

**Matrix of Public Comments with Staff's Recommended Responses**  
**Proposed PEI Regulations Sections 3560. 3560.010. 3560.020, and 3750**  
**Presented at October 23, 2014 MHSOAC Meeting**

Section #	Comment Author	Comment Summary	Response	Action	Rationale
3560.010	Commenter #3	<p><u>Comment 3.03</u>  <b>MHSOAC Data Tracking Regulations Ignore Mandatory Relapse Prevention Programs And The Most Basic Diagnostic Requirements For Evaluation Of Programs That Prevent "Mental Illness" From Becoming "Severe Mental Illness."</b></p> <p><b>MIPO proposes the following changes to proposed section 3560.010:</b></p> <p>Section 3560.010. Annual Prevention and Early Intervention Report.            (a) The requirements set forth in this section shall apply to the Annual Prevention and Early Intervention Report to be included in the Annual Update for fiscal year 2015/16 and each Annual Update and Three-Year Program and Expenditure Plan thereafter.            (b) The County shall report the following information annually as part of the Annual Update or Three-Year Program and Expenditure Plan. The report shall include the following information for the reporting period:            (1) For each Prevention program and each Early Intervention program list:</p>	Reject		<ol style="list-style-type: none"> <li>1. <u>Diagnosis of mental illness</u>: Proposed PEI Regulations require the County to document the basis for determining that a client is at risk of a mental illness (3755(d)(1)(B)) or is manifesting early onset of a mental illness (3755(c)(1)(C)) and to report the number of individuals at risk and the number with early onset served by each Prevention and each Early Intervention Program. This requirement appropriately balances the need for rigor in determining and reporting risk or onset of a mental illness with flexibility for counties to report on Prevention and Early Intervention programs that take place in a wide range of settings, some of which do not involve formal admission or discharge procedures and serve clients with a range or risk factors and diagnoses. Prevention and Early Intervention programs are required to address the applicable outcomes in 5840(d), which refer to negative outcomes that may result from untreated mental illness. The requirements in 5840(d) make no reference either to serious or, severe mental illness or diagnosis, but rather refer to "untreated mental illness." See response to comment 3.32 on page 5 of the Matrix of Public Comments presented at the September 30, 2014 MHSOAC meeting. In addition, the regulations do require a basis for determining that a client is at risk of a mental illness (3755(d)(1)(B)) or is manifesting early onset of a mental illness (3755(c)(1)(C)): See responses to comment 8.30 on page 16 below.</li> <li>2. <u>Severe mental illness</u>: The comment's suggestion to have the counties report exclusively on "severe mental illness" ignores the various references to</li> </ol>

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		<p>(A) Unduplicated numbers of individuals served annually</p> <p>(i) If a program serves <del>both a</del> <u>combination of individuals</u> at risk of <u>severe mental illness</u> (Prevention), individuals with early onset of <u>severe mental illness</u> (Early Intervention) a <del>potentially serious mental illness</del> and/ or <u>individuals with existing severe mental illness in relapse prevention/early intervention programs</u>, the County shall report numbers served separately for <u>each of these categories</u>.</p> <p>(ii) If a program serves families the County shall report information for each individual family member served.</p> <p><u>(B) All diagnoses of "mental illness" and of "severe mental illness" as defined in this Article, and the number of clients carrying each such diagnosis, for all recipients of services who are not family members, at admission, discharge, and over the course of the year. As basis for the foregoing data, the county shall require each program to document, at minimum, the Axis I diagnosis of each "mentally ill" or "severely mentally ill" client on admission, for each year on a consistent date for all program enrollees, and on client discharge from the program.</u></p>			<p>mental illness in the MHSA PEI section 5840, which include:</p> <ul style="list-style-type: none"> <li>a. severe mental illness: (b)(2), (c)</li> <li>b. potentially severe and disabling mental illness (b)</li> <li>c. mental illness: (a), (b)(3), (b)(4), (c), (d)</li> <li>d. mental health services: (b)(3), (c), (e)</li> </ul> <p>See response to comment 3.31 on page 1 of the Matrix of Public Comment presented at the September 30, 2014 MHSOAC meeting.</p> <p>3. <u>Relapse prevention</u>: Proposed PEI Regulations specify that relapse prevention is both an important and inherent element of an Early Intervention Program and also an allowable population at risk of a potentially serious mental illness eligible to be the focus of a Prevention Program. There is no need to create a separate reporting category for a “relapse prevention/early intervention program.” See responses to comment 3.05 on page 7 and comment 3.31 on page1 of the Matrix of Public Comments presented at the September 30, 2014 MHSOAC meeting.</p> <p>4. <u>Effective programs</u>: Proposed PEI regulations sections 3750 and 3755 require both Prevention and Early Intervention programs to use methods that have demonstrated their effectiveness for the intended population to bring about the applicable outcomes listed in WIC 5840(d)(1) – (7). These methods to evaluate the success of Prevention and Early Intervention programs are entirely consistent with the MHSA. See response to comment 3.34 on page 10 of the Matrix of Public Comment presented at the September 30, 2014 MHSOAC meeting.</p> <p>5. <u>Intervening at point of risk of mental illness</u>: It is not accurate that “MHSOAC’s authority is restricted to addressing individuals with an existing ‘mental illness’ that may become a ‘severe mental illness,’</p>

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		<p>Statutory Authority/Necessity for MIPO's deletions: The use of the term "both" is inaccurate and contrary to statute. There are <i>three</i> mandatory categories of "mentally ill" recipients, specifically including individuals who are already severely mentally ill. Similarly, the use of the term, "individuals at <i>risk of</i>" a "<i>potential serious</i>" mental illness is inaccurate and contrary to statute. MHSOAC has no statutory authority to address individuals "at risk of" a "potential serious" mental illness. MHSOAC's authority is restricted to addressing individuals with an existing "mental illness" that may become a "severe mental illness," and to intervening early in/preventing relapses of a "severe mental illness." See Welf. &amp; Inst. Code §5840(a) which provides, "The State...<i>shall</i> establish a program designed to prevent <i>mental illnesses</i> from becoming <i>severe and disabling</i>"; section 5840(c), which provides, "The program <i>shall</i> include mental health services similar to those provided under other programs effective in <i>preventing mental illnesses</i> from becoming <i>severe</i> and shall also include components similar to programs that have been successful in reducing the duration of <i>untreated severe mental illnesses</i> and assisting people in quickly regaining productive lives."; section 5840(b) (2), which authorizes only "<i>medically necessary</i> care provided by county mental</p>			<p>and to intervening early in/preventing relapses of a 'severe mental illness.'" These individuals are the focus of the requirement for all counties to offer at least one Early Intervention Program. An additional way to prevent a mental illness from becoming severe and disabling is to intervene at the point of risk, before a mental illness has developed. Doing so can in some instances prevent the serious mental illness from occurring and/or can significantly reduce negative consequences if a serious mental illness develops. See response to comment 8.31 page 28 below.</p>

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		<p>health programs for children with <i>severe mental illness</i>, as defined in Section 5600.3, and for adults and seniors with <i>severe mental illness</i>, as defined in Section 5600.3, as early\ in the onset of <i>these conditions</i> as practicable.” (Emphasis added.)</p> <p>Statutory Authority/ Necessity for MIPO's proposed additional phrases: Necessary for clarity and conformity to statute. It is impossible to evaluate programs designed to prevent "mental illness" from becoming "severe mental illness," and to prevent/intervene early in relapses into "severe mental illness," without tracking diagnostic information</p>			
3560.010	Commenter #3	<p><u>Comment 3.04</u>  (5) For the information reported under subdivisions (1) through (4) of this section, disaggregate numbers served, number of potential responders engaged, and number of referrals for treatment and other services by:  (A) The following age groups:  (i) 0-15 (children/youth);  (ii) 16-25 (transition age youth);  iii) 26-59 (adult);  (iv) ages 60+ (older adults).  <u>(B) Diagnosis of "mental illness" or of "severe mental illness" as defined in this Article, as applicable, for all referrals and all recipients of services who are not family members. For programs under subdivision (b)(l) of</u></p>	Reject except suggestion for 3560.010(b)(5)(F)	<p>Change existing language indicated by underlined (new language) or strikethrough (remove existing language):</p> <p>Amend 3560.010(b)(5)(F) as follows:  (F) Disability, if any, <u>which is not a disability as a result of a mental illness</u>  (i) Yes, specify  (ii) No  (iii) Declined to state</p>	<ol style="list-style-type: none"> <li>1. <u>Recommended change:</u> 3560.010(b)(5)(F). MHSOAC staff suggest slightly revised language to clarify that the “disability” to be reported is in addition to any disability that results from the mental illness. This differentiation makes sense, since the intention is to track the number of individuals served by PEI programs who have other disabilities that are not the result of a mental illness.</li> <li>2. <u>Diagnosis requirement:</u> Designation of the diagnosis associated with "mental illness" or of "severe mental illness" is not required for PEI programs and therefore is not an appropriate category to require for County reporting. See responses to Comment 3.03 on page 1 and 3.32 on page 5 of the Matrix of Public Comments presented on the September 30, 2014 MHSOAC meeting. As County and State evaluation and data capacities develop, it is possible that future amendments to the regulations will have additional reporting</li> </ol>

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		<p><u>this Section, diagnostic data shall be aggregated by diagnosis and shall track aggregate changes in diagnoses over time, based on data required at subsection (b)(1)(A)(iii). Such data shall be stated separately for 1) Section 3710 programs, 2) Section 3720 programs, 3) 3710(e) relapse early intervention programs for severely mentally ill persons, and 4) 3720(d) relapse prevention programs for severely mentally ill persons.</u></p> <p><del>(B)</del> <u>(C)</u> Race by the following categories:</p> <ul style="list-style-type: none"> <li>(i) American Indian or Alaska Native</li> <li>(ii) Asian</li> <li>(iii) Black or African American</li> <li>(iv) Native Hawaiian or other Pacific Islander</li> <li>(v) White</li> <li>(vi) Other</li> </ul> <p><del>(C)</del> <u>(D)</u> Ethnicity by the following categories:</p> <ul style="list-style-type: none"> <li>(i) Hispanic or Latino as follows <ul style="list-style-type: none"> <li>(a) Caribbean</li> <li>(b) Central American</li> <li>(c) Mexican</li> <li>(d) South American</li> <li>(e) Other</li> </ul> </li> <li>(ii) Non-Hispanic or Non-Latino as follows <ul style="list-style-type: none"> <li>(a) African</li> <li>(b) Cambodian</li> <li>(c) Chinese</li> <li>(d) Eastern European</li> <li>(e) European</li> </ul> </li> </ul>			<p>requirements, including the possibility of tracking diagnostic data, where applicable. The MHSOAC will collaborate with counties, people at risk of and with mental illness and their family members, representatives of diverse underserved communities, other State departments, and other interested stakeholders, to assess priorities and best uses of additional program and evaluation data for future amendments to the PEI Regulations.</p> <p>3. <u>Relapse prevention</u>: Separate category for a “relapse prevention/relapse early intervention program”: see responses to comment 3.03 on page 1 above.</p> <p>4. <u>Effective practices for all programs</u>: See responses to comment 3.03 on page 1 above and comment 3.34 on page 10 of the Matrix of Public Comments presented at the September 30, 2014 MHSOAC meeting.</p> <p>5. <u>Medically necessary care</u>: Comment misquotes WIC Section 5840(b)(2) requirement for access to medically necessary care for individuals across the lifespan with severe mental illness, as defined in 5600.3: See responses to comment 3.03 on page 1 above and comment 3.31 on page 1 of Matrix of Public Comments presented at the September 30, 2014 MHSOAC meeting.</p>

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		<p>(f) Filipino  (g) Japanese  (h) Korean  (i) Middle Eastern  (j) Vietnamese  (k) Other</p> <p><del>(D)</del> <u>(E)</u> Primary language spoken listed by threshold languages for the individual county</p> <p><del>(E)</del> <u>(F)</u> Sexual orientation,  <del>(F)</del> <u>(G)</u> Disability, if any, <u>that is not a mental illness or severe mental illness</u></p> <p><del>(G)</del> <u>(H)</u> Veteran status,  <del>(H)</del> <u>(I)</u> Gender identity,  <del>(I)</del> <u>(J)</u> Any other data the County considers relevant.</p> <p>Statutory Authority for MIPO's proposed additional definition: MHSOAC's authority under the MHSA is to address an existing "mental illness" that may become "severe and disabling." See the Findings, Declarations, Purposes and Intent provisions; see <i>also</i> Welf. &amp; Inst. Code § 5840(a) which provides, "The State... <i>shall</i> establish a program designed to prevent <i>mental illnesses</i> from becoming <i>severe and disabling</i>"; section 5840(c), which provides, "The program <i>shall</i> include mental health services similar to those provided under other programs effective in <i>preventing mental illnesses</i> from becoming <i>severe and shall</i> also include components similar to programs that have been successful in reducing the duration of <i>untreated</i></p>			

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		<p><i>severe mental illnesses</i> and assisting people in quickly regaining productive lives. "; section 5840(b)(2), which authorizes only "<i>medically necessary</i> care provided by county mental health programs for children with <i>severe mental illness</i>, as defined in Section 5600.3, and for adults and seniors with severe mental illness, as defined in Section 5600.3, as early in the onset of <i>these conditions</i> as practicable." (Emphasis added.)</p> <p>Necessity for MIPO's proposed additional definition: Required for clarity and conformity to statute. It is impossible to evaluate programs designed to prevent "mental illness" from becoming "severe mental illness" and to prevent/intervene early in relapses into "severe mental illness" without tracking diagnostic information.</p>			
3560.010	Commenter #3	<p><u>Comment 3.05</u> MIPO submits the following comments on proposed section 3560.010:</p> <p>The most basic defect in the lengthy, duplicative and burdensome tracking regulations that MHSOAC has proposed (which MIPO will address at length in the appropriate order) is in what was omitted. Nowhere do these proposed regulations require diagnostic information. It is impossible to evaluate a program that is</p>	Reject		<ol style="list-style-type: none"> <li>1. <u>Require diagnostic information</u>: See responses to comment 3.03 on page 1 above, comment 3.04 on page 4 above, and comment 3.32 on page 5 of the Matrix of Public Comment presented at the September 30, 2014 MHSOAC meeting.</li> <li>2. <u>Relapse Prevention</u>: Prevention of relapse is an inherent element of effective Early Intervention Program. At the August 28, 2014, the MHSOAC adopted a modification to the language in §3710 to make it clear that Early Intervention Programs inherently includes relapse prevention. See response to comment 3.03 on page 1 above.</li> </ol>

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		<p>supposed to prevent "mental illness" from becoming "severe mental illness" and to "reduc[e] the duration of untreated severe mental illnesses and assist[] people in quickly regaining productive lives" without diagnostic information that can be tracked and examined over time.</p> <p>The agency in the above-referenced proposed regulation has also marginalized statutorily-mandated relapse prevention programs -which it included only because MIPO vociferously demanded them in the public process that predated these proposed regulations - by failing to acknowledge them at all.</p>			
3560.010	Commenter #25	<p><u>Comment 25.03</u> In addition, the lack of recognition for home visiting and the services of trained professional nurses (registered nurses [RN] and public health nurses [PHNs]) needs to be corrected in the following:</p> <p><b><u>Section 3560.010. Annual Prevention and Early Intervention Report, (2)</u></b> calls for the "outreach for Increasing Recognition of Early Signs of Mental Illness" to differentiate the type of setting as referenced in Section 3750(d) (3) (A), but this reference list does not include home visiting by trained professionals (e.g., such as public health nurses in the Nurse-</p>	Reject in part	Retain existing language in Section 3560.01 but modify section 3715(c) to include concept suggested by this comment.	MHSOAC voted at its August 28, 2014 meeting to change 3715(c) to add "visiting nurses" to the list of examples of potential responders. The August 28 <sup>th</sup> changes will produce the effect requested by the comment.

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		<p>Family Partnership Program) in the description of setting types.</p> <p>And in our learned experiences in Los Angeles, an addition to the strategies of the following additional revision is warranted, because we absolutely could not get our home visited clients to visit community based mental health agencies. The causes were varied, lack of transportation, child care, resources (financial), and fear. When services were provided, they often did not address the perinatal mood disorders often seen in our NFP clients. If MHSA is to do what it initially was called to do (i.e., “develop integrated plans for prevention, innovation and system of care services”, then issues as detailed by funded MHSA programs need to be taken into account in developing accessible mental health services for all.</p>			
3560.010	Commenter #25	<p><u>Comment 25.04</u>  <u>Section 3560.010. Annual Prevention and Early Intervention Report, (3)</u>  should include a (F) category, detailing if and how alternate strategies to provide mental health support were explored/adapted/ used for those individuals who did not comply to the mental health referrals given. Note that this constitutes a very large portion of the 800 pregnant and early parenting mothers served in NFP in Los Angeles County and other</p>	Accept	<p>Change existing language indicated by underlined (new language) or strikethrough (remove existing language):</p> <p>Add as subsection under 3560.010 (4):  <u>Description of ways the County encouraged access to</u></p>	<p><u>Recommended change:</u> Increasing access to services, including treatment, for individuals from underserved populations often requires persistent and creative strategies, as the comment points out. Reporting the methods/approaches employed makes it more likely that these important MHSA PEI goals will be accomplished. Requiring such reporting is particularly important for local stakeholders and decision-makers, who must prioritize the most effective approaches to improve timely access to services for underserved populations, as well as for state quality improvement and training and technical assistance.</p>

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		home visiting programs. (This should also be a (G) category in # (4).		<u>services and follow-through on referrals.</u>	
3560.010	Commenter #26	<u>Comment 26.03</u> <b>Section 3560.010.</b> Annual Prevention and Early Intervention Report, (2) calls for the “outreach for Increasing Recognition of Early Signs of Mental Illness” to differentiate the type of setting as referenced in Section 3750(d) (3) (A), but this reference list does not include home visiting by trained professionals (e.g., such as public health nurses in the Nurse-Family Partnership Program) in the description of setting types.	Reject	No change	See response to Comment 25.03 on page 8 above
3560.010	Commenter #26	<u>Comment 26.04</u> <b>Section 3560.010.</b> Annual Prevention and Early Intervention Report, (3) should include a (F) category, detailing if and how alternate strategies to provide mental health support were explored/adapted/ used for those individuals who did not comply to the mental health referrals given. Note that this constitutes a very large portion of parenting mothers served in home visiting as a result of existing MHSA funding.	Accept	No change	See Response to Comment 25.04 on page 9 above
3560.010	Commenter #44	<u>Comment 44.04</u> <b>ISSUE 1:</b> We understand some may prefer to omit language altogether appearing in subdivision (b)(3)(A) of this section which deletes the requirement that counties collect information related to the "... duration	N/A	N/A	N/A because no changes are recommended

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		<p>of untreated mental illness as defined in Section 2(a)(5)(A)(i)" altogether and which these regulations then reestablish in subdivision (b)(3)(B) of this section..</p> <p><b>RECOMMENDATION:</b> We urge that the language related to the requirement to measure the duration of untreated mental illness be retained as proposed.</p> <p><b>COMMENT and RATIONALE:</b> The initiative statute at Welfare and Institutions Code Section 5840(c) which governs Prevention and Early Intervention Programs specifically states (emphasis added in bold) that</p> <p style="padding-left: 40px;">"The program shall include mental health services similar to those provided under other programs effective in preventing mental illnesses from becoming severe, and shall also include components similar to <b>programs that have been successful in reducing the duration of untreated severe mental illnesses</b> and assisting people in quickly regaining productive lives."</p> <p>WIC Section 5848(c) specifically requires counties to report on performance outcomes in each three-year MHSa program and expenditure plan. The duration of untreated</p>			

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		<p>mental illness would seem to be required to be one of those outcomes reported according to section 5840(c). As well, oversight and accountability may not be exercised as required in the MHPA statute if this key, required indicator is deleted.</p>			
3560.010	Commenter #44	<p><u>Comment 44.05</u>  <b>ISSUE 2:</b> Subdivision (b)(3)(B) of this section defines engagement as "number of individuals who participated at least once in the program to which they were referred" and (b)(3)(D) requires collection of data indicating "How long the individual received services in the program to which the individual was referred."  <b>RECOMMENDATION:</b> Language needs to be added to require reporting the number of those individuals who were thought to be able to benefit from a program, were approached and offered participation in that program, but refused to participate whatsoever. As well, data collected should distinguish between those who simply dropped out at some point after initial engagement versus those who graduated, completed and/or moved on successfully to lower levels of care and support.  <b>COMMENT:</b> These two key measurements are the only ones calculated to help determine the</p>	Reject	<p>Change existing language indicated by underlined (new language) or strikethrough (remove existing language):</p> <p>3560.010(b)(3)(D) omit from reporting requirement:</p> <p><del>How long the individual received services in the program to which the individual was referred.</del></p> <p>3560.010(b)(3)(D) add new reporting requirement:</p> <p><u>Average interval between referral and engagement in treatment, defined as participating at least once in the treatment to which referred.</u></p>	<p><u>Recommended changes:</u></p> <p>(1) Delete the requirement to report how long the individual received services because it is not a practical measure. It does not provide any means to differentiate between those who simply dropped out at some point after initial engagement versus those who graduated, completed and/or moved on successfully to lower levels of care and support. The length of time the individual engaged in a treatment program is likely to vary depending on the kind of program to which the person was referred. A person who participated for 12 weeks in a 12-week program is not equivalent to someone who participated for 12 weeks in a one-year program. Because of these variations and complications, as well as the difficulty for a County to track the length of stay for individuals in programs that are not offered through the County, the length of time that the individual received services in the treatment program to which the individual was referred is not a practical measure.</p> <p>(2) Add the requirement to measure the length of time between referral and participation at least once in the treatment. Engagement in treatment is a crucial element of program effectiveness that is highly relevant to the MHPA purpose of increasing linkages to treatment as early as possible in onset and as quickly as possible after the referral. This measure is already required for improving timely</p>

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		success of efforts at engagement and must be part of any evaluation of program effectiveness.			<p>access to services for underserved populations and is equally important for access to treatment in general. There is not yet any clear, effective, and reliable way to define or measure the effectiveness of engagement. MHSOAC is committed to working with counties and stakeholders to develop consistent definitions and effective measures for possible future amendments to PEI Regulations.</p> <p><u>Measure those who refused to participate:</u> The Proposed PEI Regulations (3560.010) require the County to report the number of individuals with serious mental illness referred to treatment and the kind of treatment to which the individual was referred which is similar or equivalent to the suggestion of “the number of those individuals who were thought to be able to benefit from a program, were approached and offered participation in that program.” The County is also required to report the number of individuals who followed through on the referral. These two requirements combine to yield the requested information: the number of individuals who were offered a referral and who did not choose to participate.</p>
3560.010(b)	Commenter #8	<p><u>Comment 8.24</u>  <u>(5) For Program Similar to Other Programs Effective in Preventing Mental illness from Becoming Severe</u>  <u>(A) Identify the 'Similar Program'</u>  <u>(B) Provide number of people served</u>  <u>(C) Describe how county measures effectiveness in preventing mental illness from becoming severe, i.e., by reductions in outcomes</u></p>	Reject	Retain Existing Language with No Change	<p>1. <u>Effective programs:</u> Proposed PEI Regulations sections 3740 and 3755 require all PEI-funded programs and required strategies to use methods that have demonstrated their effectiveness to bring about their intended MHSA outcomes for the intended population, to document the basis for the determination of demonstrated effectiveness, and to document the method used to measure the effectiveness of the intended MHSA outcomes, including, for Prevention and Early Intervention Programs, the outcomes specified in WIC 5840(d)(1) – (7). See responses to comments 3.03 on page 1 above and 3.34 on page 10 of the Matrix</p>

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		<u>described in 5840(d) (1-7) in people with mental illness.</u>			of Public Comments presented at the September 30, 2014 MHSOAC meeting.
3560.010(b)	Commenter #8	<u>Comment 8.25</u> <u>(6) For Program Successful in Reducing the Duration of Untreated Severe Mental illness</u> <u>(A) Describe how the program reduces the duration of untreated serious mental illness</u> <u>(B) Provide number of people with untreated mental illness or untreated severe mental illness served.</u>	Reject	Retain existing language with no change	Both of the suggested additions are already measured in different ways in the proposed regulations. All PEI-funded programs are required to link individuals with severe mental illness to treatment and to improve timely access to services, including treatment, for underserved populations using effective methods for this purpose. Since duration of untreated mental illness is the interval from onset of the mental illness to initiation of treatment, the required strategy to Increase Access to Treatment for individuals with severe mental illness, which can also be a program, is the most relevant PEI component activity. Counties are required to report the number of referrals to treatment and the outcomes of these referrals and to measure the interval from onset of the illness until entry into treatment. See response to comment 3.33 on page 9 of the Matrix of Public Comments presented at the September 30, 2014 MHSOAC meeting.
3560.010(b)	Commenter #8	<u>Comment 8.26</u> <u>(7) For Program that Assists People with Severe Mental illness in Regaining Productive Lives</u> <u>(A) Provide number of people served by severe mental illness diagnostic categories.</u> <u>(B) Provide reductions in outcomes described in 5840(d) (1-7) in people with severe mental illness</u>	Reject	Retain existing language with no change	<ol style="list-style-type: none"> <li>1. <u>Reporting by diagnosis</u>: See responses to comment 3.03 on page 1 above and comment 3.04 on page 4 above.</li> <li>2. Proposed PEI Regulations §3750(c) requires the County to describe measures and report applicable outcomes listed in WIC §5840(3)(1) – (7) for their Early Intervention Programs for people with early onset of a potentially serious mental illness.</li> </ol>

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3560.010(b)	Commenter #8	<p><u>Comment 8.28</u>  <u>(9) Number of people with mental illness who</u>  <u>(a) committed suicide</u>  <u>(b) were arrested and/or incarcerated and number served by AOT and Mental Health Courts</u>  <u>(c) increase in units of housing for people with severe mental illness (or number of mentally ill housed) and number of mentally ill who remain homeless.</u></p>	Reject	Retain existing language with no change	<p>The suggestion applies to some but not all PEI-funded Early Intervention programs. Proposed PEI Regulations section 3750(c) requires the County to describe measures and report outcomes listed in WIC 5840(3)(1) – (7) that are relevant for their Early Intervention Programs for people with early onset of mental illness. Some of the suggested outcomes, such as decrease in suicide rates or increase in units of housing, are population-level outcomes that take longer to manifest.</p> <p>For most Early Intervention programs, it would be more relevant to measure indicators: steps along the way toward broad outcomes for people with mental illness in general. For applicable programs, these indicators might include reduction in suicidal ideation, increased help-seeking behavior, reduced depression, diversion from the juvenile justice system, successful participation in mental health courts, or participation in supportive housing. These indicators toward MHSA outcomes will be reported in the Three-year PEI Program and Evaluation report and not in this section which refers to the Annual PEI Program and Evaluation report.</p> <p>Beyond individual program outcomes, population measures at the county, regional, or statewide level to demonstrate trends that might be, in part, a function of MHSA PEI programs are extremely valuable; MHSA is in full support of these kinds of measures in addition to MHSA-required measures of program outcomes.</p>

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3560.010(b)	Commenter #8	<u>Comment 8.29</u> (10) For Stigma and Discrimination Reduction Programs/Approaches and Suicide Prevention Programs/Approaches, the County <del>may</del> <u>shall</u> report <u>number of suicides in the county, and if possible, number by people with mental illness, available numbers of individuals with mental illness or seeking services reached, including demographic and diagnostic breakdowns.</u> An example would be the number of individuals <u>with mental illness</u> who received training and education or who clicked on a web site.	Reject	Retain existing language with no change	<ol style="list-style-type: none"> <li>1. Stigma and Discrimination Reduction Programs and Suicide Prevention Programs are required by proposed section 3750(e) to measure a change in attitude, knowledge, or behavior that is relevant to the program. This could include a range of objective measures, depending on applicability to the specific program. The county must report this data in the Three-year PEI Program and Evaluation report per 3560.020. The information requested in this section, such as clicks on a web site, are optional <i>additions</i> to required outcome measures in 3560.020. See response to comment 8.53 on page 46 below.</li> <li>2. <u>Diagnostic breakdowns</u>: See responses to comment 3.03 on page 1 above, comment 3.04 on page 4 above and comment 3.32 on page 5 of the Matrix of Public Comment presented at the September 30, 2014 MHSOAC meeting.</li> </ol>
3560.010(b)	Commenter #8	<u>Comment 8.30</u> (12) For all programs. <u>the county must report steps taken to ensure that people receiving services meet the criteria of having a mental illness for which services are needed to prevent it from becoming severe and disabling, or have a serious mental illness for which treatment is needed to reduce it's untreated duration.</u>	Reject	Retain existing language with no change	Proposed PEI Regulations require that the County document both the basis and the process for determining a client's appropriateness for an Early Intervention Program: specifically, that he or she is manifesting early onset of a mental illness (3755(c)(1)(C)). See response to comment 3.03 on page 1 above.
3560.010(b) (1)-(b)(1)(A)(i)	Commenter #8	<u>Comment 8.21</u> (1) For each <u>Prevention and Early Intervention Program</u> , Prevention program and each Early Intervention program list: (A) Unduplicated numbers of individuals served annually (i) If a program <del>serves both individuals at risk of</del> <u>prevents</u>	Reject	Retain existing language with no change	<ol style="list-style-type: none"> <li>1. The comment uses different definitions than those used in Proposed PEI Regulations. Both Prevention and Early Intervention Programs prevent mental illnesses from becoming severe and disabling: Prevention Programs by intervening at the point of risk of developing a mental illness and Early Intervention Programs by responding early in the onset of a mental illness. Access and Linkage to Treatment and Improved Timely Access to Services</li> </ol>

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		<p><u>mental illness from becoming severe and disabling (Prevention) and individuals with early onset of reduces the duration of untreated severe mental illness or provides "Access and linkage to medically necessary care provided by county mental health programs for children with severe mental illness, as defined in Section 5600.3, and for adults and seniors with severe mental illness, as defined in Section 5600.3, as early in the onset of these conditions as practicable, (Early Intervention) a potentially serious mental illness, the County shall report numbers served separately for each category,</u></p>			<p>for Underserved Populations strategies, which are required for all PEI programs, are the principle means to reduce the duration of untreated mental illness by linking individuals with serious mental illness to treatment as early as possible in onset. See responses to comments 3.31 on page 1 and 8.03 on page 54 of the Matrix of Public Comment presented at the September 30, 2014 MHSOAC meeting.</p> <p>2. The information suggested to be added is already required in a different subdivision. See 3560.010(g). Counties are required to report numbers served separately for Prevention and Early Intervention programs and also to report both process (referrals) and outcome (results of referrals) data regarding Access and Linkage to Treatment for individuals with a severe mental illness for all PEI programs. Counties are required to report disaggregated data by various demographic categories, including age groups.</p>
3560.010(b) (2)	Commenter #6	<p><u>Comment 6.01</u> Please make specific mention of Family Law (mediators, courts, etc.) as potential responders -- they must be identified because families who are thrown into that system are highly fragile and vulnerable for emotional and mental distress. That arena is breeding ground for serious mental health conditions such as suicidal and homicidal ideation, substance abuse, anxiety and academic failure affecting children, extreme stress and depression for parents and extended family members. In the past, Family law has not been engaged and must</p>	Reject	Retain existing language with no change	MHSOAC voted at its August 28, 2014 meeting to change 3715(c) to add "family law practitioners such as mediators", to the list of examples of potential responders. The August 28 <sup>th</sup> changes will produce the effect requested by the comment.

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		<p>be targeted diligently to be potential responders.</p> <p>Also, for ethnic groups - CPS (Child Protective Services) and mandated reporting are basically unknown concepts and these responders must be sensitive to cultural values, roles, and practices and open to educating appropriately rather than rushing to convict.</p>			
3560.010(b)(3)(A) and (b)(3)(B)	Commenter #8	<p><u>Comment 8.22</u>  (3) For Access and Linkage to Treatment Strategy the County shall provide:</p> <p>(A) <del>Number</del> <u>Number and diagnosis by category of mental illness</u> of individuals with serious mental illness referred to treatment, and the kind of treatment to which the individual was referred.</p> <p>(B) Number of individuals <u>and diagnosis by category of those</u> 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.</p>	Reject	Retain existing language with no change	<u>Diagnosis:</u> See responses to comment 3.03 on page 1 above, comment 3.04 on page 4 above, and comment 8.26 on page 14 above.
3560.010(b)(3)(B)	Commenter #6	<p><u>Comment 6.02</u>  Referral and engagement need to be separated out because a person can follow thru and participate once; however, that does not mean that individual is yet engaged.  Engagement happens beyond the</p>	Reject	Retain existing language with no change	While participating once in the treatment to which a person is referred is not the same as engagement, reporting whether the person participated in at least once in treatment is a basic first step that is reasonable for counties to take in reporting outcomes of referrals to treatment. There is no valid agreed-upon way at this

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		first session and evolves with subsequent participation -- of at least 3 or more sessions.			point to measure “engagement” that would apply to the many variations of treatment.
3560.010(b)(4)(B)- b(4)(D)	Commenter #8	<p><u>Comment 8.23</u>  (B) Number of referrals <u>by diagnosis</u> of members of underserved populations to a Prevention program, an Early Intervention program and/or to treatment beyond early onset including kind of care that resulted from the outreach.  (C) Number of <del>individuals</del> <u>individuals</u>, <u>by diagnosis</u> who followed through on the referral, defined as the number of individuals who participated at least once in the program to which they were referred.  (D) Interval between <del>onset of risk indicators</del> <u>onset of risk indicators</u> and initial symptoms of a mental illness as self-reported or reported by a parent/family member or as identified by medical records and if applicable, <del>entry</del>, <u>entry</u> into treatment or services <del>of a Prevention program or an Early Intervention program.</del></p>	Accept in part	<p>Retain existing language with no change except as indicated by underlined (new language) or strikethrough (remove existing language):</p> <p>3560.010(b)(4)(D):  <del>Interval between onset of risk indicators and initial symptoms of a mental illness as self-reported or reported by a parent/family member or as identified by medical records and if applicable, entry into treatment or services of a Prevention program or an Early Intervention program.</del></p>	<ol style="list-style-type: none"> <li><u>Recommended change</u>: MHSOAC staff suggests eliminating the requirement to measure the interval between the onset of indication of risk of a mental illness and entry into services because of methodological issues. Estimating the onset of risk is too imprecise to constitute a useful basis for measuring improved timeliness of access for underserved populations. While it is possible to report estimated time of onset for a mental illness, onset of risk could have occurred prenatally or could be ongoing.</li> <li><u>Diagnoses</u>: See responses to comment 3.03 on page 1 above, comment 3.04 on page 4 above, and 8.26 on page 14 above.</li> </ol>
3560.010(b)(5)	Commenter #4, 5, 10, 11, 12, 16, 17, 22, 24, 27, 28, 37, 43, 46, 62, 69, 70, 72	<p><u>Comment 4.06, 5.05, 10.06, 11.06, 12.06, 16.06, 17.06, 22.06, 24.06, 27.06, 28.06, 37.07, 43.06, 46.06, 62.06, 69.06, 70.07, 72.07</u>  <b>Remove separate reporting of race and ethnicity and create consistency between current county reporting to the Client</b></p>	Reject	No change	Proposed PEI Regulations require disaggregation of data as essential to document progress toward reducing disparities in access to and outcomes of PEI-funded services. It is important that counties report demographic data using consistent categories in order to roll up data for statewide reporting, for a range of accountability and quality improvement purposes. All listed demographic categories are also included in at least one Federal reporting requirement and each

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		<p><b>Services Information (CSI) system and PEI reporting.</b></p>			<p>category has a populations in California above 100,000 according to 2010 census data. The MHSOAC worked with stakeholders to determine the list of the ethnicity categories and the specific additional non-race and ethnicity categories requested to be reported. MHSOAC staff is working with DHCS in its development of CSS and general reporting requirements, to ensure consistency for county reporting requirements regarding demographic data. The MHSA requires that “any regulations adopted by the department pursuant to Section 5898 shall be consistent with the commission’s regulations” (WIC 5846(b)).</p>
3560.010(b) (5)	Commenter #6	<p><u>Comment 6.03</u>  Although CBHDA has suggested that race and ethnicity not be separated, disaggregation is crucial to gather specific information about heritage of groups in order to move forward the reduction of disparities and craft targeted outreach:  (B) <b>Race</b> by the following categories:  (i) American Indian or Alaska Native  (ii) Asian (it would help to clarify that this <b>should not be based on geographical location</b>; i.e., it is unclear why Afghani and Iranian populations, as examples, identify racially as Asian, even though they are located in the Asian continent)  (iii) Black or African American  (iv) Native Hawaiian or other Pacific Islander  (v) White</p>	Reject	Retain existing language except as indicated by underlined (new language) or strikethrough (remove existing language):  (B) Race by the following categories: (i) American Indian or Alaska Native (ii) Asian (iii) Black or African American (iv) Native Hawaiian or other Pacific Islander (v) White (vi) Other (vii) <u>More than one race</u> (viii) <u>Declined to state</u>	<u>Recommended changes:</u> (1) <u>Adding, “other”, “more than one race”, and “declined to state”</u> : Because research demonstrates that not all individuals identify with the current federal race categories the recommendation is the additional category of “other.” The additional category of “declined to state” is added to account for individuals who declined to provide the requested information. Nationally, the population reporting more than one race grew from about 6.8 million in 2000, the first year that this reporting option was in provided, to 9.0 million people in 2010. In California five percent of the population identifies as being more than one race, approximately twice the rates as in the rest of the United States. (2) <u>Adding additional ethnicity categories</u> : The additional demographic categories are recommended because they are included in at least one Federal reporting requirement and each category has a populations in California above 100,000 according to 2010 census data. (3) <u>Sexual orientation</u> : subcategories of sexual orientation is recommended to encourage

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		<p>(vi) Other (specify _____)</p> <p>(C) Ethnicity by the following categories:</p> <p>(i) Hispanic or Latino as follows</p> <p>(a) Caribbean (specify _____)</p> <p>(b) Central American (specify _____)</p> <p>(c) Mexican</p> <p>(d) South American (specify _____)</p> <p>(e) Other (specify _____)</p> <p>(ii) Non-Hispanic or Non-Latino as follows</p> <p>(a) African (specify _____)</p> <p>(b) Cambodian</p> <p>(c) Chinese</p> <p>(d) Eastern European (specify _____)</p> <p>(e) European (specify _____)</p> <p>(f) Filipino</p> <p>(g) Japanese</p> <p>(h) Korean</p> <p>(i) Middle Eastern/Arabic background (specify _____)</p> <p>(j) Vietnamese</p> <p>(k) Other (specify; e.g., Iranian, Afghani, etc.)</p>		<p>(C) Ethnicity by the following categories:</p> <p>(i) Hispanic or Latino as follows</p> <p>(a) Caribbean</p> <p>(b) Central American</p> <p>(c) Mexican/Mexican-American/Chicano</p> <p>(d) Puerto Rican</p> <p>(e) South American</p> <p>(f) Other</p> <p>(g) Declined to state</p> <p>(ii) Non-Hispanic or Non-Latino as follows</p> <p>(a) African</p> <p>(b) Asian Indian/South Asian</p> <p>(c) Cambodian</p> <p>(d) Chinese</p> <p>(e) Eastern European</p> <p>(f) European</p> <p>(g) Filipino</p> <p>(h) Japanese</p> <p>(i) Korean</p> <p>(j) Middle Eastern</p> <p>(k) Vietnamese</p> <p>(l) Other</p> <p>(m) Declined to state</p>	<p>standardized reporting across counties which will facilitate data aggregation statewide. These subcategories are not intended to be inclusive of all possibilities. They will provide a basic estimate of the number of individuals served by PEI programs whose non-heterosexual sexual orientation might be the basis of oppression, discrimination, and other trauma that has been associated with greater than average risk of developing a mental illness and negative consequences associated with experiencing a mental illness.</p> <p>(4) <u>Disability, Veteran and Gender</u>: the additional subcategories provide for standardized reporting.</p> <p><u>Reject</u>: Adding additional requirements regarding how individuals determine the appropriate demographic categories, such as specifying that the category should not be based on geographical location, is a level of detail best left to the individual respondent.</p> <p>Adding sub-categories more detailed than those specified would provide information that could be useful locally, but would likely pose a burden for counties and respondents in which the categories are not applicable. Both for consistency with federal reporting requirements and because of current statewide demographic patterns, suggested categories appear to be sufficient and strike a reasonable balance. As local and statewide data capacities develop, it is very likely that there will be additional reporting and evaluation requirements, including the possibility of tracking additional demographic categories. The MHSOAC will collaborate with counties, people at risk of and with mental illness and their family members, representatives of diverse underserved communities, other State departments, and other interested stakeholders, to assess priorities and best uses of additional program and evaluation data for possible future amendments to the PEI Regulations.</p>

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				<ul style="list-style-type: none"> <li>(iii) <u>More than one ethnicity</u></li> <li>(iv) <u>Declined to state</u></li> <li>(D) Primary language spoken <u>used</u> listed by threshold languages for the individual county</li> <li>(E) Sexual orientation <ul style="list-style-type: none"> <li>(i) <u>Gay, Lesbian or Bisexual</u></li> <li>(ii) <u>Heterosexual</u></li> <li>(iii) <u>Other</u></li> <li>(iv) <u>Declined to state</u></li> </ul> </li> <li>(F) Disability, if any, <u>which is not a result of a severe mental illness</u></li> <li>(G) Veteran status, <ul style="list-style-type: none"> <li>(i) <u>Yes</u></li> <li>(ii) <u>No</u></li> <li>(iii) <u>Declined to state</u></li> </ul> </li> <li>(H) Gender identity, <ul style="list-style-type: none"> <li>(i) <u>Male</u></li> <li>(ii) <u>Female</u></li> <li>(iii) <u>Transgender</u></li> <li>(iv) <u>Other</u></li> <li>(v) <u>Declined to state</u></li> </ul> </li> </ul>	

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3560.010(b) (5)	Commenter #8	<u>Comment 8.27 (8)</u> For the information reported under subdivisions (1) through (4 <u>7</u> ) of this section, disaggregate numbers served, number of potential responders engaged, and number of referrals for treatment and other services by: (I) Diagnostic categories (i.e., psychotic illness. severe major depression. severe bipolar disorder. other)	Reject	Retain existing language with no change	See responses to comments 3.03 on page 1 above and 3.04 on page 4 above.
3560.010(b) (5)	Commenter #70	<u>Comment 70.08</u> In order to provide consistent and meaningful demographic data, please consider: <ul style="list-style-type: none"> <li>• Including "Multi-Racial" in the race categories. In the absence of that option, individuals may not respond to the question or check more than one category, leading to challenges in aggregating the data.</li> <li>• Providing clear definitions of "Homeless" and "Disabled" that are consistent with current county reporting requirements.</li> </ul>	Accept: include "multi-racial"  Reject: Add definitions	<u>Multi-racial</u> : Same change listed in response to comment 6.03 above on pages 22 -24.  Add new sub-category:  (vii) <u>More than one race</u>	1. <u>Adding Multi-racial category</u> : Without a specific category, it is impossible to estimate the number of individuals served by PEI programs who identify as multi-racial. Nationally, the population reporting more than one race grew from about 6.8 million in 2000, the first year that the reporting option was provided, to 9.0 million people in 2010. In California, five percent of the population identifies as being of more than one race, approximately twice the rate as in the rest of the United States. For all of these reasons, adding this reporting category makes sense. 2. <u>Definitions of "homeless" and "disabled"</u> These definitions are not unique to PEI regulations and should be part of the general MHSA regulations, for which the Department of Healthcare Services has responsibility. See response to comment 6.03 on page 20 that suggests a clarification that "disabled" refers to a disability not resulting from a serious mental illness and request.
3560.010(b) (5)	Commenter #71	<u>Comment 71.02</u> With regard to the expanded reporting of race/ethnicity I have 2 comments.	Accept in part.	Same changes in response to comment 6.03 on page 20.	1. <u>Expansion of categories</u> : The recommendation is to add three additional subcategories under ethnicity that meet the following criteria: the category is listed in at least one Federal reporting requirement

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		<p>1. This is a needed expansion, but still needs work – In particular I note the complete absence of “South Asians.” There is a very large community of such people in California and they see, to be routinely ignored in mental health. Also Middle Easterner seems vague – is this people from the Levant only? Or people (culturally related) from North Africa or Iran?</p> <p>2. I agree with CBHDA that there should be consistency with CSS/CSI, but is this effort (or its ultimate variant) that should set the standard.</p> <p>However, given the difficulty of different reporting categories for different programs, it is an open question as to whether <u>these</u> regs at <u>this</u> time are the most effective venue for such a change.</p>			<p>and has populations in California above 100,000 according to 2010 census data. South Asians is one of those three that are recommended to be added because it meets the criteria. See response to comment 6.03 on page 20.</p> <p>2. <u>Consistency with CSS/CSI</u>: The MHSOAC is committed to work collaboratively with other state departments including DHCS. In addition, MHSOAC requires that “any regulations adopted by the department pursuant to Section 5898 shall be consistent with the commission’s regulations” (WIC 5846(b)).</p>
3560.010(b)(5)(A)-(b)(5)(H)	Commenter #32	<p><u>Comment 32.03</u>  <b><u>2. Recommendation: Section 3560.010(b)(5)(A)-3560.010(b)(5)(H). Annual Prevention and Early Intervention Report.</u></b></p> <p><b>We strongly support Section 3560.010(b)(5)(A)- 3560.010(b)(5)(H) published in the Notice of June 6th, 2014 by the MHSOAC.</b></p> <p>Proposed regulations lay out promising steps towards the effective disaggregation of data to reflect race,</p>	No action proposed	Same changes as in response to comment 6.03 on page 20	See response to comment 6.03 on page 20 above.

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		<p>ethnicity, disability, sexual orientation and gender identity, among others, and lay the ground work for improved data collection and reporting by the counties.</p> <p>Collecting this data is essential to measure how gaps in services are being effectively addressed over time, and where the most significant inequities remain.</p> <p>Reverting data collection of race and ethnicity, among others, to align with current (or outdated) reporting systems, such as the Client Services Information (CSI) systems, will result in the loss of invaluable information and curtail the potential effectiveness of tracking PEI outcomes in general.</p>			
3560.010(b) (5)(A)- (b)(5)(H)	Commenter #74	<p><u>Comment 74.02</u> <b>REMHDCO strongly supports the language as proposed by the MHSOAC</b></p> <p>One of the strong themes supported in many of the Special Populations reports of the California Reducing Disparities Project is that the counties must begin collecting more data, especially disaggregated data on underserved racial and ethnic communities. It is not enough to collect minimum demographic data in order to analyze and improve upon mental health disparities.</p>	No action proposed	Same changes as in response to comment 6.03 on page 20	See response to comment 6.03 on page 20 above.

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		<p>We hear from our local REMHDCO members that when they ask for services targeted and tailored toward their specific underserved community, they are often told that “you must show a need and we do not have adequate data on your community to really know whether there is a need or not...” Unless this section is adopted as proposed by the OAC and counties begin collecting more specific, disaggregated data, these underserved communities are going to be in a “Catch- 22” situation. That is, they cannot get services for their communities due to lack of data –but then the counties are declining to collect the data.</p>			
3560.010(b) (5)(B)(v)	Commenter #36	<p><u>Comment 36.02</u> <b>Section 3560.010, subdivision (5) (B) (v)</b></p> <p><b>Recommendation:</b> Specify identity options to enable a disaggregation of Middle Easterners and Eastern Europeans from the ‘white’ category.</p> <p><b>Rationale:</b> The lack of reliable count for Middle Easterners and Eastern Europeans continues to lead to a significant undercount of these communities, creating barriers to many basic rights and services.</p>	Reject	Retain existing language with no change	These categories do not meet the criteria. See response to comment 71.02 on page 23 above.
3560.010(b) (5)(C)(ii)	Commenter #36	<p><u>Comment 36.03</u> <b>Section 3560.010, subdivision (5) (C) (ii)</b></p>	Reject	Retain existing language with no change	These categories do not meet the criteria. See response to comment 71.02 on page 23 above.

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		<p><b>Recommendation:</b> Add Native Hawaiian, Guamanian or Chamorro, Samoan, Pacific Islander, Polynesian (Tahitian, Tongan, and Tokelauan), Micronesian (Marshallese, Palauan, and Chuukese), and Melanesian (Fijian, Guinean, and Solomon Islander) to ensure accurate population counts.</p> <p><b>Rationale:</b> Harmonize local, county, state and federal methodology in counting Native Hawaiians and Pacific Islanders. The Office of Management and Budget uses the term “Native Hawaiian or Other Pacific Islander” to refer to a person having origins in Hawaii, Guam, Samoa, or other Pacific Islands. To ensure accurate population counts of this group, we recommend adding Native Hawaiian, Guamanian, or Chamorro, Samoan, Pacific Islander, Polynesian (Tahitian, Tongan, and Tokelauan), Micronesian (Marshallese, Palauan, and Chuukese), and Melanesian ( Fijian, Guinean, and Solomon Islander).</p>			
3560.010(b) (5)(C)(ii)(a)	Commenter #36	<p><u>Comment 36.04</u> <b>Section 3560.010, subdivision (5) (C) (ii) (a)</b></p> <p><b>Recommendation:</b> Expand to include a broader listing of self-identified ethnicity as listed in the California Reducing Disparities Project African American SPW report (pp.149): American Indian Black;</p>	Reject	Retain existing language with no change	See response to comment 71.02 on page 23 above.

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		<p>Black French; Black Irish; Black Filipino, Ugandan, Nigerian, Kenyan, Burundian, Sudanese, Ethiopian, Jamaican, Dominican, and Eritrean.</p> <p><i>Rationale:</i> We need more meaningful identification for those who identify their ethnicity as African.</p>			
3560.010(b)(5)(I)	Commenter #36	<p><u>Comment 36.05</u>  <b>Section 3560.010, subdivision (5) (I)</b></p> <p><b>Recommendation:</b> Include the Deaf and Hard-of-Hearing.</p> <p><i>Rationale:</i> The regulations need to help ensure equal access for the deaf and hard of hearing communities to the same opportunities afforded their hearing counterparts. We recommend that the collection of demographic data enable the disaggregation of Deaf and Hard-of-Hearing persons -- a culture infused with its own language, heritage, and mental health needs.</p>	Accept in part	<p>Amend subdivision as follows:</p> <p>(D)Primary language <del>spoken</del> <u>used</u> listed by threshold languages for the individual county</p>	<p><u>Recommended change:</u> reporting language in 3560.010(b)5(D) and 3755(c)1(A) to include non-spoken language.</p> <p>The deaf and hard-of-hearing are included under the reporting requirement of “Disability” in subdivision (b)(5)(F) of section 3560.010. See response to comment 71.02 on page 23 above.</p>
3560.020(a)	Commenter #8	<p><u>Comment 8.31</u>  (a) The County shall submit the Three-Year Evaluation Report to the Mental Health Services Oversight and Accountability Commission every three years as part of the Three-Year Program and Expenditure Plan. The Three-Year Evaluation Report answers questions about the impacts of Prevention and Early Intervention component programs on individuals with <u>risk mental</u></p>	Reject	Retain existing language with no change	<p>Intervening at the point of risk of a potentially serious mental illness is the required focus of a Prevention Program, which is part of the Three-Year Evaluation Report. Deleting “risk” would eliminate reporting on Prevention Programs.</p> <p>The MHSA refers specifically to “prevention and intervention programs” (WIC 5840(e) and (f)) and to “prevention services” combined with “a full range of integrated services” (uncodified Section 2(d) of MHSA, Findings and Declarations), successful programs “including prevention” (uncodified Section 2(e) Findings</p>

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		<u>illness</u> or early onset of serious mental illness and on the mental health and related systems.			and Declarations), and “prevention and early intervention services” (uncodified Section 3(a) Purpose and Intent), suggesting that the intention is to offer both kinds of services.
3560.020(b)	Commenter #8	<u>Comment 8.32</u> (b) The Three-Year Evaluation Report shall describe the evaluation of each <u>Prevention and Early Intervention Program or Component</u> program and strategy, including approaches used to select <u>recipients</u> , outcomes and indicators, collect data, and determine results, and how often the data were collected	Reject	Retain existing language with no change	<ol style="list-style-type: none"> <li>1. The comment is using different definitions than those used in the Proposed PEI Regulations. The PEI Component refers to “the section of the Three-Year Program and Expenditure Plan intended to prevent mental illnesses from becoming severe and disabling” (3200.245(a)) and as such already includes all of the programs.</li> <li>2. Counties are required to specify the approaches used to select appropriate recipients of Prevention and Early Intervention programs in a different section. See proposed section 3755(c)(1)(C) and 3755(d)(1)(B)). See response to comment 3.03 on page 1 above.</li> </ol>
3750	Commenter #1	<u>Comment 1.02</u> Please amend the regulations so they measure outcomes, not just process. Agencies and the counties that contract to them should be client-focused and results-oriented in providing services to seriously mentally ill clients. Regulations should require counties to measure and report on the number of people with serious mental illness who were arrested incarcerated, hospitalized, were victimized (beaten, killed, robbed) committed suicide or are homeless as well as the progress and degrees of recovery clients have obtained through these services.  Due to agency shortcomings, my son's decompensation was neglected	Reject	Amend the name of the annual and the three year reports as follows:  3560.010. Annual <u>Program and Evaluation</u> Report  3560.020. Three-Year <u>Program and Evaluation</u> Report	<u>Recommended change:</u> re-name the Annual and the Three-Year Evaluation Reports to make it clear that while the Three-Year Report is the primary vehicle for counties to report evaluation data, both the Annual Report and the Three-Year Report include both program (process) and evaluation (outcome) data.  The proposed regulation in section 3750 does require specific outcome measures, in addition to program or process data, for all PEI programs. In addition, sections 3560.010 and 3560.020 require reporting of those outcomes measures. Specifically: (a) Prevention and Early Intervention Programs are required to report on applicable WIC 5840(d) outcomes including direct mental health outcomes (reduction of prolonged suffering); (b) Outreach for Increasing Recognition of Early Signs of Mental Illness Programs are required to measure the number of responders reached and their settings; (c) Suicide Prevention and Stigma and Discrimination Reduction Programs are required to

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		<p>and ignored, and he was homeless and then imprisoned over the course of a year. That's one year's loss of brain function, when in fact, his therapy should have been attending to rebuilding brain function. Agencies and counties should be held accountable, for our tax moneys are entrusted to them, and such neglect violates the contracts and our trust. Only by measuring those outcomes can we know if funds are spent effectively. Measures being proposed by you (number of clicks on a website, number of presentations made, etc.) are merely process measures, not measures of progress. They allow failed programs to continue receiving funds.</p>			<p>measure applicable changes in attitude, knowledge, and behavior of the intended target audience or group; and (d) Access and Linkage to Treatment Programs and Improving Timely Access to Services for Underserved Population Programs are required to report the number of referred individuals who followed through by engaging at least once in the treatment or, for underserved populations, Prevention Program, to which they were referred as well as the reduction in the duration of untreated mental illness.</p>
3750	<p>Commentesr #4, 10, 11, 12, 16, 17, 22, 24, 27, 28, 37, 43, 46, 62, 69, 70, 72</p>	<p><u>Comments 4.02, 10.02, 11.02, 12.02, 16.02, 17.02, 22.02, 24.02, 27.02, 28.02, 37.03, 43.02, 46.02, 62.02, 69.02, 70.03, 72.03</u>  <b>Promote small county compliance with new and complex standards.</b>  Initial MHSOAC PEI guidelines to counties exempted the smallest counties (with populations under 100,000) from evaluation, recognizing the significant complexity of the evaluation process and the learning curve counties will encounter in meeting its requirements. Going forward, CBHDA strongly recommends giving small counties a one-year extension to comply with the</p>	Accept	<p>Change existing language indicated by underlined (new language) or strikethrough (remove existing language):</p> <p>3750: new subsection (k): <u>Counties with population under 100,000, according to the most recent projection by the California State Department of Finance, are exempt from evaluation requirements for one</u></p>	<p>Counties with populations under 100,000 typically have fewer resources, staff, and infrastructure than larger counties. Providing these counties with an extra year to develop or pool resources to meet evaluation requirements is a reasonable accommodation.</p>

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		<p>evaluation standards and/or to pursue regional evaluation strategies.</p> <p><b>Recommendation:</b> Section 3750. Prevention and Early Intervention Program Evaluation. Add the following language: <i>Small counties, under 100,000 in population, are exempt from evaluation requirements for one year after final adoption of the PEI regulations.</i></p>		<p><u>year from the date that the PEI Regulations go into effect.</u></p>	
3750	Commenter #8	<p><u>Comment 8.07</u> The regulators fail to "require reports on the achievement of performance outcomes" (i.e, measure 'progress', like number of suicides, number of people homeless, number incarcerated) and instead rely solely on "process" indicators (like how many people clicked on a web site, amount of money spent, etc.)</p>	Reject	<p>Change existing language indicated by underlined (new language) or strikethrough (remove existing language):</p> <p>3750(b):</p> <p>For each Prevention program the County shall measure the reduction of prolonged suffering as referenced in Welfare and Institutions Code Section 5840, subdivision (d) that may result from untreated mental illness by measuring a reduction in risk factors/<u>indicators</u> and/or increased protective factors that may lead to improved mental, emotional,</p>	<p><u>Recommended change:</u> The addition of "indicators" is essential because some risk factors (e.g. prenatal exposure to toxins, exposure to trauma, genetic factors) cannot be changed; in these instances, it is the indicator of risk that the County intends to reduce and measure (e.g. sub-clinical symptoms of mental health problems, such as depression and anxiety, that interfere with a person's cognitive, emotional, relational, or social activities to a lesser extent than a mental illness). In other instances, the program might intend to reduce the actual risk factor such as bullying or family conflict. In all instances, the measurement of direct mental health indicators of reduced risk factors and/or increased protective factors are required for Prevention Programs.</p> <p><u>Reporting of outcomes:</u> Proposed PEI Regulations require both program (process) data and outcomes for all PEI programs. Counties are required to measure MHSA outcomes for all PEI programs and for the required strategies to Improve Timely Access to Services for Underserved Populations and to Increase Access to Treatment for individuals with a severe mental illness. Counties are required to report on direct mental health outcomes (reduction of prolonged suffering) and all other applicable MHSA outcomes in 5840(d) for Prevention and all Early Intervention</p>

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				and relational functioning.	programs. See responses to comment 1.02 on page 29 above, comment 8.28 on page 15 above, and comment 8.29 on page 16 above.
3750	Commenter #8	<p><u>Comment 8.17</u>  <u>The regulations fail to ensure the funds achieve legislatively mandated goals.</u>  The Findings and Declarations from which all the other provisions of the act derive, state that the object of the legislation is to address the fact that</p> <p style="padding-left: 40px;">"Many people left untreated or with insufficient care see their mental illness worsen.... (and) many become homeless and are subject to frequent hospitalizations or jail."</p> <p>These goals are also specifically stated in PEI Section.</p> <p>The program shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness: (1) Suicide. (2) Incarcerations. (3) School failure or dropout. (4) Unemployment. (5) Prolonged suffering. (6) Homelessness. (7) Removal of children from their homes.(5840 (d))</p> <p>In spite of this clear direction, the regulations fail to require counties to measure rates of homelessness, rates of hospitalizations, or number of people incarcerated who have serious</p>	Reject	Retain existing language with no change	See responses to comment 1.02 on page 29 above, comment 8.07 on page 31 above, comment 8.28 on page 15 above, and comment 8.29 on page 16 above.

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		<p>mental illness. Rather than focusing on the <i>outcomes</i> the regulations focus exclusively on the <i>process</i>. As a result, regulators will have no idea if the programs are serving the intended target or not, and therefore can not determine if they were successful or not. They can only determine that money was spent. The regulators have disingenuously chosen to measure process, rather than progress. A county with increasing rates of suicide, homelessness, arrest, incarceration, school drop out, will not be called to account for their failure.</p>			
3750 and 3560.010	Commenter #9	<p><u>Comment 9.01</u> I am writing to submit a public comment on the Notice of Proposed Prevention and Early Intervention Regulations. I serve as an evaluator for a very successful PEI prevention project. Staff on this project have worked conscientiously to collect and interpret both required data and data that will improve services.</p> <p>The proposed PEI regulations outline data collection requirements that will dissuade participation in data collection activities. Already our project asks many questions regarding individuals' status. Too many questions makes it difficult for staff to establish a productive relationship with program participants.</p>	Accept in part	<p>Retain existing language with no change except:</p> <p>Add a new subcategory to all of the demographic reporting requirements in 3560.010(b)(5)</p> <p>Add new subcategory: <u>Declined to state</u></p>	<p>There is a need to balance the requirement to measure essential MHSA goals, such as the reduction of the duration of untreated mental illness and the need to provide culturally and linguistically competent services in order to reduce well documented disparities in mental health access and outcomes, with the need for evaluation requirements that are reasonable both for counties/practitioners and clients. The Proposed PEI Regulations, in consultation with a very broad array of contributors and stakeholders, offer a balanced approach.</p> <ol style="list-style-type: none"> <li>1. Demographic data: the additional "declined to state" category provides more flexibility for respondents who are unable or unwilling to provide the requested information and for standardized reporting</li> <li>2. Measuring duration of untreated mental illness: See response to comments 4.03, 10.03, 11.03, 12.03, 16.03, 17.03, 22.03, 24.03, 27.03, 28.03, 37.04,</li> </ol>

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		<p>For example, I would suggest reducing the Ethnicity data question to Hispanic/Non-Hispanic and then adding the specific ethnicities that the project is targeting, rather than a list of 14 possible ethnicities with which people may or may not identify. Several other data points may be problematic to collect. For some projects, it will be difficult for participants to identify information such as the duration of the untreated mental illness; the interval between the onset of risk indicators and initial symptoms; total numbers of individual family members served (depending on how family is defined); and increased protective factors.</p> <p>While I laud your intent to improve performance assessment, it is important to target data collection and/or increase evaluation resources. To comply with the proposed data collection requirements more staff time will be needed, reducing the time spent on direct services to those at risk of mental illness. For data that needs to be collected at the onset of services, additional funding should be allotted to programs for this effort, both to collect and to analyze the data. For prevention programs, the use of an evidence-based or promising practice should ameliorate the need to collect data regarding increased protective factors, as this</p>			<p>43.03, 46.03, 62.03, 69.03, 70.04, 72.04 on page 47 below.</p> <ol style="list-style-type: none"> <li>3. Family members: Counties are encouraged to facilitate, respect, and accept individuals' and families' own definitions of family. Such an approach is crucial to culturally competent and client- and family-centered practice, all of which are required by the MHSA for all programs, including PEI.</li> <li>4. Protective factors: Proposed PEI Regulations require counties to measure indicators of direct mental health outcomes (reduction of prolonged suffering as indicated by reduced risk factors and/or increased protective factors (3750(b))) and other applicable MHSA outcomes (WIC 5840(d)) that apply to the specific program (3750(c)). There is no narrow requirement to measure "protective factors" in any particular way, but flexibility to measure changes in relevant protective factors, such as increased positive social support, improved coping skills, increased physical activity, or better nutrition.</li> <li>5. While all PEI programs and strategies are required to use approaches that have demonstrated their effectiveness, this requirement does not substitute for the MHSA requirement in WIC 5848(c) to measure outcomes for all PEI programs.</li> </ol>

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		can be extrapolated from the research base.			
3750 and 3560.010	Commenter #14	<p><u>Comment 14.01</u> Please amend the regulations so they measure outcomes, not just process. Regulations should require counties to measure and report on the number of people with serious mental illness who were arrested incarcerated, hospitalized, were victimized (beaten, killed, robbed) committed suicide or are homeless. Only by measuring those outcomes can we know if funds are spent effectively. Measures being proposed by you (number of clicks on a website, number of presentations made, etc.) are merely process measures, not measures of progress. They allow failed programs to continue receiving funds.</p> <p>Please amend the regulations so counties limit PEI funded services to people with serious mental illness or have mental illness but need services to prevent it from becoming severe and disabling.</p>	Reject	Retain existing language with no change	<ol style="list-style-type: none"> <li>1. <u>Require outcomes</u>: See responses to comment 1.02 on page 29 above, comment 8.07 on page 31 above, comment 8.28 on page 15 above, and comment 8.29 on page 16 above.</li> <li>2. <u>Serious mental illness</u>: See response to comment 3.03 on page 1 above.</li> </ol>
3750 and 3560.010	Commenter #15	<p><u>Comment 15.02</u> Please amend the regulations so they assess outcomes. Although some continue to cite how successful county programs are, there is little evidence of most of this. We need studies to measure programs. Many of our current programs simply are not helping our most severely ill and</p>	Reject	Retain existing language with no change	<u>Require outcomes</u> : See responses to comment 1.02 on page 29 above, comment 8.07 on page 31 above, comment 8.28 on page 15 above, and comment 8.29 on page 16 above.

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		<p>this is a terrible waste of funds and harms many.</p> <p>Regulations should require counties to measure and report on the outcome of services to those with serious mental illness who were arrested and incarcerated, hospitalized, victimized (beaten, killed, and robbed) , committed suicide, or who live mentally ill and homeless on our streets. Only by measuring outcomes can we determine whether these funds are spent effectively and whether they are helping those that MHPA funds were intended for. Measures currently being proposed by you (<i>number of clicks on a website, number of presentations made, etc.</i>) are merely process measures and are not factual measures of progress. They allow failed programs to continue at great financial and personal cost while other programs that might help our most ill never get enacted.</p>			
3750 and 3560.010	Commenter #18	<p><u>Comment 18.01</u> As a psychotherapist I have used Dr. Scott Miller's outcomes measurements as a way of demonstrating that what I say I do is actually indeed what I am doing. And, that what I am doing in a private practitioners office is making the difference I say it is. I owe that to the public, to insurance companies</p>	Reject	Retain existing language with no change	<p><u>Require outcomes:</u> See responses to comment 1.02 on page 29 above, comment 8.07 on page 31 above, comment 8.28 on page 15 above, and comment 8.29 on page 16 above.</p> <p>MHSOAC staff agrees that requirements in Proposed PEI Regulations to measure outcomes must be supplemented with technical assistance and support for high quality programs and evaluations.</p>

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		<p>paying the bills and to regulators of our profession.</p> <p>Please amend the regulations so they measure <i>actual outcomes</i>, not just process. Regulations should require counties to <b>measure and report on the number of people with serious mental illness who were arrested incarcerated, hospitalized, were victimized (beaten, killed, robbed) committed suicide or are homeless</b>. Only by measuring those outcomes can we know if funds are spent effectively. Measures being proposed by you (i.e., number of clicks on a website, number of presentations made, etc.) are merely process measures, not measures of progress. They allow failed programs to continue receiving funds. <b>THIS MUST END.</b></p> <p>I have lived for 18 years seeking treatment for my son. He was homeless and very ill for 14 of those years, unable to seek treatment of any kind due to the severity of his illness, let alone receive actual "services." Yet the county continued to project "successful" programs by the numbers of people who didn't return to the hospital. Just because you can remain homeless and under the radar of police - doesn't mean the county is successfully using their funds! Sitting in these meetings listening to inaccurate reporting</p>			

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		leaves us as advocating parents raw with heart break, a profound sense of powerlessness and rage that programs can be allowed to taut outcomes that they don't even know HOW to measure, let alone actually are measuring !			
3750 and 3560.010	Commenter #19	<u>Comment 19.02</u> Regulations should require counties to measure and report on the number of people with serious mental illness who were arrested incarcerated, hospitalized, were victimized (beaten, killed, robbed) committed suicide or are homeless. The proposed measures, including number of clicks on a website, number of presentations made, etc. merely measure processes, they are not measures of progress. Please amend the regulations so they measure outcomes.	Reject	Retain existing language with no change	<u>Require outcomes:</u> See responses to comment 1.02 on page 29 above, comment 8.07 on page 31 above, comment 8.28 on page 15 above, and comment 8.29 on page 16 above.
3750 and 3560.010	Commenter #20	<u>Comment 20.01</u> Please amend the regulations so they measure outcomes, not just process. Regulations should require counties to measure and report on the number of people with SMI who were arrested, incarcerated, hospitalized, were victimized (beaten, killed, robbed) committed suicide, or homeless. Only by measuring those outcomes can we know if funds are spent effectively. Measures being proposed by you (number of clicks on a website, number of presentations made, etc.) are merely process	Reject	Retain existing language with no change	<u>Require outcomes:</u> See responses to comment 1.02 on page 29 above, comment 8.07 on page 31 above, comment 8.28 on page 15 above, and comment 8.29 on page 16 above.

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		measures, not measures of progress. They allow failed programs to continue receiving funds.			
3750 and 3560.010	Commenter #33	<p><u>Comment 33.02</u>  <b>PEI Evaluation</b>            In its expanded role, the MHSOAC is assigned new tasks in the areas of technical assistance and evaluation and to work in close collaboration with State Department of Health Care Services (DHCS), the California Mental Health Planning Council (CMHPC), and in consultation with California Behavioral Health Directors Association (CBHDA), to design a comprehensive joint plan for a coordinated evaluation of client outcomes in the community-based mental health system. (W&amp;I Sections 5845 and 5846). Although the proposed regulations include PEI outcomes language and description of how to collect baseline data, the regulations do not provide a clear pathway for the measuring and achievement of outcome (changes: increase or decrease /reduction) over time.</p> <p><b>Recommendations:</b>            Since the clear intent of the MHSA is to ensure that services are provided in accordance with best practices in programs that are subject to local and state oversight so as to ensure accountability to taxpayers and the public. CSPC understands that the current measures are ‘baby steps’</p>	Reject	Retain existing language with no change	<ol style="list-style-type: none"> <li>1. Because of the vast variations in the PEI programs, requiring standardized methods for measuring and achieving the outcomes is not feasible or practicable. Proposed PEI Regulations’ evaluation requirements are basic in recognition of the limited data infrastructure, resources, and capacities of many counties. As evaluation capacity develops both for counties and State agencies, it is very likely that there will be additional reporting and evaluation requirements for future amendments to PEI Regulations. MHSOAC will collaborate with people at risk of and with serious mental illness and their family members, representatives of diverse underserved communities, counties, practitioners, other State Departments, and interested stakeholders to assess priorities and recommend next steps for increasing and improving evaluation requirements in PEI Regulations. This work is also consistent with the MHSA requirement (5848(c)) to work collaboratively to develop an integrated performance outcomes system.</li> <li>2. Proposed PEI Regulations require counties to use practices that have demonstrated their effectiveness to bring about intended MHSA outcomes for the intended population (3735(c)(4)). Technical assistance and other kinds of support can assist counties both to identify and utilize practices that have demonstrated their effectiveness for specific PEI goals and intended outcomes and to evaluate their programs most effectively and consistent with ways developed and recommended by evidence-based practices.</li> </ol>

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		<p>which have never been mandated before. However, the proposed regulations in addition to the proposed outcomes should include clear requirements and a pathway for the measure and achievement of the corresponding target outcomes specific to the various Evidence Based Practice (EBP), Emerging Practices (EP), and Community Informed Practices (CIP) utilized various counties to demonstrate program/system effectiveness in meeting the needs of the PEI target population and the effective and efficient utilization of funds.</p>			
3750 and 3560.010	Commenter #34	<p><u>Comment 34.01</u> I am becoming aware of certain things in regard to funding for mental illness. In regard to the Prevention and Early Intervention Regulations being considered I would ask that you amend those regulations so they measure outcomes, not just process. Only by measuring and reporting the number of people with serious mental illness who were arrested, hospitalized, were victimized , committed suicide like my son or are homeless can we know if funds are spent effectively. I am to understand that the measures being proposed by you are merely process measures, not measures of progress. They probably allow failed programs to continue receiving funds.</p>	Reject	Retain existing language with no change	See responses to comment 1.02 on page 29 above, comment 8.07 on page 31 above, comment 8.28 on page 15 above, and comment 8.29 on page 16 above.

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3750 and 3560.010	Comment #35	<p><u>Comment 35.02</u>  <b>Outcomes and Evaluations:</b> The Alliance supports the efforts for data collection and program evaluation of PEI projects throughout California. However, the proposed 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.</p> <p><b>Recommendation A:</b> 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.</p> <p><b>Recommendation B:</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.</p>	Reject	Retain existing language with no change	<ol style="list-style-type: none"> <li>1. <u>Quality improvement and integrated data collection:</u> The evaluations required in proposed PEI Regulations are intended to serve various purposes, of which one of the most important is quality improvement, in addition to communication and accountability. While there are no mandated specific approaches to utilizing evaluation results for quality improvement purposes, the best ways to accomplish this goal are appropriate areas of focus for training and technical assistance and not mandates in regulations. MHSOAC is fully committed to a collaborative and integrated approach to data collection, evaluation, and reporting wherever possible.</li> <li>2. <u>Defined evaluation criteria:</u> Proposed PEI Regulations strive to balance consistency with all MHSA requirements and rigorous evaluation with necessary flexibility for the broad range of counties' PEI programs. MHSOAC staff believes that at this time it is inappropriate to mandate specific outcomes, indicators, criteria, etc. Such specifications, developed collaboratively with counties and stakeholders, including diverse clients and family members, and mindful of other evaluation and reporting requirements, are possible options for possible future amendments to PEI Regulations and also are appropriate and essential areas of focus for training and technical assistance.</li> <li>3. <u>Cultural focus in defining parameters of duration of untreated mental illness:</u> The cultural competency general standard in the current MHSA regulations would apply, meaning that the client's or family member's conception of when the mental illness began would, in the absence of medical records, would be considered definitive.</li> <li>4. <u>Demographic data:</u> The definition of transition-age to mean youth 16 years to 25 years of age youth is in Title 9 of California Code of Regulations Section</li> </ol>

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		<p><b>Recommendation C:</b> 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 these sections which recognize cultural specific terms which describe mental health symptoms and risk factors.</p> <p><b>Recommendation D:</b> The California Alliance supports Section 3510.010 (a)(5) 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>			3200.280 and in WIC Section 5847(c). With regard to expanded demographic reporting categories, see response to comment 71.02 on page 23.
3750 and 3560.010	Commenter #38	<p><u>Comment 38.01</u> Evaluation and reporting is essential to demonstrating the success of the programs, and we recognize and respect the effort that has been made to capture the outcomes. Overall, we feel that any reporting requirements should be congruent and consistent with existing reporting requirements such as those for Consumer Services Information.</p>	Reject	Retain existing language with no change	MHSOAC is fully committed to a collaborative and integrated approach to data collection, evaluation, and reporting to the fullest extent possible. However, in some instances, the differences between PEI and CSS make complete consistency impossible.
3750(a)	Commenter #8	<p><u>Comment 8.49</u> (a) For each Early Intervention program and <u>Prevention and Early Intervention Program</u> the County shall</p>	Reject	Retain existing language with no change	1. There is no separate category for a Prevention and Early Intervention Program. Requirements for a combined program are clearly articulated and require the County to report separate outcomes for

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		<p>evaluate the reduction of prolonged suffering as referenced in Welfare and Institutions Code Section 5840, subdivision (d) that may result from untreated mental illness by measuring reduced symptoms and/or improved recovery, including mental, emotional, and relational functioning. The County shall <u>measure number of people with mental illness who committed suicide, number of people with severe mental illness who were provided housing, number of people with mental illness unhoused, and number of mentally ill arrested and/or incarcerated.</u> The County may select, define, and measure <u>other</u> appropriate indicators that are applicable to the program.</p>			<p>individuals at risk of a mental illness and for individuals with early onset of a mental illness, both of which require reporting direct mental health outcomes (reduction of prolonged suffering).</p> <p>2. Proposed PEI Regulations require the measurement of the reduction of prolonged suffering for all Early Intervention Programs as measuring “reduced symptoms and/or improved recovery, including mental, emotional, and relational functioning.” The County is required to “select, define, and measure appropriate indicators that are applicable to the program” (3750(b)). In addition, the County will designate any of the MHSAs PEI negative outcomes (WIC 5840(d)(1)-(7)) that apply to the particular program. Although the broad measures that the comment suggests might apply to a specific program, it is more likely that the program will measure indicators: steps along the way toward progress in reducing the outcome. See response to comment 8.28 on page 15.</p>
3750(b)	Commenter #8	<p><u>Comment 8.50</u>  (b) For each Prevention program the County shall measure the reduction of prolonged suffering as referenced in Welfare and Institutions Code Section 5840, subdivision (d) that may result from untreated mental illness by measuring a <u>number of people with mental illness who committed suicide, number of people with severe mental illness who were provided housing, number of people with mental illness unhoused, and number of mentally ill incarcerated.</u> <u>reduction in risk factors</u></p>	Reject	Retain existing language with no change	See responses to comment 8.49 on page 42 above.

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		and/or increased protective factors that may lead to improved mental, emotional, and relational functioning. The County shall select, define, and measure appropriate indicators that are applicable to the program			
3750(c)	Commenter #8	<u>Comment 8.51</u> (c) For each <u>Prevention and Early Intervention</u> , Early Intervention and each Prevention program that the County designates as intended to reduce any of the other Mental Health Services Act negative outcomes referenced in Welfare and Institutions Code Section 5840, subdivision (d) that may result from untreated mental illness, the County shall select, define, and measure appropriate indicators that the County selects that are applicable to the program.	Reject	Retain existing language with no change	See responses to comment 8.49 on page 42 above
3750(d)	Commenter #8	<u>Comment 8.52</u> (d) For Outreach for Increasing Recognition of Early Signs of Mental Illness as either a stand-alone program or a strategy within another program, referenced in Section <del>3715</del> , <u>3715</u> , the County shall track (1) <u>The number of people who had their early signs of mental illness identified</u> (2) <u>The success of referring those people to service</u> (4) <del>(3)</del> The number of potential responders. <del>(2)</del> (4) The type of potential responders.	Reject	Retain existing language with no change	<ol style="list-style-type: none"> <li>1. <u>Measuring the number of people with signs and symptoms of a mental illness who were identified and successfully referred to services</u>: MHSOAC staff agrees that these kinds of outcome measures are important to measure the success of the MHSA intention behind the requirement to reach out to people who are well-positioned to identify signs and symptoms of a mental illness. However, it is believed that these measurements are currently beyond the capacity of many counties to measure and report. See response to comment 33.02 on page 39 above.</li> <li>2. <u>Proposed additions to list of examples of settings</u>: Examples listed in Proposed PEI Regulations are non-exclusionary and more examples are not needed. The goal is to identify early signs and</li> </ol>

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		<p><del>(3)</del> (5) The setting in which the potential responders were engaged.</p> <p>(A) Settings providing opportunities to identify early signs of mental illness include, but are not limited to, <u>psychiatric hospitals, jails, prisons,</u> family resource centers, senior centers, schools, cultural organizations, churches, faith-based organizations, primary health care, recreation centers, libraries, public transit facilities, support groups, law enforcement departments, residences, shelters, and clinics.</p>			<p>symptoms of a mental illness to prevent the “fail first” consequence of delayed identification and response in settings such as psychiatric hospitals, jails, and prisons.</p>
3750(d)(3)(A)	Commenter #26	<p><u>Comment 26.06</u>  <b>Section 3750(d) (3) (A)</b>, Should include home visits by trained professionals in the settings in which the potential responders are engaged.</p>	Reject	Retain existing language with no change	Increasing the use of effective methods of outreach to potential responders is an appropriate focus of training and technical assistance, not of PEI Regulations.
3750(e)(1)	Commenter #6	<p><u>Comment 6.09</u>  Consideration must be given to how stigma manifests in cultural communities and the myths about mental illness that need to be dispelled.</p>	Reject	Retain existing language with no change	Proposed PEI Regulations require all Stigma and Discrimination Reduction Programs to measure changes in attitude, knowledge, and behavior, as applicable to the specific program. The examples cited in the comment could be the focus of context for the changes to be measured. For example, a County could measure changes in specific attitudes, knowledge, and/or behavior related to how stigma manifests in cultural communities and/or to increase accurate knowledge to dispel myths about mental illness.

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3750(e)-(f)	Commenter #8	<p><u>Comment 8.53</u>            (e) If the County chooses to offer a Stigma and Discrimination Reduction Program/Approach referenced in Section 3725, the County shall select and use a validated method to measure one or more of the following:</p> <p>(1) Changes in attitudes, knowledge, and/or behavior <u>in people with mental illness or seeking services</u> related to mental illness that are applicable to the specific program/approach.</p> <p>(2) Changes in attitudes, knowledge, and/or behavior related to seeking mental health services <u>in people with mental illness or seeking services</u>.</p> <p><del>If the County chooses to offer a For the Suicide Prevention Program/Approach referenced in Section 3730, the County shall select and and measure how many individuals committed suicide and if possible the number with mental illness use a validated method to measure changes in attitudes, knowledge, and/or behavior regarding suicide related to mental illness that are applicable to the specific program/approach.</del></p>	Reject	Retain existing language with no change	<ol style="list-style-type: none"> <li>Proposed PEI Regulations define a Stigma and Discrimination Reduction Program as specifically addressing negative attitudes and behaviors associated with either being diagnosed with a mental illness or seeking mental health services, consistent with WIC 5840(b)(3) and (4). The MHSA does not specify any particular method by which the reduction is to be accomplished and there are many effective approaches that address changes in attitude, knowledge, and behavior of a broad range of people, including the general public, with the potential to benefit people with serious mental illness or people who might seek mental health services. While anti-stigma efforts can address internal attitudes of people with a serious mental illness, limiting Stigma and Discrimination Reduction Programs to addressing internalized stigma would be unduly restrictive and ineffective.</li> <li>Completed suicides are one but not the only measure of an effective suicide prevention programs, which, if offered by a County, are required to measure changes in attitude, knowledge, or behavior, as applicable to the program. See response to comment 8.28 on page 15 above.</li> </ol>
3750(g)(2)	Commenter #28	<p><u>Comment 28.07</u>            In addition to the recommendations stated above, the County of San</p>	Reject	Retain existing language with no change	The MHSA (WIC 5848(c)) requires the County to report on the achievement of performance outcomes for all PEI programs. The MHSA requirement to provide

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		<p>Diego has serious concerns about the requirement to have Outreach/Prevention programs track referrals for treatment and the outcome of those referrals as stated in Section 3750, subdivisions (g)(2). We recommend the removal of this requirement.</p>			<p>“access and linkage to medically necessary care provided by county mental health programs for children with severe mental illness, as defined in Section 5600.3, and for adults and seniors with severe mental illness, as defined in Section 5600.3, as early in the onset of these conditions as practicable” under WIC 5840(b)(2) cannot be measured without tracking and reporting on the outcomes of referrals.</p>
3750(g)(3)(A)	<p>Commenters #4, 10, 11, 12, 16, 17, 22, 24, 27, 28, 37, 43, 46, 62, 69, 70, 72</p>	<p><u>Comments 4.03, 10.03, 11.03, 12.03, 16.03, 17.03, 22.03, 24.03, 27.03, 28.03, 37.04, 43.03, 46.03, 62.03, 69.03, 70.04, 72.04</u>  <b>Develop a meaningful measure of untreated mental illness.</b> Counties understand the MHSOAC’s intention to use “Duration of untreated mental illness” as a measurement. However, as written, the proposed measure would require counties to obtain, track, and submit data that is unavailable and unreliable. Counties wish to work with the MHSOAC to develop measures that provide useful, accurate data.</p> <p><b>Recommendation:</b> Delete the following language in Section 3750, subdivisions (g)(3)(A): <i>Duration of untreated mental illness shall be measured by the interval from onset of symptoms of mental illness, based on available medical records or if medical records are not available, on self-report or report of a parent or family member, until initiation of treatment.</i></p>	Reject	Retain existing language with no change	<p><b>Rationale for keeping the requirement:</b></p> <ol style="list-style-type: none"> <li>1. Recording and reporting the duration of untreated mental illness is necessary to measure and strengthen, statewide over time, progress toward linking people to lower levels of treatment that are less crisis-oriented as a result of identifying mental illness earlier in its onset. Further, because WIC 5840(b)(2) specifies that referrals to treatment for individuals with severe mental illness should occur “as early in the onset of these conditions as practicable,” it is necessary to track how early in the onset of a mental illness the referral occurs.</li> <li>2. The Proposed PEI regulations define reduced duration in the simplest possible terms as the interval between the onset of the mental illness and the individual’s entry into treatment, with flexibility for the County to report onset of the mental illness based on medical records, if available, or on patient or family/parent report if medical records are unavailable. It is common practice in healthcare to ask the patient or parent when symptoms began. Even if the recollection is not completely accurate, it is often the most accurate available source of information. Further, measuring the duration of untreated mental illness on this basis is equally accurate or inaccurate from year to year; therefore, any reduction in the duration, over time, will not be a result of the accuracy or inaccuracy of the measure but will systematically reflect changes in actual or perceived reduced duration. The literature</li> </ol>

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					<p>does not suggest any comparably simple and less burdensome approach to measuring reduced duration of untreated mental illness.</p> <p>3. Measuring the duration of untreated mental illness in the proposed regulations applies only to individuals with a serious mental illness who are referred to the CSS component or some other treatment. Proposed PEI Regulations require the County to record and report the interval between a referral and entry into treatment (3560.010(b)(4)(C)); therefore, the only new element required to be reported for duration of untreated mental illness is the estimated or recorded date of onset of symptoms.</p> <p>4. There has been a significant delay since passage of the MHSA in November 2004, with no data available to assess whether there has been progress in reducing the duration of untreated mental illness, which disproportionately affects individuals from communities of color. Removing this requirement from Proposed PEI Regulations means that there will be additional delay.</p> <p><u>Rationale for deleting the requirement:</u></p> <ol style="list-style-type: none"> <li>1. According to some counties and CBHDA this requirement will be burdensome and costly.</li> <li>2. While the literature indicates that duration of untreated mental illness is an important measure, it also documents methodological controversies about the best measurement.</li> <li>3. Variation exists regarding how to define and measure onset as well as how to define and measure entry into treatment. Deleting this requirement would provide for more time to work collectively with CBHDA and stakeholders to develop other methods to measure the duration of untreated mental illness for future amendment the PEI regulations.</li> </ol>

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3750(g)(3)(A)	Commenter #5	<p><u>Comment 5.02</u>  <b>Measuring the duration of untreated mental illness.</b> We understand the MHSOAC's intention to use "Duration of untreated mental illness" as a measurement. However, as written, the proposed measure would require counties to obtain, track, and submit data that is unavailable and unreliable. Counties would appreciate the opportunity to work with the MHSOAC to develop meaningful measures that would provide meaningful data.</p> <p><b>Recommendation:</b> Delete the following language in Section 3750, subdivisions (g)(3)(A): <i>Duration of untreated mental illness shall be measured by the interval from onset of symptoms of mental illness, based on available medical records or if medical records are not available, on self-report or report of a parent or family member, until initiation of treatment.</i></p>	Reject	Retain existing language with no change	See responses to comments 4.03, 10.03, 11.03, 12.03, 16.03, 17.03, 22.03, 24.03, 27.03, 28.03, 37.04, 43.03, 46.03, 62.03, 69.03, 70.04, 72.04 on page 47 above.
3750(g)(3)(A)	Commenter #32	<p><u>Comment 32.07</u>  <b>6. Recommendation: Section 3750 (g)(3)(a). Duration of Untreated Mental Illness.</b></p> <p><b>We strongly support section 3750(g)(3)(a) as it stands in regulation, proposed by the MHSOAC.</b></p> <p>We applaud the significant shift towards emphasizing measured</p>	No change requested	Retain existing language with no change	See responses to comments 4.03, 10.03, 11.03, 12.03, 16.03, 17.03, 22.03, 24.03, 27.03, 28.03, 37.04, 43.03, 46.03, 62.03, 69.03, 70.04, 72.04 on page 47 above.

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		<p>outcomes in the MHSA, especially in regards to Prevention and Early Intervention (PEI).</p> <p>We feel strongly that section 3750(g)(3)(a) is a core component of measuring outcomes for reducing the duration of untreated mental illness from the onset of symptoms or risk factors and the time services are accessed. Measuring this outcome directly and immediately responds to the MHSA goal of increasing Access and Linkage to Treatment.</p> <p>We agree that the current proposed regulation allows the counties flexibility to collect this important information through medical records, self-reporting or reporting by of a parent or family member. Further, we feel this method of collecting data is easily conducted, reliable, measurable, and should be standard practice in the mental health arena, as it is with other health care issues.</p> <p>We feel that tracking the duration of untreated mental illness is important because:</p> <ol style="list-style-type: none"> <li>1. It gives counties valuable information about which populations may have more difficulty seeking services to positively inform county outreach and service delivery strategies.</li> </ol>			

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		<p>2. It provides a more robust data set than solely reporting on the time between request for services and access to services.</p> <p>3. It adds a core component of reducing disparities in racial and ethnic communities that have a history of waiting to seek treatment of mental illness until crisis has already arisen.</p> <p>We have concerns that postponing or eliminating this provision would compromise the ability to track meaningful outcomes for PEI and the MHSA from the earliest point and that valuable information regarding disparities of untreated mental illness for underserved communities will not be collected.</p>			
3750(g)(3)(A)	Commenter #38	<p><u>Comment 38.03</u>  Section 3750, subdivisions (g)(3)(A): <i>Duration of untreated mental illness shall be measured by the interval from onset of symptoms of mental illness, based on available medical records or if medical records are not available, on self-report or report of a parent or family member, until initiation of treatment.</i></p> <p>Comment: The Council is aware of the difficulties in capturing documentation of symptoms and supports the effort to include this vital measurement in program evaluation.</p>	No change requested	Retain existing language with no change	See responses to comments 4.03, 10.03, 11.03, 12.03, 16.03, 17.03, 22.03, 24.03, 27.03, 28.03, 37.04, 43.03, 46.03, 62.03, 69.03, 70.04, 72.04 on page 47 above.

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		<p>We are not confident that the proposed measurements are documentable but we believe that EQRO data (as suggested by CMBHDA) is a measurement of access, not intervention measures. We believe that there needs to be more work to identify indicators or measurements through available Public Health Data.</p>			
3750(g)(3)(A)	Commenter #71	<p><u>Comment 71.03</u>            In Sec 3750(g)(3)(A) “Duration of untreated mental illness” is measured “until initiation of treatment.” This raises the question of whether we should differentiate those, who in the course of this program experience “5150.”</p> <p>In other words what do we wish to mean by “initiation of treatment” as an outcome? In CSS regs, those whose only contact with the system is through holds are regarded as “unserved.” As an MHA value, “service” begins with the voluntary. What is the crosswalk between “initiation of treatment” and becoming “served.”</p> <p>This becomes important if “duration of untreated mental illness” comes to be used in broader contexts.</p>	Reject	Retain existing language with no change	<p>The proposed measure of duration of untreated mental illness as the interval from onset of symptoms of a mental illness until entry into treatment does not differentiate between voluntary and involuntary treatment. It is clear that a principal reason that the PEI Component includes a focus on reducing the duration of untreated severe mental illness (WIC 5840(c)) is to increase the provision of various access and stigma-reducing strategies to encourage links to effective, recovery-oriented, voluntary treatment earlier in onset. It is highly likely that most referrals to treatment through the PEI Component will be to voluntary services, consistent with the overall purpose of PEI.</p> <p>Success in reducing the duration of untreated mental illness is likely to reflect success with regard to increasing access to voluntary treatment, which could be determined by future analysis of the data on the kind of treatment to which individuals with severe mental illness are being referred. To answer this question, among others, it is essential to measure over time whether there is a reduction in the duration of untreated severe mental illness, without limiting the kind of treatment that is included in the measure.</p>

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3750(g)(3)(A)	Commenter #74	<p><u>Comment 74.03</u>  <b>REMHDCO strongly supports the language as proposed by the MHSOAC</b> for measuring duration of untreated mental illness by those receiving PEI services.</p> <p>According to OAC staff, this might be as simple to start off by asking the consumer <b>one question</b>: “How long have you had these symptoms?” or “When do you first remember experiencing these symptoms?” This is such a simple question that is routinely asked when one goes to a helping professional for other illness or maladies, why would it be irrelevant for mental health conditions?</p> <p>There is a strong belief and some evidence that consumers and family members from racial and ethnic underserved communities delay seeking treatment (longer than others). Tracking this information would help determine whether and to what degree that progress was being made towards addressing this problem.</p>	No change requested	Retain existing language with no change	See responses to comments 4.03, 10.03, 11.03, 12.03, 16.03, 17.03, 22.03, 24.03, 27.03, 28.03, 37.04, 43.03, 46.03, 62.03, 69.03, 70.04, 72.04 on page 47 above.
3750(g)(3)(A)	H7	<p><u>Comment H7.01</u>  Good morning, Commissioners. My name is Noemi Castro. I am the assistant director of the Racial and Ethnic Mental Health Disparities Coalition. I am here today to represent a letter signed to the OAC -  - or submitted to the OAC by nine</p>	No change requested	Retain existing language with no change	See responses to comments 4.03, 10.03, 11.03, 12.03, 16.03, 17.03, 22.03, 24.03, 27.03, 28.03, 37.04, 43.03, 46.03, 62.03, 69.03, 70.04, 72.04 on page 47 above.

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		<p>organizations and individual signers regarding the proposed PEI Regulations.</p> <p>These organizations are the Racial and Ethnic Mental Health Disparities Coalition, the California Pan-Ethnic Health Network, United Advocates for Children and Families, California Family Resource Association, African American Health Institute, Native American Health Center, California Youth Empowerment Network, Sacramento Native American Health Center, and the Muslim American Social Services Foundation.</p> <p>There are eight meaningful recommendations in this letter for review and consideration that address protecting prevention programs, support fifty-one percent of PEI funds for children, youth, and families, and for the continued funding of the Student Mental Health Initiative. However, due to time constraints, I'm only going to highlight provision six in the letter.</p> <p>We would like the Commission to consider our recommendation to support the proposed mandate to track and measure the duration of untreated mental illness from the onset of symptoms to the point of access and linkage to treatment.</p>			

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		<p>First and foremost, we applaud the shifts towards emphasizing measured outcomes in the MHSA and, in particular, PEI. We feel collecting this data is important, and in particular for underserved communities that have a history of waiting to seek services only until crisis has arisen.</p> <p>We also feel that the OAC's proposed methods of collecting this data are easily conducted, reliable, and measurable. For transparency, I would like to respectfully acknowledge that the County Behavioral Health Directors Association has a contrary view and has proposed that this mandate be deleted from regulations.</p> <p>Further, their amendment does not recommend a deferment or propose a timeline to begin tracking or measuring outcomes. This gives counties an undefined and unlimited amount of time before they develop a system to collect this information, if ever, because it is not mandated.</p> <p>It is our view that it is impossible to measure outcomes for underserved communities or reduce disparities if we cannot track and measure where the disparities are in access and linkage to care.</p> <p>I believe that the eight recommendations in our collective</p>			

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		letter envision a greater and inclusive mental health care system that appropriately serves and represents a diverse California, as opposed to perpetuating the status quo. We invite the Commission to consider our recommendations. Thank you.			
3750(g)(3)(A)	H10	<p><u>Comment H10.02</u> The second thing that -- is, at present, counties and their providers do not have a reliable way to collect information around the duration of untreated mental illness. That requires at least two data points. And we would like to work with this Commission and the OAC staff to develop a methodology and a data collection system to do just that.</p> <p>But, at present, right now, we don't have a reliable way in which to do that. Therefore, the information that you might obtain would not be valuable to, I think, how it actually could be valuable in the future. That's the second thing.</p>	N/A	Retain existing language with no change	See responses to comments 4.03, 10.03, 11.03, 12.03, 16.03, 17.03, 22.03, 24.03, 27.03, 28.03, 37.04, 43.03, 46.03, 62.03, 69.03, 70.04, 72.04 on page 47
3750(h)	Commenter #8	<p><u>Comment 8.54</u> (Commenter had changed the subdivision number) (g) For each strategy to Improve Timely Access to Services for Underserved Populations the County shall measure: (1) Number of referrals of members of underserved populations to a Prevention program, an Early Intervention program, and/or treatment</p>	Reject		See response to comment 8.23 on page 19 above.

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		<p>(beyond early onset) including the kind of care.</p> <p>(2) Number of persons 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 the person was referred.</p> <p>(A) The County may use a methodologically sound sampling method to satisfy this requirement.</p> <p>(3) Timeliness of care.</p> <p>(A) Timeliness of care for individuals from underserved populations with a mental illness is measured by the interval from onset of symptoms of a mental illness, based on available medical records, or if not available, on self-report or report of a parent or family member, until initiation of treatment.</p> <p>(B) Timeliness of care for individuals from underserved populations with <del>risk factors for a</del> mental illness is measured by the duration between onset of indicators of <del>risk of</del> mental illness and initial receipt of services.</p> <p>(4) How long the person received services in the program to which the person was referred.</p>			

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		(A)The County may use a methodologically sound sampling method to satisfy this requirement.			
3750(h)(3)(A) and(h)(3)(B)	Commenter #4, 10, 11, 12, 16, 17, 22, 24, 27, 28, 37, 43, 46, 62, 69, 70, 72	<p><u>Comment 4.04, 10.04, 11.04, 12.04, 16.04, 17.04, 22.04, 24.04, 27.04, 28.04, 37.05, 43.04, 46.04, 62.04, 69.04, 70.05, 72.05</u></p> <p><b>Facilitate consistent county reporting.</b> <i>Counties currently report access and timeliness of care data to the Department of Health Care Services (DHCS) under the Medi-Cal Program and are working with DHCS to operationalize these indicators and determine standards of care. CBHDA proposes that the MHSOAC utilize the same reporting standard from referral to entry into services, enabling counties to consistently report data across programs instead of having to assume duplicative efforts that do not generate meaningful new data.</i></p> <p><b>Recommendation:</b> Section 3750, subdivisions 3(A) and (B). Prevention and Early Intervention Program Evaluation. Delete the following:</p> <p><i>(A) Timeliness of care for individuals from underserved populations with a mental illness is measured by the interval from onset of symptoms of a mental illness, based on available medical records, or if not available, on self-report or report of a parent or</i></p>	Accept in part	<p>Retain existing language except change language indicated by underlined (new language) or strikethrough (remove existing language):</p> <p>3750(h)(3)(A) and (B)</p> <p><del>(A)Timeliness of care for individuals from underserved populations with a mental illness is measured by the interval <u>between referral and engagement in services, defined as participating at least once in the service to which referred from onset of symptoms of a mental illness, based on available medical records, or if not available, on self-report or report of a parent or family member, until initiation of treatment.</u></del></p>	<p><u>Recommended change:</u></p> <ol style="list-style-type: none"> <li>1. <u>3750(h)(3)(A):</u> Measuring the interval between referral and access to services is a better and sufficient measure of timeliness to access to services for underserved populations. As such, MHSOAC staff suggests replacing the current measurement of interval from onset of symptoms to initial treatment with the measurement of interval from referral to service. The proposed new language expresses the same concept as that recommended by the Commenters but is more appropriate for the PEI component because of the range of kinds of services to which individuals from underserved populations will be referred. Information about whether individuals from underserved populations followed through on the referral, defined as participating at least once in the program to which they were referred, is an essential indicator of progress toward the PEI Component goal of improving access to services.</li> </ol> <p>Measuring and reporting on the interval between referral and the individual's engagement in services, including treatment, is essential to document improved timeliness of service delivery, defined as the wait time between referral and entry into services. These provisions cumulatively, are essential to assess local and statewide progress toward reducing disparities in timeliness of access, which has been documented as a serious and persistent injustice for communities of color, particularly with accompanying poverty.</p>

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		<p><i>family member, until initiation of treatment.</i></p> <p><i>(B) Timeliness of care for individuals from underserved populations with risk factors for a mental illness is measured by the duration between onset of indicators of risk of mental illness and initial receipt of services.</i></p> <p>Replace proposed measures with the following language to ensure consistency with DHCS External Quality Review Organization (EQRO) audit standards:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <i>Average length of time from first request for service to first clinical assessment (All services/adult services/children's services)</i></li> <li><input type="checkbox"/> <i>Mental Health Plan (MHP) standard or goal (All services/adult services/children's services)</i></li> <li><input type="checkbox"/> <i>Percent of appointments that meet this standard (All services/adult services/children's services)</i></li> <li><input type="checkbox"/> <i>Range (All services/adult services/children's services)</i></li> </ul>		<p><del>(B) Timeliness of care for individuals from underserved populations with risk factors for a mental illness is measured by the duration between onset of indicators of risk of mental illness and initial receipt of services.</del></p>	<p>2. <u>3750(h)(3)(B)</u>: Staff suggests deleting subdivision (B) because measuring the onset of risk is too imprecise to constitute a useful basis for measuring improved timeliness. It is well-documented that communities of color experience disparities in access to mental health services and that their mental health needs are frequently unmet. The interval between onset of initial risk or symptoms of a mental illness and entry into mental health services including treatment is an important way of measuring whether the programs or strategies are effective in assisting individuals to access services earlier, a key indicator of timeliness. Timely Access to Services for Underserved Populations in some instances overlaps with Improving Access to Treatment for individuals with a severe mental illness. MHSOAC staff has proposed eliminating measuring the interval from estimated or recorded onset of symptoms until entry into treatment from Proposed PEI Regulations because of methodological issues, which apply to an even greater degree to efforts to measuring timeliness of services by estimating the date of the onset of risk of a mental illness. For this reason, staff recommends deleting this requirement.</p> <p>The specific suggested language is applicable to programs and strategies to provide Access and Linkage to Treatment for people with a severe mental illness, beyond early intervention but not for this subdivision which deals with programs and strategies for Improving Timely Access to Services for Underserved Populations, which is broader and includes referrals to Prevention and Early Intervention Programs. The Medi-Cal standards do not apply to the timeframe for referrals to Prevention Programs. The Commission will work closely with DHCS to ensure consistency of reporting requirements.</p>

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					Average length of time from first request for service to first clinical assessment is not the same as average length of time from referral to treatment because the clinical assessment to determine the need for the referral in many instances will occur at the point of PEI contact that initiates the referral to treatment. The reference to percentage of referrals that meet a standard for timeliness is not applicable both because of the range of kinds of services to which individuals from underserved populations will be referred and also because no standard is provided. Staff has proposed new language that expresses the same concept but that is more appropriate for the PEI component.
3750(h)(3)(A) and(h)(3)(B)	Commenter # 5	<p><u>Comment 5.03</u>  <b>Facilitate consistent county reporting.</b> Counties currently report access and timeliness of care data to the Department of Health Care Services (DHCS) under the Medi-Cal Program and are currently working with DHCS to operationalize these indicators and determine standards of care. The California Mental Health Directors Association proposes that the Commission utilize the same reporting standard from referral to entry into services, enabling counties to consistently report data across programs rather than undertaking duplicative efforts that do not generate meaningful new data.</p> <p><b>Recommendation:</b> Section 3750, subdivisions 3(A) and (B). Prevention and Early Intervention Program Evaluation. Delete the following:</p>	Accept in part	Same as for Comments 4.04, 10.04, 11.04, 12.04, 16.04, 17.04, 22.04, 24.04, 27.04, 28.04, 37.05, 43.04, 46.04, 62.04, 69.04, 70.05, 72.05 on page 58 above	See responses Comments 4.04, 10.04, 11.04, 12.04, 16.04, 17.04, 22.04, 24.04, 27.04, 28.04, 37.05, 43.04, 46.04, 62.04, 69.04, 70.05, 72.05 on page 58 above

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		<p><i>(A) Timeliness of care for individuals from underserved populations with a mental illness is measured by the interval from onset of symptoms of a mental illness, based on available medical records, or if not available, on self-report or report of a parent or family member, until initiation of treatment.</i></p> <p><i>(B) Timeliness of care for individuals from underserved populations with risk factors for a mental illness is measured by the duration between onset of indicators of risk of mental illness and initial receipt of services.</i></p> <p>Replace proposed measures with the following language to ensure consistency with DHCS External Quality Review Organization (EQRO) audit standards:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <i>Average length of time from first request for service to first clinical assessment (All services/adult services/children's services)</i></li> <li><input type="checkbox"/> <i>Mental Health Plan (MHP) standard or goal (All services/adult services/children's services)</i></li> <li><input type="checkbox"/> <i>Percent of appointments that meet this standard (All services/adult services/children's services)</i></li> <li><input type="checkbox"/> <i>Range (All services/adult services/children's services)</i></li> </ul>			

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3750(h)(3)(A) and(h)(3) (B)	Commenter #32	<p data-bbox="658 170 1161 300"><u>Comment 32.08</u> <b>7. Recommendation: Section 3750(h)(3)(A)and(B). Timeliness of Care.</b></p> <p data-bbox="658 332 1161 462"><b>We strongly support section 3750(h)(3)(A) and (B) as it stands in regulation, proposed by the MHSOAC.</b></p> <p data-bbox="658 503 1161 665">Welfare and institutions code 5840(a) mandates that PEI programs “shall emphasize improving timely access to services for underserved populations.”</p> <p data-bbox="658 706 1161 998">As with measuring the duration of untreated mental illness, Timeliness of Care, particularly for underserved communities, is a core component of an outcomes-based approach that embeds reducing disparities for racial and ethnic communities and other underserved communities in the framework of the MHSA.</p> <p data-bbox="658 1039 1161 1274">However, the method for measuring improved timely access to services for underserved populations is a concern. We believe that the method for collecting data, can directly impact the quality of data to be interpreted for measuring outcomes.</p> <p data-bbox="658 1307 1161 1437">For this reason, we oppose tracking Timeliness of Care for underserved communities through measuring tools such the DHCS External Review</p>	Accept in part	Same as for comments 4.04, 10.04, 11.04, 12.04, 16.04, 17.04, 22.04, 24.04, 27.04, 28.04, 37.05, 43.04, 46.04, 62.04, 69.04, 70.05, 72.05 on page 58 above	Information about whether individuals from underserved populations followed through on the referral, defined as participating at least once in the program to which they were referred, is an essential indicator of progress toward the PEI Component goal of improving access to services. Measuring and reporting on the interval between referral and the individual’s engagement in services, including treatment, is essential to document improved timeliness of service delivery, defined as the wait time between referral and entry into services. These provisions cumulatively, are essential to assess local and statewide progress toward reducing disparities in timeliness of access, which has been documented as a serious and persistent injustice for communities of color, particularly with accompanying poverty.

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		Organization (EQRO) standards that are not reliable for capturing many consumer and family members served by PEI services.			
3750(h)(3)(A) and(h)(3) (B)	Commenter #74	<p><u>Comment 74.05</u>  <b>REMHDCO strongly supports the language as proposed by the MHSOAC.</b></p> <p>This issue is extremely important to underserved communities and current evaluation practices to not capture or measure all served by PEI programs. As with the tracking of <i>duration of untreated mental illness</i>, there are indications that people from underserved communities must wait longer to receive services.</p> <p>However, without sufficient data, our communities are told there is not enough evidence of a need or problem that must be addressed.</p> <p>If the current demographic and other data collected by counties were adequate, it would be reasonable to expect more progress in reducing disparities by this time. If counties do not want to change <i>the way they do business</i>, then it is very difficult to understand how results for any underserved communities will improve, and even if they do, how will we know?</p>	Accept in part	See response to comment 32.08 on page 62 above.	See response to comment 32.08 on page 62 above.

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3750(i) and (j)	Commenter #8	<p><u>Comment 8.55</u>            (Commenter has changed the subdivision numbers)            (i) The County shall design the evaluations to be culturally appropriate and shall include the perspective of diverse people with lived experience of mental illness, including their family members, as applicable.</p> <p>In addition, to the required evaluations listed in this section, the County may also, as relevant and applicable, define and measure the impact of programs funded by Prevention and Early Intervention funds on the mental health and related systems, including, but not limited to education, physical healthcare, law enforcement and justice, social services, homeless shelters and other services, and community supports specific to age, racial, ethnic, and cultural groups. Examples of system outcomes include, but are not limited to, increased provision of services by ethnic and cultural community organizations, hours of operation, integration of services including co-location, involvement of clients and families in key decisions, identification and response to co-occurring substance-use disorders, staff knowledge and application of recovery principles, collaboration with</p>	No specific action suggested	No specific action suggested	N/A

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		diverse community partners, or funds leveraged.			
Definitions	Commenter #71	<p><u>Comment 71.01</u> The definitions section needs to be vastly expanded. I worked as a paid contractor in the development of the CSS component regs by the old DMH. The definitions section was explicitly regarded as the foundation for everything else. Also, I might note, definitions are not limited to clarifying terms from law, but can be used for terms that arise during the writing of the regs themselves. Good examples from the CSS side would include “Full Service Partnerships” and “General System Development.”</p> <p>In some cases MHSOAC seems to be relying on the “Initial Statement of Reasons” for definitional context. While there is wrong with mentioning such matters in the Statement, such a practice lacks the clarity and authority of a definition in the regs.</p> <p>An example of where a formal definition would be useful is in Sec. 3750 (g)(3)(A) and (h)(3)(A) and (B). The terms “Duration of untreated mental illness” and Timeliness of care” would benefit from a formal clarifying of not only how they are to be measured but what their evaluative role is.</p>	Reject	Retain existing language with no change	<ol style="list-style-type: none"> <li>1. Most definitions of terms that apply to more than just the PEI component will be included in the general regulations section that is the responsibility of the DHCS. Proposed PEI Regulations include additional definitions that provide a necessary foundation for the PEI component. MHSOAC is committed to work collaboratively with DHCS on the additional definitions.</li> <li>2. The definition of “responder” is included in the MHSA as people who can “recognize the early signs of potentially severe and disabling mental illnesses” (WIC 5840(b)(1)).</li> <li>3. The definitions of duration of untreated mental illness and timeliness of access to services for underserved populations and to treatment for individuals with a severe mental illness is defined operationally in the evaluation requirements in proposed section 3750(g) and (h)). The evaluative role of these, as with all of the other evaluation requirements, is to create a framework to evaluate the outcomes set forth in the MHSA and determine the impact of the PEI component programs on the mental health and related systems.</li> <li>4. Recognizing and responding to one’s own signs and symptoms of mental illness is explicitly acknowledged in Proposed PEI Regulation section 3715(d).</li> </ol>

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		<p>The CBHDA letter asking to substitute EQRO measure the latter term (Timeliness...) completely misses the point.</p> <p>Another place where as definition would be helpful is in Sec 3750(d) with the use of the term “responders.” Responder, outside the context of this passage suggest “1<sup>st</sup> Responders” Fire, Police, Paramedics – The Term is clearly of much broader use here, but without clear definition the mind, I believe, still goes towards the professionals.</p> <p>I would also like to add, that it is evident that often the “responder” in this context is the afflicted person themselves – if they have enough information to understand what is happening. Even in 1<sup>st</sup> break schizophrenia there is a period of relative lucidity where people can self recognize that something is wrong.</p> <p>A definition could make clear that such people were included in the “audience” for this type of program.</p>			
Evaluation	Commenter #44	<p><u>Comment 44.02</u> While the CPA would generally prefer that available funds be allocated for direct services to people with serious mental illness, it also recognizes that data collection, analysis and reporting play a critical role in establishing accountability and directing resources to effective programs. The key</p>	No specific action suggested	No specific action suggested	N/A

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		<p>criterion for useful data must be that it contribute to the improvement of treatment and services as well as the well-being of people with serious mental illness and not become an end in and of itself.</p>			
Evaluation	Commenter #60	<p><u>Comment 60.01</u>            Pertaining to outcomes, tracking, and evaluation efforts, UACF supports current efforts to address and discuss the necessary data collection and program evaluations of PEI projects in the counties. Tracking and outcome measurement in both qualitative and quantitative measures is a true indicator of progress (or, in some cases, lack thereof) of PEI strategies and dollars spent.</p> <p>UACF requests that data collection process align with, and when possible, mirror the current efforts made by the counties with regard to processes already in place (i.e. POS, CSI, EQRO) so as to not have duplicative and exhaustive efforts that require additional staff and overhead expense. This would help streamline systems and ensure that additional organizational dollars are not needed to ensure compliance. Consistent and efficient processes ensure that monies can be spent programmatically in the communities and not administratively on procedures.</p>	No specific action suggested	No specific action suggested	MHSOAC staff is in full support of integrated data reporting requirements and systems to the fullest extent possible. See responses to comment 35.02 on page 41 above.

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Evaluation	H6	<u>Comment H6.04</u> Lastly, we recommend that data collection be looked at, data be disaggregated around racial and ethnic communities, not to universalize data collection, because that will further enhance and increase disparities.	Accept	Retain existing language with no change	See responses to comment 6.03 on page 20 above and to comments 4.06, 5.05, 10.06, 11.06, 12.06, 16.06, 17.06, 22.06, 24.06, 27.06, 28.06, 37.07, 43.06, 46.06, 62.06, 69.06, 70.07, 72.07 on page 19 above.
Evaluation	H11	<u>Comment H11.01</u> Good morning, Commissioners. My name is Michael Helmick. I am the program assistant at REMHDCO. I will be giving public comment on behalf of Janet King. She's the vice president of REMHDCO and the SPW lead on Native American SRDP.  Ms. King wholeheartedly supports and commends the points made in the REMHDCO letter. She feels that not only should data be collected on ethnicity to show movement toward reducing disparities, but also that the data needs to be improved so some populations do not continue to be invisible - therefore not receiving services.	No specific action suggested	Retain existing language with no change	See responses to comment 6.03 on page 20 above and to comments 4.06, 5.05, 10.06, 11.06, 12.06, 16.06, 17.06, 22.06, 24.06, 27.06, 28.06, 37.07, 43.06, 46.06, 62.06, 69.06, 70.07, 72.07 on page 19 above.
No Specified Section	Commenters #4, 72	<u>Comments 4.07, 72.08</u> CBHDA strongly supports measuring the outcomes of Prevention and Early Intervention efforts to address mental health in the state. Continuous program and outcomes improvement assures all Californians that tax dollars are being used efficiently and effectively to provide quality county mental health services.	No specific action suggested	No specific action suggested	N/A

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		CBHDA and its members have been greatly encouraged by the collaborative efforts the MHSOAC made to strengthen these important regulations. We look forward to continuing to work with you to serve the needs of California.			
Reporting	H10	<p><u>Comment H10.03</u> Third is consistency of reporting. There are three areas where you're asking for information. One is access and timeliness; the second one is language and ethnicity; and the third are evaluation costs. Counties currently report all of those things right now, and what we're asking for is that they be consistent with what we report right now.</p> <p>And, in the case of language and ethnicity, it's through the CSI database the DHCS is the owner and manager of. Access and timeliness is currently reported by counties through EQRO, and we would like that the language be consistent so we can report it once.</p> <p>And third, evaluation costs are now being reported by counties through the Revenue and Expenditure Report, and we get that guidance through the Department of Health Care Services. So, we would like to be able to report that once and not twice. And the key here is that, with PEI, we're being asked to report at the program level and not at the component level, which</p>	Reject	Retain existing language with no change	<p>1. <u>Consistency of reporting</u>: MHSOAC is committed to making PEI regulations reporting and evaluation requirements and categories as consistent as possible with other reporting requirements. In some instances, differences between PEI and CSS make complete consistency impossible. See responses to comments 4.04, 10.04, 11.04, 12.04, 16.04, 17.04, 22.04, 24.04, 27.04, 28.04, 37.05, 43.04, 46.04, 62.04, 69.04, 70.05, 72.05 on page 58 above and to comment 71.02 on page 23 above.</p> <p>It is also impossible to make all reporting requirements consistent with what counties currently report because there are many critical MHSA PEI outcomes on which counties do not report because there have, to date, been no requirements to measure or report outcomes of PEI programs.</p> <p>2. <u>Demographic data</u>: See response to comments 4.06, 5.05, 10.06, 11.06, 12.06, 16.06, 17.06, 22.06, 24.06, 27.06, 28.06, 37.07, 43.06, 46.06, 62.06, 69.06, 70.07, 72.07 on page 19 above.</p> <p>3. <u>Improve timeliness of services to underserved populations and increase access to treatment for individuals with a severe mental illness</u>: EQRO categories are not applicable to improving timely access to Prevention services, and possibly not to Early Intervention services, which are important elements of this PEI MHSA requirement. See response to comments 4.04, 10.04, 11.04, 12.04, 16.04, 17.04, 22.04, 24.04, 27.04, 28.04, 37.05,</p>

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		<p>is what DHCS has asked us to do. So, just consistency of reporting.</p> <p>And I think every county would like to see prevention and early intervention services demonstrate a difference in the lives of the people we serve. And we think, with these changes, we will have reliable and achievable regulations, and will demonstrate the impact of the Mental Health Services Act, and prevention and early intervention specifically. Thank you very much</p>			<p>43.04, 46.04, 62.04, 69.04, 70.05, 72.05 on page 58 above and to comment 71.02 on page 23.</p> <p>4. <u>Reporting cost at the component level</u>: The last several annual instructions for the Annual Revenue and Expenditure Report that DHCS issued required counties to report expenses for PEI by PEI program and not just by PEI component. However, under the instructions there were only two types of programs: prevention or early intervention. The proposed regulations follow the MHSA categories for programs. See responses to comments 4.05 et.al on page 17 of the Matrix of Public Comments presented at the September 30, 2014 MHSOAC meeting.</p>
Reporting	H13	<p><u>Comment H13.01</u> Good morning, Chair, Commissioners. Tahira Cunningham with the California Pan-Ethnic Health Network. CPEHN is a multicultural health advocacy organization that works to improve the health of communities of color.</p> <p>We align our comments with those of Noemi Castro, with REMHDCO, and the letter that was provided to you all that identified several different recommendations regarding the PEI regs.</p> <p>In the interest of time, I will highlight two areas, and I will couch that by saying, you know, California is one of the most diverse states in the country. We have almost sixty percent of our population are communities of color with over one hundred languages</p>	No specific action suggested	No specific action suggested	N/A

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		<p>spoken. And so, with that in mind, I will frame my comments.</p> <p>First, we strongly support the recommendation around annual prevention and early intervention reporting. The proposed regulations lay out promising steps toward the effective disaggregation of data that reflect race, ethnicity, disability, sexual orientation, and others, and lay the groundwork for improved data collection moving forward.</p> <p>Collecting this data is essential to measuring gaps in services to determine if they're being effectively reached and addressed over time, and to see where significant inequities remain within our communities.</p> <p>We have concerns that reverting data collection of race, ethnicity, and others to align with current or outdated reporting systems, such as the Client and Service Information System, will result in the loss of valuable information.</p>			
No specified section	Commenter #3	<p><u>Comment 3.46</u>  <b>1. MHSOAC's proposed regulation also violates the Office of Administrative Law's "clarity" standard.</b>  The MHSOAC has taken an entirely subjective concept-prolonged suffering and buried it with vague qualifiers, such as "protective factors</p>			<p>Proposed PEI regulations' approach to measuring the reduction of prolonged suffering is objective. Prolonged suffering is defined, for purposes of evaluating an Early Intervention Program, as measuring "reduced symptoms and/or improved recovery, including mental, emotional, and relational functioning."</p> <p>The county is required to "select, define, and measure appropriate indicators that are applicable to the</p>

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		<p>that may lead to improved mental, emotional, and relational functioning," "measuring a reduction in risk factors and/or increased protective factors," and "select, define, and measure appropriate indicators that the County selects that are applicable to the program." This language is meaningless, unenforceable, and violates the clarity standard for regulations required by California Office of Administrative Law.</p>			<p>program" (§3750(b)). The specific reduced symptoms (depression, PTSD, unusual thoughts and beliefs, withdrawal from friends and family, depersonalization, etc.) to be measured will vary depending on the focus of the specific program.</p> <p>A recovery orientation, mandated by the MHSA (WIC §5813.5(d)), requires the inclusion of positive indicators of recovery, which include mental, emotional, and relational functioning. Flexibility for the County to select applicable objective indicators of reduced suffering and increased recovery that are relevant to their specific Early Intervention Program is essential given the wide range of program areas.</p> <p>The same approach to designating objective and relevant indicators of MHSA outcomes applies to Prevention Programs, with the requirement to measure "a reduction of risk factors, indicators, and/or increased protective factors that may lead to improved mental, emotional, or relational functioning" (§3750(b)). The approach balances the requirement for objectivity, clarity, and relevance to the specific program.</p>