic categories for purposes of demographic reporting was to select a standard with clear, consistent criteria that would best balance the purposes of usefulness (for oversight and accountability purposes including but not limited to policy development, evaluation, quality improvement, support to counties and providers, and</p>

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		<p>are suggesting changes to the sexual orientation reporting categories based on research on best practices in the field.</p> <p>Hello Christina,</p> <p>Regarding Section 3560.010 (b) (5) (B), (C), and (D): Are these sections based on any state codes or act, such as Section 5846, Welfare and Institutions Code, MHSA act, or other source?</p> <p>There is a note on page 4 but I can't tell where in the section it applies.</p> <p>Regards, Laurel Benhamida, Ph.D.</p> <p>Interdisciplinary cooperation is the best practice required to construct the categories for race, ethnicity, culture, and language in these sections. It is inappropriate for government and other health, mental health and social service entities to aggregate, disaggregate, reaggregate data about race, ethnicity and language without consulting with linguists, sociolinguists, anthropologists, linguistic anthropologists, sociologists, and/or area studies experts and community stakeholders, including consumers. An interdisciplinary process is required and is the standard for "best practice" in planning for culturally and linguistically appropriate services.</p> <p>An ad hoc or politically motivated effort is ill-advised. The international mental health community is watching what the California MHSOAC does. The upcoming WPA Each Mind Matters conference in San Francisco will be attended by members of the international mental health community. They know that understanding how stigma based on race, ethnicity, culture, and language contributes to mental illness is part of the work to reduce stigma in mental health. If the data</p>			<p>communication), feasibility, and representation of groups with significant prevalence in California. The result of this effort was the selection of the following standard: The subcategory is included in at least one Federal reporting requirement and has a populations in California above 100,000 according to 2010 census data. See responses to comments 71.04 above on page 103 and 93.01 below on page 107.</p>

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		<p>collection categories are poor, the process is compromised. In the politically sensitive area of collecting data about race, ethnicity, culture, and language does California want to lead by example?</p> <p>Health, mental health and social service experts would not agree if the government and the American Psychiatric Association changed policy and engaged only linguists, anthropologists, sociologists, and area studies specialists to write the Diagnostic and Statistical Manual of Mental Disorders.</p> <p>Poshi Mikalson's request at the September meeting that the OAC seek expert guidance, including consumers, to construct gender identity categories etc. was exactly correct. The PEI regulation writers need to do that with race, culture, ethnicity, and language.</p> <p>California will always be behind if it does not tentatively map out the world more carefully over the next few years. Every few years a new group of refugees and immigrants take up residence in California. They are traumatized and need services but are invisible in the data. Mapping and categorizing could be done continent by continent. The most urgent need now is North Africa east through Asia (all of it), East Africa (the Horn of Africa), Europe, and Central America. Where are indigenous people of Central America? Where are the Hmong and Burmese on the ethnicity list? Where are the Southwest Asians, such as the hundreds of thousands of Iranians (maybe even a half a million in Los Angeles area alone) and Afghans on the list? If the current Myanmar government decides to put all Rohingya who cannot complete the newly proposed citizenship process into concentration camps, the Rohingya may become the next group to enter the refugee waiting lists. Flexibility is needed.</p>			

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		<p>The categories could also be more flexible by adding a category of "arrived as asylum seeker, immigrant, or refugee, family reunification, or undocumented entrant." This would create a regulatory incentive for county MHSA projects to reach out to traumatized recent residents at risk for suicide, depression, PTSD, and other serious mental health problems without waiting for threshold language requirements to be met.</p>			
3560.010(b)(5)(C)(ii)	Commenter #93	<p><u>Comment 93.01</u> Thank you for working on the disaggregated data. The list you have for APIs are very good beginning. With regards to 3560.010 for disaggregated data: (page 4 under 5 (C) (ii) Non-Hispanic or Non-Latino,</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. we would suggest you add "Other South East Asians" in addition to the existing Vietnamese and Cambodian. OTHER South East Asians, this will include, but not limited to: Burmese (17,978), Hmong (91,224), Laotian (69,303), Thai (51,509).... [the numbers are from the 2010 census data and are recorded in our API Population Report, page 20; http://crdp.pacificclinics.org/files/resource/2013/04/Report.pdf] many residents from this group suffers war trauma and when they immigrate here, they have the highest language isolation, poverty, school dropout rate. This group probably experienced the most disparity of all. 2. We would also like to suggest you add one more group Taiwanese (109,928; 2010 census data) as Taiwanese and Chinese are quite different in terms of its perception and experience about mental health services; the cultural background is also quite different (democratic vs. socialists/communist) 	Reject	<p>Change existing language as indicated:</p> <p>3560.010(b)(6): Any other data the County considers relevant, <u>for example, data for additional demographic groups that are particularly prevalent in the County, at elevated risk of or with high rates of mental illness, unserved or underserved, and/or the focus of one or more PEI services.</u></p>	<p><u>Recommended Change:</u> Staff suggests amending subdivision (b)(6) to expand the use of the "any other data" category to include ethnic groups that might be particularly prevalent in a County or a particular focus of PEI efforts but that do not meet criteria for statewide reporting.</p> <p>The included demographic categories are based on the following criteria: is included in at least one Federal reporting requirement and has a populations in California above 100,000 according to 2010 census data. While MHSOAC staff appreciates all of the specific suggestions contained in the comment, none of the suggested additions meet these criteria because they are not included in one or more federal reporting categories.</p> <p>It is not feasible to require County reporting for any specific ethnic group without reference to explicit criteria. Nor were we able to identify alternative criteria that appropriately balanced the need for consistency with existing</p>

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		<p>3. As for(b) Asian Indian/South Asian, I would suggest separate it into two groups “Asian Indian (590,445)” and “Other South Asians (about 100,000)” to account for people from Afghanistan, Iran, Bangladeshi (10,494), Pakistani (53,474), and Sri Lankan (11,929). South Asians are quite different from other parts of Asia in terms of their cultural and (often) religious background.</p>			<p>federal reporting requirements and inclusion of groups of California residents with sufficient population to justify statewide reporting requirements.</p> <p>It is also important to note that the fact that a specific ethnic group is not a required reporting category in no way precludes a County from offering a PEI program that focuses on that group because of the kind of risk factors mentioned in the comment.</p> <p>See responses to comments 71.04 and 95.01 above on pages 103 and 105.</p>
3560.010(b)(5)(E) & (H)	Commenter #94	<p><u>Comment 94.01</u> We are very pleased to see that the proposed changes add data collection about sexual orientation and gender identity to the regulations, but the specific categories proposed for those items are insufficient. Members of LGBTQ communities have reported fear and trepidation when seeking mental health services. Collecting sexual orientation and gender identity demographic data in a culturally sensitive manner is a first step in creating an inclusive and safe environment for clients/consumers who identify somewhere along the LGBTQ spectrum.</p> <p>In addition, the Institute of Medicine recommends increased data collection about sexual orientation and gender identity both because there is so little data collected, and because the existing data show health disparities specific to different identities. For example, bisexual women are twice as likely to have an eating disorder as lesbians, and transgender women experience higher rates of violence than transgender men. It is imperative that data be collected in a way that furthers understanding of mental health needs and disparities, and</p>	Accept in part	<p>Change existing language as indicated:</p> <p><u>3560.010(b)(5)(E): Sexual Orientation</u></p> <p>Sexual Orientation</p> <ul style="list-style-type: none"> (i) Gay <u>or</u> Lesbian or Bisexual (ii) Heterosexual <u>or Straight</u> (iii) <u>Bisexual</u> (iv) Other (v) <u>Number of respondents who declined to answer the question</u> <p><u>3560.010(b)(5)(H): Gender Identity</u></p>	<p><u>Recommended Change:</u> The specific changes suggested are consistent with recommended best practices in the field and are intended to balance priorities that include gathering crucial information, avoiding unnecessary administrative burdens for counties, and broadening reporting categories to reflect a wider range of ways people identify and experience themselves both with regard to gender identify and to sexual orientation. Minority gender identify and sexual orientation can both be the basis for trauma and oppression with potentially significant mental health dimensions.</p> <p><u>Sexual orientation:</u> With regard to asking questions about sexual orientation, staff recommends the approach suggested by the Williams Institute, UCLA School of</p>

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		<p>knowledge of interventions that are successful with different populations.</p> <p>We propose adding additional categories to the sexual orientation and gender identity items, and adding a question that asks for sex assigned at birth. Increasing the number of response categories enables respondents to better see themselves in the answer options and allows for a finer understanding of disparities between different categories, while still facilitating data aggregation and large-group analysis.</p> <p>Capturing gender identity accurately requires asking two questions, one question about the person’s gender identity and a second question about the person’s assigned sex at birth. Many people who were assigned a sex at birth and have transitioned to another gender later in life do not think of themselves as transgender. If asked to choose between male, female, or transgender, they would choose their current gender identity (male or female) rather than transgender. Researchers report up to 50% more transgender people identified by the two-question method we propose here than by a one question method.</p> <p>These recommendations are based on a variety of clinical studies, as well as the experience gained when conducting research for the California LGBTQ Reducing Disparities Project.</p> <p><u>Proposed Questions</u> <i>For sexual orientation:</i> Do you consider yourself to be:</p> <ul style="list-style-type: none"> • Straight or heterosexual • Gay or lesbian • Bisexual/pansexual/sexually fluid • Queer 		<p>(H) Gender identity</p> <ul style="list-style-type: none"> (i) Male (ii) Female (iii) Transgender (iv) Other (v) Declined to state <p><u>(i) Assigned sex at birth:</u></p> <ul style="list-style-type: none"> (a) <u>Male</u> (b) <u>Female</u> (c) <u>Number of respondents who declined to answer the question</u> <p><u>(ii) Current gender identity:</u></p> <ul style="list-style-type: none"> (a) <u>Male</u> (b) <u>Female</u> (c) <u>Transgender</u> (d) <u>Do not identify as female, male, or transgender</u> (e) <u>Number of respondents who declined to answer the question</u> 	<p>Law, Sexual Minority Assessment Research Team in (November 2009) <i>Best Practices for Asking Questions about Sexual Orientation on Surveys</i>, which includes some but not all of the language recommended by the comment. This approach differentiates three major dimensions of sexual orientation that could be the basis for gathering information: sexual attraction, sexual behavior, and self-identification. Since self-identification is most relevant for PEI reporting, staff recommends utilizing the three categories within this dimension that the Williams Institute suggests.</p> <p><u>Gender identity:</u> With regard to gender identify, staff recommends the approach of the Williams Institute, UCLA School of Law, Gender Identify in U.S. Surveillance group (September 2014), <i>Best Practices for Asking Questions to Identify Transgender and other Gender Minority Respondents on Population-based Surveys</i>, which includes some but not all of the language recommended by the comment. Consistent with the comment’s request, the Williams Institute recommends a two-step approach to asking about gender identify.</p>

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		<ul style="list-style-type: none"> • Another sexual orientation (Fill in the Blank) • I'm not sure <p><i>For gender identity:</i> What is your current gender identity? (Check one that best describes your current gender identity.)</p> <ul style="list-style-type: none"> • Male • Female • Trans male/transman • Trans female/transwoman • Genderqueer • Another gender identity (Fill in the Blank) • I'm not sure <p>What sex were you assigned at birth, on your original birth certificate?</p> <ul style="list-style-type: none"> • Male • Female 			
3560.010(b)(5)(F)	Commenter #88	<p><u>Comment 88.05</u> The currently proposed language for section 3560.10 (b)(5)(F) Disability reads:</p> <p>(F)Disability, if any, that is not the result of severe mental illness (a)Yes (specify the disability) (b) No (c) Declined to state</p> <p>Comment: This manner of collecting data on other types of disability is problematic. The variety of answers is infinite and the resulting data will not be usable for analysis. Therefore the requirement to specify the disability would appear to place an undue burden on the counties to collect data that has low, if</p>	Accept	<p>Change existing language as indicated</p> <p>3560.10 (b)(5)(F): Disability, if any, <u>defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity,</u> which is not the result of a severe mental illness (i) Yes, <u>report the number that apply in each domain of disability(ies):</u></p>	<p><u>Recommended Change:</u> The specific change suggested expands slightly on the categories used by the U.S. Census Bureau (Brault, 2012), which divides disabilities into three domains: communicative, physical, and mental.</p> <p>As the comment points out, there are advantages to limiting the responses to pre-defined categories of disabilities to facilitate statewide roll-up of data. There is no standardized way of defining a disability, which is widely regarded as essentially a social construct, nor a standardized approach to categorizing kinds of disabilities. There is also no</p>

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		<p>any, utility. These comments also apply to the demographics section of the PEI regulations.</p> <p>Instead, I suggest having a short list of areas of disability that hold utility for the analysis of the data set as a whole. Directions would be to choose all the categories that applied. Recommended wording:</p> <p>(F) Disability, if any, that is not the result of severe mental illness</p> <p>(a) Yes (specify the disability) <u>Pain-related disability</u></p> <p>(b) <u>Mobility-related disability</u></p> <p>(c) <u>Deaf/HoH</u></p> <p>(d) <u>Other</u></p> <p>(e) No</p> <p>(f) Declined to state</p> <p>The rationale for these categories is as follows:</p> <p>Pain-related disability means the possibility of dual diagnosis needs to be excluded. Once dual diagnosis has been ruled out, the impact of pain-related disability on the development and maintenance of mental illness has clear treatment implications. For example, it may indicate the need to refer these consumers to a psychiatrist who specializes in treatment of patients with both mental illness and pain.</p> <p>Mobility-related disability may indicate a need for transportation services or special access to treatment centers. Missing appointments due to lack of transportation clearly impacts treatment outcomes.</p> <p>Deaf/HoH as a disability category may be somewhat controversial since some in the Deaf community do not consider themselves disabled. But among older adults, one of the target populations, hearing loss is a very important source</p>		<p><u>(a)communication domain (including but not limited to difficulty seeing, hearing, or having speech understood)</u></p> <p><u>(b)mental domain not including a mental illness (including but not limited to a learning disability, developmental disability, dementia)</u></p> <p><u>(c)physical/mobility domain</u></p> <p><u>(d)chronic health condition (including but not limited to chronic pain)</u></p> <p><u>(e)other (specify)</u></p>	<p>current standard way that counties report disabilities of clients served.</p> <p><u>Domain of disabilities:</u> The suggested reporting categories are intended to balance useful information for PEI purposes regarding disabilities that often co-occur with a mental illness with minimizing the administrative burden on counties. The recommended categories expand slightly on the categories used by the U.S. Census Bureau (Brault, 2012), which divides disabilities into three domains: communicative, physical, and mental.</p> <p><u>Chronic health:</u> The suggested language adds chronic health conditions, which includes chronic pain, because of the significant mental health dimension.</p> <p><u>At least six months duration:</u> The suggested added qualifier that the condition has lasted at least six months is intended to differentiate transient conditions from more long-standing disabilities.</p>

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		<p>of additional disability, may be a contributing factor to the onset and maintenance of mental illness (see reference) and forms a huge barrier to treatment.</p> <p>From a clinical and program perspective these categories are useful since they can inform care and the distribution of resources such as transportation.</p>			