

Matrix of Public Comments with Staff's Recommended Responses
Proposed PEI Regulations Sections 3200.245, 3200.246, 3510.010, 3745, 3755, and 3755.010

Section #	Comment Author	Comment Summary	Response	Action	Rationale
3200.245	Commenter #3	<p><u>Comment 3.31</u> Section 3200.245. Prevention and Early Intervention. (a) "Prevention and Early Intervention Component" means the section of the Three-Year Program and Expenditure Plan intended to prevent mental illnesses from becoming severe and disabling. (b) "<u>Severe mental illness, "severe and disabling mental illness" and "severely mentally ill" are the conditions defined in Welfare & Institutions Code section 5600.3. Individuals who meet the diagnostic definitions in 5600.3 and who are not currently disabled but are at risk of relapse shall be considered "severely mentally ill" for purposes of Relapse Early Intervention and Relapse Prevention Programs. Insurers of individuals with severe mental illness shall be billed directly for covered services funded pursuant to this Chapter. Insured clients have no personal financial responsibility if coverage is denied.</u></p> <p>Authority/Reference for added subsection (b): Welfare & Institutions Code section 5840(b)(2), which provides for "medically necessary care provided by county mental health programs for children with severe mental illness, as defined in Section 5600.3, and for adults and seniors with severe mental illness, as defined in Section 5600.3, as early in</p>	Reject in part	<p>Add new section to define "serious mental illness" and "severe mental illness"</p> <p><u>Section 3704.</u> <u>"Serious mental illness" and "severe mental illness" as used in the Prevention and Early Intervention regulations means, a mental illness that is severe in degree and persistent in duration, which may cause behavioral functioning which interferes substantially with the primary activities of daily living, and which may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period of time. Serious mental illnesses and severe mental illness include, but are not limited to, schizophrenia, bipolar disorder, post-traumatic stress disorder, as well</u></p>	<ol style="list-style-type: none"> <u>Recommended change:</u> Staff recommends adding a definition of "serious mental illness" and "severe mental illness". The PEI provision of the MHPA (Welfare and Institutions Code (WIC) Section 5840) mentions "severe mental illness" "as defined in Section 5600.3." The definition in WIC 5600.3 is for "serious mental disorder" implying that for purpose of PEI programs the definitions are the same. As such, for purpose of the PEI regulations, the recommendation is to have "severe mental illness" have the same definition as serious mental illness as set forth Section 5600.3. <u>Insurance:</u> The concept of billing "insurers" is rejected because the MHPA funds are intended solely "to provide services that are not already covered by federally sponsored programs or by individuals' or families' insurance programs," consistent with MHPA uncodified Section 3(d): Purpose and Intent. <u>Medically necessary treatment:</u> The comment misquotes WIC Section 5840(b)(2). Subdivision (b)(2) does not require "medically necessary treatment" it requires "access and linkage" to such treatment. The medically necessary care to which the individual is referred would not be a PEI program. The requirement in (b)(2) is addressed in proposed PEI Regulation section 3735(a)(1) that requires all PEI programs to provide access and linkage to medically necessary care for people across the lifespan with serious mental illness as defined in 5600.3. <u>Relapse prevention:</u> Proposed PEI Regulations already require relapse prevention. Required Early Intervention Programs include relapse prevention and Prevention Programs can include relapse prevention for individuals in recovery from a serious mental illness "who are not currently disabled but are at risk of relapse." There is no need for a separate category of a Relapse Early

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		<p>the onset of <i>these conditions</i> as practicable" (emphasis added); MHSA Section 3(d), which provides, "[s]tate funds shall be available to provide services that are not already covered by federally sponsored programs or by individuals' or families' insurance programs."</p> <p>Necessity/Rationale for added subsection (b): Necessary for clarity and conformity to statute. Because PEI programs are supposed to prevent "mental illness" from becoming "severe mental illness," the regulations should have a clear definition of "severe mental illness." The statute has already addressed this problem: it internally defines "severe mental illness" in section 5840(b)(2), quoted above, incorporating by reference the definitions in Welfare & Institutions Code section 5600.3.</p>		<p><u>as major affective disorders or other severely disabling mental disorders.</u></p>	<p>Intervention or Relapse Prevention Program.</p>
Definitions	Commenter #3	<p><u>Comment 3.36</u> MHSOAC's proposed regulations do not define statutory terms that are ambiguous or in need of amplification to accomplish the MHSA's statutory purposes. MIPO's proposed definitions to be added to proposed regulation 3200.245 are as follows:</p> <p><u>Definition of "severe mental illness."</u> Unlike the rest of the MHSA, which uses the term, "serious mental illness," the PEI provisions consistently use the term, "severe mental illness." It also defines the term. Section 5840(b)(2) defines "severe mental illness" by reference to section 5600.3 of the Welfare &</p>	Reject	Retain existing language with no change	1. See responses to comment 3.31 on page 1

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		<p>Institutions Code by calling for "medically necessary care provided by county mental health programs for children with <i>severe mental illness, as defined in Section 5600.3</i>, and for adults and seniors <i>with severe mental illness, as defined in Section 5600.3</i>, as early in the onset of <i>these conditions</i> as practicable." Welf. & Inst. Code § 5840(c) (emphasis added).</p> <p>Section 5600.3 is the provision that qualifies mentally ill people for various welfare benefits. It is a complex definition that has both diagnostic (mental illness) and disability components, i.e., it defines a serious mental illness that is both "severe" and "disabling." Because "severe mental illness" qualifies people for MHSA relapse prevention/early intervention programs and represents the condition that the PEI provisions were Proposed to prevent, its definition is crucial. MHSOAC failed to define this term and does not seem to understand that the MHSA's PEI provisions were intended to keep mentally ill and severely mentally ill people off the welfare rolls by keeping them from becoming disabled, or relapsing into disability.</p> <p>Fortunately, counties understand section 5600.3, because they work with this complex definition every day. MIPO's proposed definition of "severe mental illness" varies from the statute only as needed to clarify that individuals</p>			

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		<p>diagnosed with a "severe mental illness" qualify for relapse prevention and early intervention programs, even if they are not currently disabled, if they are at risk of relapse into disability. For example, there are functioning schizophrenics working and raising families who do not currently qualify for public programs under MHPA Section 6 because they are not currently disabled. Due to the severity of their illnesses, however, they are in danger of relapsing and becoming disabled. The MHPA intends these individuals to qualify for relapse prevention programs-programs that will "reduce the duration" of their "untreated severe mental illness" and help them in "quickly <i>regaining productive</i> lives." Welf. & Inst. Code § 5840(c). If these individuals are insured, MHPA also expects their insurance to pay for these services.</p> <p>MIPO has chosen to address the issue of insurance in the Definitions, because they should tell the counties who qualifies for care. While most MHPA funding funnels directly into the county Systems of Care, meaning that it can be used <i>only</i> for county welfare clients, PEI funding is different. Counties can use it for people who may be heading into (or out of) the county Systems of Care, but who are not currently sufficiently disabled to be in the Systems of Care. Many of these individuals-especially children-have private insurance, and this will be increasingly true as Affordable</p>			

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		<p>Care becomes more widespread.</p> <p>County systems are not used to dealing with private insurance. However, MHSA clearly states that insurance should be billed when recipients have "coverage." If the insurer denies coverage, it is a matter between the county and the insurer; the individual has no financial responsibility. MIPO has incorporated this legal requirement by requiring direct billing to the insurer, so that people already struggling with mental illness and severe mental illness do not have to deal with bills and insurance paperwork. MHSAOAC did not include any provision for insurance billing in its proposed regulations at all. This needs to be addressed.</p>			
3200.245	Commenter #3	<p><u>Comment 3.32</u> <u>(c) "Mental illness" includes prodromal symptoms of severe mental illness in persons genetically or neurologically predisposed towards severe mental illness, as defined in Section 5600.3, and any condition defined as "mental illness" in the Diagnostic and Statistical Manual for Mental Disorders (DSM) or its future equivalent applicable at the time of the diagnosis, provided, that the county certifies each mental illness diagnosis based on the DSM or its future equivalent as one that carries a substantial risk of becoming a severe mental illness as defined herein. Insurers of individuals with mental illness shall be billed directly for covered services funded pursuant to this Chapter. Insured</u></p>	Reject in part	<p>Add new section to define "mental illness"</p> <p><u>Section 3703.</u> <u>"Mental illness" as used in the Prevention and Early Intervention regulations means, a syndrome characterized by clinically significant disturbance in an individual's cognitive, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying</u></p>	<ol style="list-style-type: none"> 1. <u>Recommended change:</u> the proposed new definition of "mental illness" is from the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (p. 20). 2. <u>Consistency with WIC 5600.3:</u> Proposed PEI regulations are consistent with the WIC §5600.3 definition of a "serious mental disorder." The definition does not specify particular diagnoses, though it includes a range of examples of applicable Diagnostic and Statistical Manual for Mental Disorders (DSM) axis one disorders. See response to comment 3.31 on page 1. 3. <u>Certification:</u> Additional certification that the illness that the Early Intervention Program addresses "carries a substantial risk of becoming a severe mental illness" is unnecessary because WIC §5847(b)(1) already requires the County Mental or Behavioral Health Director to certify that MHSA programs, including PEI, comply with "all pertinent regulations, laws, and statutes of the Mental Health Services Act". Proposed PEI Regulations are consistent with WIC §5840(a), and

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		<p><u>clients have no personal financial responsibility if coverage is denied.</u> Authority/reference for added subsection (c): See Welfare & Institutions Code section 5840(a), the introductory provision to the Prevention/Early Intervention requirements, which provides for a "program designed to prevent <i>mental illness</i> from becoming severe and disabling"; section 5840(c), which provides: "The program <i>shall</i> include mental health services similar to those provided under other programs effective in preventing <i>mental illnesses</i> from becoming severe"; section 5840(b)(2), which provides for "<i>medically necessary</i> care rovided by county mental health programs for children with severe mental illness, as defined in Section 5600.3, and for adults and seniors with severe mental illness, as defined in Section 5600.3, as early in the onset of <i>these conditions</i> as practicable." (Emphasis added.) See also MHPA Section 3(d), which provides, "[s]tate funds shall be available to provide services that are not already covered by federally sponsored programs or by individuals' or families' insurance programs."</p> <p>Necessity/Rationale for added subsection (c): Necessary for clarity and conformity to statute. It is impossible to administer a program intended to prevent "mental illness" from becoming "severe mental illness" without defining "mental illness."</p>		<p><u>mental functioning. Mental illness is usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental illness. Socially deviant behavior (e.g. political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental illnesses unless the deviance or conflict results from a dysfunction in the individual, as described above.</u></p>	<p>emphasize throughout that Prevention and Early Intervention Programs are intended to prevent mental illnesses from becoming severe and disabling.</p> <p>4. <u>Insurance</u>: See response to comment 3.31 on page 1.</p> <p>5. <u>Medically necessary</u>: See response to comment 3.31 on page 1.</p>

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Definitions	Commenter #3	<p><u>Comment 3.37</u> <u>Definition of "mental illness":</u> "Mental illness: is a term that different people understand very differently. People in the mental "lhealth" profession define it in a way that is completely counter-intuitive to members of the public. Obviously, therefore, the term needs a definition. MIPO proposes that it be defined as the medical profession does, based on the diagnostic criteria in the Diagnostic and Statistical Manual for Mental Disorders (known as the "DSM"), currently in its 5th edition, or on "its future equivalent applicable at the time of the diagnosis."</p> <p>The DSM definitions are both under-inclusive and over-inclusive for purposes of the PEI provisions, however. They are under-inclusive because there are genetic and neurological predictors of "severe mental illness" that make it imperative to monitor and provide early intervention for certain individuals, such as those with a history of schizophrenia in the family. It often happens that these individuals deteriorate rapidly into full blown "severe mental illness" without ever having been diagnosed with a "mental illness" at all. The first sentence of MIPO's proposed definition therefore addresses this category, which the DSM does not currently define as a "mental illness."</p> <p>The DSM definition of "mental illness" is over-inclusive because there are many conditions now considered to be "mental</p>	Reject	<p>Change existing language in 3755(d) as indicated:</p> <p>Section 3755 (d)(1)(A)</p> <p>Participants' risk of a potentially serious mental illness, either based on individual risk or membership in a group or population with greater than average risk of a serious mental illness, <u>i.e. the condition, experience, or indicators of greater than average risk.</u></p> <p>Section 3755 (d)(1)(B)</p> <p>How the risk of a potentially serious mental illness will be defined and determined, <u>i.e. what criteria and process the County will use to establish that the intended beneficiaries of the Program have a greater than average risk of developing a potentially severe mental illness.</u></p> <p>Section 3755 (c)(3)(A) and (d)(3)(A)</p>	<ol style="list-style-type: none"> 1. <u>Recommended change:</u> changes to Proposed PEI Regulations are intended to clarify the difference between risk factors, which sometimes are and sometimes are not possible to change, and measurable mental health indicators, such as sub-clinical symptoms, which are a required focus of evaluation of Prevention Programs. 2. <u>Serious mental illness:</u> See response to comment 3.31 on page 1. There is no agreement about which mental illnesses can become a serious mental illness consistent with the definition in WIC 5600.3. 3. <u>Certification of risk of development of a severe mental illness:</u> See response to comment 3.32 on page 5. 4. <u>New definition of mental illness:</u> See response to comment 3.32 on page 5.

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		<p>illness" that are very unlikely to become "severe mental illness." Only "mental illness" that carries a substantial risk of "severe mental illness" is appropriately addressed with MHSA PEI funds.</p> <p>The MIPO proposed regulation asks the counties to certify a "mental illness" diagnosis as one with a "substantial risk" of becoming a "severe mental illness." This is because counties are in the best position to identify which diagnoses are most likely to become "severe mental illness," as defined by Welfare & Institutions Code section 5600.3. Counties work with the section 5600.3 definitions on a daily basis; they know what the definitions entail; they know who would be disqualified for services under the 5600.3 standard; and they know by experience those individuals who don't currently qualify for section 5600.3 services but who will continue to deteriorate until they do qualify. Similarly, counties are familiar with the process of relapse. They know which clients need relapse prevention/early intervention services to remain stable. Their experience also will allow them to identify other severely mentally ill individuals, not currently in the Systems of Care, who can remain stable with the kind of monitoring and early intervention that good relapse prevention/early intervention services provide.</p> <p>Counties also have a financial stake in making the correct judgments on these</p>		<p>List the <u>mental health</u> indicators that the County will use to measure reduction of prolonged suffering as referenced in Section 3750, subdivision (b).</p>	

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		<p>issues. As stated in MHSA Section 2(f), "[e]arly diagnosis and adequate treatment provided in an integrated service system is very effective; and by preventing disability, it also saves money...".</p> <p>MHSOAC, of course, has a role. By requiring counties to certify a mental illness diagnosis as one that "that carries a substantial risk of becoming a severe mental illness" before allowing clients into PEI programs, and by further requiring counties to document all diagnoses for all Prevention and Early Intervention clients, MHSOAC can perform its oversight function, which is its appropriate role.</p>			
3200.245	Commenter #3	<p><u>Comment 3.33</u> <u>(d) "Untreated severe mental illness" means a severe mental illness as defined herein that is severely symptomatic, regardless of whether the patient is receiving treatment or is self-treating.</u></p> <p>Authority/reference for added subsection (d): See Welfare & Institutions section 5840(c), which provides: "The program .. <i>shall</i> also include components similar to programs that have been successful in reducing the duration of <i>untreated severe mental illnesses</i> and assisting people in quickly regaining productive lives." (Emphasis added.)</p> <p>Necessity/Rationale for added subsection (d): Necessary for clarity and</p>	Reject	Retain existing language with no change	<p>1. <u>Untreated mental illness</u>; The MHSA PEI requirement to reduce the duration of untreated mental illness refers to reducing the time between the onset of the mental illness and entry into treatment. For this reason, Proposed PEI Regulations require all PEI programs to include strategies to create access and linkage to treatment for individuals with severe mental illness (§3735(a)(1)(A)), to use effective methods for this purpose (§3740), and to measure the duration between onset of symptoms and entry into treatment (§3560.010(b)(3)(C)).</p>

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		adherence to statutory purpose. Many desperately ill people who need relapse prevention/early intervention services self-treat or are receiving inadequate treatment.			
Definitions	Commenter #3	<u>Comment 3.38</u> <u>Definition of "untreated severe mental illness."</u> MIPO proposes defining "untreated severe mental illness" as severe mental illness that is severely symptomatic, because many severely mentally ill individuals refuse treatment, or engage only partially in treatment, or choose to self-treat with bizarre personal regimens, or are simply receiving substandard treatment. Relapse prevention and relapse early intervention programs need to plan for and address severe symptoms, without being stymied if a severely mentally ill individual is receiving some form of treatment.	Reject	Retain existing language with no change	See response to comment 3.33 on page 9.
3200.245	Commenter #3	<u>Comment 3.34</u> <u>(e)"Services similar to those provided under other programs effective in preventing mental illnesses from becoming severe" means services modelled on a previous program or programs that have already been proven effective in preventing mental illness from becoming severe mental illness, using scientific evidence consistently showing improvement in one or more of the negative outcomes listed in Section 5840(d), including, but not limited to, independent scientific peer-reviewed research using randomized clinical trials.</u> Authority/Reference for added	Reject	Retain existing language with no change	<ol style="list-style-type: none"> 1. <u>Similar programs</u>: Proposed PEI regulation's requirement that a County <i>shall</i> include at least one Early Intervention Program implements the MHSA mandate mentioned in the Comment that the County's PEI program includes "mental health services similar to those provided under other programs effective in preventing mental illnesses from becoming severe" and shall also include components similar to programs that have been successful in "assisting people in quickly regaining productive lives." 2. <u>Effective programs</u>: Proposed PEI regulations implement §5840(c) requirement for effective programs by requiring Counties to use effective methods likely to bring about intended MHSA outcomes for all PEI programs and strategies, based on one of the following defined standards or a combination of the following standards: evidence-based practice, promising practice, and/or

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		<p>subsection (e): Welfare & Institutions section 5840(c), which provides: "The program <i>shall</i> include mental health <i>services similar to those provided under other programs effective</i> in preventing mental illnesses from becoming severe" (emphasis added). <i>See also</i> MHSA Section 3, the Purpose and Intent provision, subsection (c): "[T]o expand the kinds of <i>successful, innovative</i> service programs for children, adults and seniors begun in California....These programs have already proved their <i>effectiveness</i>. .."; and subsection (e): "To ensure that all funds are expended in the <i>most cost effective manner</i> and services are provided in accordance with <i>recommended best practices</i>. ..." (emphasis added). <i>See also</i> MHSA section 2, the Findings and Declarations Provisions, subsections (f) and (e), which call for "expanding programs that have <i>demonstrated their effectiveness</i>"; and for "<i>effective treatment</i>," "<i>effective models</i>," an approach "recognized in 2003 as a <i>model program</i> by the President's Commission on Mental Health," and "<i>successful programs</i>" (emphasis added).</p> <p>Necessity/rationale for added subsection (e): Necessary for clarity and conformity to statute. The definition in subsection (e) addresses the critical operative language in the statute.</p>			<p>community and practice-based evidence standard.</p> <p>Providing the County the option to demonstrate effectiveness regarding the likelihood to achieve intended outcomes using a range of acceptable sources of evidence, inclusive of research rigor, client and family preferences, and cultural appropriateness, is necessary because the MHSA does not include or mandate a specific standard of evidence for demonstrating program success or effectiveness.</p> <p>There is also no consensus among experts about a specific minimum threshold of evidence or cutoff point for sufficiency or insufficiency of evidence of effectiveness. The Proposed PEI Regulations' categories of evidence-based practice, promising practice, and community and practice-based evidence standards reflect a range that takes into account various methods and standards of evidence of effectiveness that are documented in mental health prevention and early intervention literature. They provide flexibility for counties to implement and evaluate programs to address PEI goals for diverse populations, for whom there is a dearth of programs that meet the evidence standards suggested by the comment.</p> <p>There is a need to allow counties to implement programs that have documented their effectiveness solely based on practice-based or community defined evidence because at this stage in the evolution of research in the field of prevention and early intervention related to potentially serious mental illness, there are insufficient programs that meet the empirical research standards required for an evidence-based practice or promising practice, as defined in these regulations. The literature also documents numerous limitations to mandating application of the empirical evidence-based practice standard for public health programs, including but not limited to impracticality, ethical issues associated with random assignment, and both the challenges and possible inadvisability in some instances of fidelity of</p>

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					application. There are well-documented issues regarding lack of research and questions of applicability of the evidence-based or promising practice standard to communities of color. For all of these reasons, inclusion of the community-defined and practice-based evidence standards is appropriate and necessary.
Definitions	Commenter #3	<p><u>Comment 3.39</u> <u>Definition of "services similar to those provided under other programs effective in preventing mental illness from becoming severe".</u> This statutory phrase, quoted verbatim from section 5840(c), incorporates a term of art in the medical community, the term, "effective." As stated at greater length in MIPO Comment No.9, it is clear that the voters were promised that Proposition 63 would deliver "effective" programs to prevent severe mental illness. MIPO has borrowed the agency's definition of "evidence-based practice standard" to define "effective in preventing mental illnesses from becoming severe." As stated at greater length in Comment No.9, this is what the provisions quoted above as "Authority" require.</p> <p>MIPO's definition also addresses a requirement in the operative language, discussed at greater length in Comment No.9, for " effective" prototypes for all Prevention and Early Intervention programs, based on the following language in MHSA Section 5840(c): The program shall include mental health services <i>similar to those provided under other programs effective</i> in preventing mental illnesses from</p>	Reject	Retain existing language with no change	<u>Similar programs and Effective practices:</u> See responses to comment 3.34 on page 10.

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		<p>becoming severe....". W.I.C. 5840(c) (emphasis added).</p> <p>Again, this statutory language and the provisions cited as "Authority" above demonstrate that voters were repeatedly promised that MHSA money designated to prevent "mental illness" from becoming "severe mental illness" would only be used for programs based on "effective" prototypes.</p>			
3200.245	Commenter #3	<p><u>Comment 3.35</u> <u>(f) "Components similar to programs that have been successful in reducing the duration of untreated severe mental illnesses and assisting people in quickly regaining productive lives" means services modelled on a previous program or programs that have shown success at intervening early in and/or preventing relapses into severe mental illness, as defined herein, based on research demonstrating success, including strong quantitative and qualitative data showing improvement in one or more of the negative outcomes listed in Section 5840(d), but the research does not meet the standards used to establish evidence-based practices and does not have enough research or replication either to prove or disprove the positive effect shown in existing studies.</u></p> <p>Authority/reference for added subsection (f): See Welfare & Institutions Code section 5840(c), which provides: "The program .. <i>shall</i> also include</p>	Reject	Retain existing language with no change	<u>Similar programs and Effective practices:</u> See responses to comment 3.34 on page 10.

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		<p><i>components similar to programs that have been successful in reducing the duration of untreated severe mental illnesses and assisting people in quickly regaining productive lives"</i> (emphasis added). See also MHPA Section 3, the Purpose and Intent provision, subsection (c): "[T]o expand the kinds of <i>successful</i>, innovated service programs for children, adults and seniors begun in California....These programs have already proved their <i>effectiveness</i>. .." (emphasis added) and subsection (e): "To ensure that all funds are expended in the <i>most cost effective manner</i> and services are provided in accordance with <i>recommended best practices</i>. ..." (emphasis added). See also MHPA Section 2, the Findings and Declarations provisions, subsections (f) and (3), which call for "expanding programs that have <i>demonstrated their effectiveness</i>", and for "effective treatment," "effective models," an approach "recognized in 2003 as a <i>model program</i> by the President's Commission on Mental Health/" and "<i>successful programs</i>" (emphasis added).</p> <p>Necessity/rationale for added subsection (f): Necessary for clarity and conformity to statute. The definition in subsection (f) the most critical operative language in the statute.</p>			
Definitions	Commenter #3	<p><u>Comment 3.40</u> <u>Definition of "similar to programs that have been successful in reducing the duration of untreated severe mental</u></p>	Reject	Retain existing language with no change	<u>Similar programs and Effective practices</u> : See responses to comment 3.34 on page 10.

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		<p>illnesses and assisting people in quickly <u>regaining productive lives</u>". In the last clause of Section 5840(c), quoted above, the drafters used the term "successful" rather than "effective" as in the previous clause. In any statute, particularly a well-drafted statute like MHSA, such changes in terminology are presumed to be deliberate. In the scientific community, there are often "successful" programs, as measured by peer-reviewed independent research, that still require further research to be considered "effective." As explained at greater length in its Comment No.9, MIPO has incorporated the agency "promising practice" standard in defining the section 5840(c) phrase, "programs that have been <i>successful</i>." And again, for the same reasons discussed above with respect to the previous definition, this phrase also makes clear that the components must be modelled on "successful" prototypes.</p>			

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3200.245	Commenter #25	<p>Comment 25.02 <u>Section 3200.245- Prevention and Intervention (a) Prevention and Early Intervention Component</u> is defined as “the section of the Three-Year Program and Expenditure Plan intended to prevent mental illness <i>from becoming severe and disabling.</i>” This sentence negates those currently funded MHSA-prevention programs that actually serve to prevent mental illness in the primary sense—before it occurs! For example, home visiting works to prevent pregnant youth from drinking alcohol, the single, most preventable cause of mental retardation, or it provides early recognition of and intervention for developmental delays in toddlers and youth that prevents adverse mental health issues from escalating into problematic behaviors. It should read...<u>”intended to prevent mental illness and/or ameliorate its’ negative, severe and/or disabling effects.”</u></p>	Reject	Retain existing language with no change	The language in Section 3200.245 is directly from the MHSA. Extensive research literature confirms the statement made by the Comment that one effective way to prevent mental illness from becoming severe and disabling is to prevent the mental illness from occurring in the first place, in instances where this is possible. The substance of the comment is included as part of the Prevention Program.
3200.245	Commenter #26	<p>Comment 26.02 <u>Section 3200.245- Prevention and Intervention (a) Prevention and Early Intervention Component</u> is defined as “the section of the Three-Year Program and Expenditure Plan intended to prevent mental illness <i>from becoming severe and disabling.</i>” This Section implies mental illness exists and the goal is to prevent the occurrence of more serious mental illness. This sentence does not address preventing mental illness in the first place and negates those currently funded MHSA-prevention</p>	Reject	Retain existing language with no change	See Response to comment 25.02 on page 15.

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		<p>programs that actually serve to prevent mental illness. For example, home visiting provides early recognition of and intervention for developmental delays in toddlers and youth that prevents adverse mental health issues from escalating into problematic behaviors. It should read ... <i>“intended to prevent mental illness and negate the the severe and disabling effects among those with mental illness.”</i></p>			
3510.010	<p>Commenter #4, 10, 11, 12, 16, 17, 22, 24, 27, 28, 37, 43, 46, 62, 69, 70, 72</p>	<p><u>Comment 4.05, 10.05, 11.05, 12.05, 16.05, 17.05, 22.05, 24.05, 27.05, 28.05, 37.06, 43.05, 46.05, 62.05, 69.05, 70.06, 72.06</u> Revenue and Expenditure reporting at the level of Prevention and Early Intervention.</p> <p>Recommendation: Section 3510.010 Prevention and Early Intervention Annual Revenue and Expenditure Report. The language currently reads: (A) Prevention and Early Intervention funds</p> <ul style="list-style-type: none"> (i) The county shall identify each program funded with Prevention and Early Intervention funds as a Prevention program, Early Intervention program, Outreach for Increasing Recognition of Early Signs of Mental Illness program, Stigma and Discrimination Reduction Program, or Suicide Prevention Program. If a program includes more than one element, the county shall estimate the 	Reject	Retain existing language with no change	<p><u>Classifying as Prevention and Early Intervention only:</u> Classifying all programs as “prevention” or “early intervention” is not consistent with the MHSA.</p> <p>The “Prevention and Early Intervention” section of the MHSA (WIC §5840) refers to several intended outcomes, all of which, collectively, move mental health from a “fail first” to a “help first” approach and prevent mental illness from becoming severe and disabling. Proposed PEI regulations include all required MHSA PEI outcomes and actions. These include programs that intend outcomes for specific individuals at risk of (prevention) or with early onset of (early intervention) a potentially serious mental illness. They also include broader efforts to address the other MHSA PEI goals:</p> <ul style="list-style-type: none"> a) Emphasize improving timely access to services for underserved populations (WIC §5840(a)), b) Conduct outreach to families, employers, primary care health care providers, and others to recognize early signs of potentially severe and disabling mental illnesses (WIC §5840(b)(1)). c) Create access and linkage to medically necessary care provided by county mental health programs (WIC §5840 (b)(2)). d) Reduce stigma associated with either being diagnosed with a mental illness or seeking mental health services

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		<p>percentage of funds dedicated to each element.</p> <p>As written, the proposed measure would require counties to track expenditures and ‘characterize “programs” using a methodology that is inconsistent with program implementation and the tracking mechanisms established in electronic health records or information technology systems. Modifying these systems would require an infusion of resources. It is much more efficient to identify a program as “Prevention,” “Early Intervention,” or both.</p> <p>Recommendation: Revise Section 3510.010 Prevention and Early Intervention Annual Revenue and Expenditure Report (A) (i) as follows: (i) The county shall identify each program funded with Prevention and Early Intervention funds as <u>a Prevention program or Early Intervention program.</u></p>			<p>(WIC §5840(b)(3)).</p> <p>e) Reduce discrimination against people with mental illness (WIC §5840(b)(4)).</p> <p>Given the above statutory requirements, classifying all programs as “prevention” or “early intervention” is not consistent with the MHSA. For example, a program to reduce stigma and discrimination associated with serious mental illness is neither “prevention” nor “early intervention.” A program to reach out to people in positions to identify early signs of potentially serious and disabling mental illness is neither prevention nor early intervention. All of these are strategies to increase timely access to the appropriate mental health service. A major goal of proposed regulations is to align PEI program and associated reporting requirements with the MHSA. Fortunately, many counties are now building electronic record systems, presenting the opportunity to align reporting categories with MHSA requirements for PEI.</p> <p>See response to comment 38.04 on page 20.</p>
3510.010	Commenter # 5	<p><u>Comment 5.04</u> Revenue and Expenditure reporting at the level of prevention or early intervention.</p> <p>Recommendation: Section 3510.010 Prevention and Early Intervention Annual Revenue and Expenditure Report. The language currently reads:</p> <p>Prevention and Early Intervention funds (i) The county shall identify each program funded with Prevention</p>	Reject	Retain existing language with no change	See response to Comments 4.05, 10.05, 11.05, 12.05, 16.05, 17.05, 22.05, 24.05, 27.05, 28.05, 37.06, 43.05, 46.05, 62.05, 69.05, 70.06, 72.06 on page 17.

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		<p>and Early Intervention funds as a <u>Prevention program</u>, <u>Early Intervention program</u>, Outreach for Increasing Recognition of Early Signs of Mental Illness program, Stigma and Discrimination Reduction Program, or Suicide Prevention Program. If a program includes more than one element, the county shall estimate the percentage of funds dedicated to each element.</p> <p>As written, the proposed measure would require counties to track expenditures and characterize “programs” using a methodology that is inconsistent with program implementation and inconsistent with the tracking mechanisms established in electronic health records or information technology systems. Modifying these systems would require an infusion of resources. It is much more efficient to identify a program as either Prevention, Early Intervention, or both.</p> <p>Recommendation: The recommendation is to revise Section 3510.010 Prevention and Early Intervention Annual Revenue and Expenditure Report (A) (i) as follows:</p> <p>(i) The county shall identify each program funded with Prevention and Early Intervention funds as <u>a Prevention program</u> or <u>Early Intervention program</u>.</p>			

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3510.010	Commenter #38	<p><u>Comment 38.04</u> In regard to Section 3510.010, Revenue and Expenditure reporting at the level of Prevention and Early Intervention, there is not enough of a reporting foundation in place to split off sub-groups of funding and accurately track the expenditures or capture the outcomes accurately. There is too much overlap and cross-over of funding to identify the individual components of services and their funding source and demonstrate the program outcomes at this time. Therefore, we support the division of categories into Prevention, Early Intervention, or both, but not smaller categories and suggest the following modification to the language:</p> <p>(A) Prevention and Early Intervention funds (i) The County shall identify each program funded with Prevention and Early Intervention funds as a Prevention Program <i>and/or</i> Early Intervention Program. Outreach for Increasing Signs of Mental Illness Program/Approach, Stigma and Discrimination Reduction Program, or Suicide Prevention Program/Approach. If a program includes more than one element., t The County shall estimate the percentage of funds dedicated to each element.</p>	Accept in part and Reject in part.	<p>Change existing language indicated by underlined (new language) or strikethrough (remove existing language):</p> <p>3510.010 (a)(1): The total funding source dollar amounts expended during the reporting period on each program and strategy funded with Prevention and Early Intervention funds by the following funding sources: (A) Prevention and Early Intervention funds (i) The County shall identify each program funded with Prevention and Early Intervention funds as a Prevention Program, Early Intervention Program, Outreach for Increasing Signs of Mental Illness Program/Approach, Stigma and Discrimination Reduction Program, or Suicide Prevention Program/Approach, <u>Access to Treatment Program, or Program to Improve Timely Access to Services for</u></p>	<ol style="list-style-type: none"> 1. <u>Recommended change:</u> Delete the provision requiring the County to report funds expended on each “strategy.” This requirement is likely to pose an unacceptable burden on counties since a “strategy” is not a separate program component but a “planned and specified method within a program intended to achieve a defined goal” (§3702(a)), for which specific funds are not necessarily allocated. The current proposed regulations require the County to report expenditures by “programs.” Since the County has the option to offer two of the “strategies,” (i.e. Access to Treatment” and “Improve Timely Access to Underserved Population”) as a program, the recommended change to 3510.010(a)(1)(A) adds these two programs to the list of programs. This requirement would only apply if the County chooses to offer these strategies as a program. 2. <u>Classifying as Prevention and Early Intervention only:</u> The comment identifies the problem that Section 3510.010 of Proposed PEI Regulations is intended to solve. It is currently impossible to report accurately how PEI funds are being expended in terms of required MHSA goals and intended outcomes. Correcting the misperception that all PEI programs are either “prevention” or “early intervention” and focusing efforts on MHSA goals and outcomes is a critically important function of Proposed PEI Regulations. The State Auditor in its 2013 report found that its reviews “failed to provide assurance that all counties consistently followed MHSA requirements and spent taxpayer money appropriately” (p. 3) and called on the MHSOAC to “develop and issue guidance or regulations, as appropriate, to counties on how to effectively evaluate and report on MHSA program performance” (p. 5). <p>See response to comments 4.05, 10.05, 11.05, 12.05, 16.05, 17.05, 22.05, 24.05, 27.05, 28.05, 37.06, 43.05, 46.05, 62.05, 69.05, 70.06, 72.06 on page 17.</p>

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				<p><u>Underserved Population.</u> If a program includes more than one element, the County shall estimate the percentage of funds dedicated to each element.</p>	
3510.010(a)	Commenter#8	<p><u>Comment 8.20</u> (a) As part of the Mental Health Services Act Annual Revenue and Expenditure Report the County shall report the following: (1) The total funding source dollar amounts expended during the reporting period on each program and strategy funded with Prevention and Early Intervention funds by the following funding sources: (A) Prevention and Early Intervention funds (i) The County shall identify each program funded with Prevention and Early Intervention funds as a <u>Prevention and Early Intervention Program</u>, Prevention Program, Early Intervention Program, Outreach for Increasing Recognition of Early Signs of Mental Illness Program/Approach, Stigma</p>	Reject	Retain existing language with no change	<ol style="list-style-type: none"> 1. The program categories in Proposed PEI Regulations, which are referenced in reporting requirements in 3510.010(a), cover all the options mentioned in the comment. All PEI programs and strategies are intended, in various ways, to prevent mental illnesses from becoming severe and disabling. Early Intervention Programs address the MHSA requirement to prevent existing early onset mental illness from becoming severe and to assist people with early onset of a potentially serious mental illness quickly to regain productive lives. 2. <u>Effective Methods:</u> All PEI programs and strategies are required to use effective methods to bring about MHSA outcomes. See response to Comment 3.34 on page 10. 3. <u>Untreated Mental illness:</u> Regarding the reduction of the duration of untreated mental illness see response to comment 3.33 on page 9. 4. Because these requirements are covered in existing required programs and/or strategies, there is no need to create the reporting categories suggested by the comment.

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		<p>and Discrimination Reduction Program, M Suicide Prevention Program/Approach, <u>a Program Similar to Other Programs Effective in Preventing Mental Illness from Becoming Severe, a Program Successful in Reducing the Duration of Untreated Severe Mental Illness: or a Program that Assists People with Severe Mental illness in Regaining Productive Lives.</u> "If a program includes more than one element, the County shall estimate the percentage of funds dedicated to each element.</p> <p>(B) Medi-Cal Federal Financial Participation (C) 1991 Realignment (D) Behavioral Health Subaccount (E) Any other funding</p>			
3510.010(a)(i)	Commenter #32	<p><u>Comment 32.02</u> 1. Recommendation: Section 3510.010(a)(i) Prevention and Early Intervention Annual Revenue and Expenditure Report. Prevention and Early Intervention Funds.</p> <p>We support Section 3510.010(a)(i), as it stands in regulation, proposed by the MHSOAC.</p> <p>Proposed regulations require counties to</p>	Accept	See response to comment 38.04 on page 20	See response to comment 38.04 on page 20.

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		<p>identify each PEI-funded program as: 1) Prevention, 2) Early Intervention, 3) Outreach for Increasing Recognition of Mental Illness, 4) Stigma & Discrimination Reduction, or 5) Suicide Prevention. When programs fall into multiple categories, the county must identify what portion of funding is dedicated to each purpose. <u>This level of tracking is critical to maximizing local transparency and accountability and measuring outcomes in each of these areas.</u> To simplify tracking solely to: 1) Prevention, 2) Intervention, or 3) Both, <u>oversimplifies data collection and will obscure tracking outcomes.</u> Therefore we support keeping the regulations inclusive of all expenditure reporting categories as currently Proposed.</p>			
3750 and 3755	Commenter #3	<p><u>Comment 3.43</u> MIPO's Comments regarding proposed regulation sections 3750 and 3755:</p> <p>MHSOAC's proposed tracking regulations are inadequate, both legally and practically. Those specific to Prevention and Early Intervention, addressed here, ignore the statutory requirement that programs follow "effective" or "successful" prototypes. They also ignore the six objective markers for severe mental illness in section 5840(d); they select the only marker that is subjective ("prolonged suffering"); and then they repeatedly require counties to figure out their own way to measure it. Collectively, these legal and practical deficiencies will</p>	Reject	Retain existing language with no change	<ol style="list-style-type: none"> 1. <u>Effective practices</u>: See response to comment 3.34 on page 10. 2. <u>Required MHSA PEI outcomes (WIC §5840(d))</u>: Proposed PEI Regulations define the reduction of prolonged suffering as objective measures of direct mental health outcomes, such as a reduction of symptoms of depression. See responses to comments 3.41 on page 29, and 3.45 on page 25. 3. <u>Uniform standards</u>: In California, there is a need to have a balance between honoring and supporting the local autonomy and decision-making and vast difference among counties with the need for uniformity for statewide tracking, reporting, and evaluation. Proposed PEI Regulations, for the first time, provide the basis for statewide reporting of PEI program (process) data and also require reporting outcomes for all PEI programs. As local and statewide data and evaluation capacities develop, it is very likely that there will be additional reporting and evaluation requirements, including the

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		<p>inevitably result in confusion, wasted time, and reams of meaningless data.</p> <p>For the tracking data to have any meaning, the regulation has to impose uniform standards that are easy to administer, so that data will be uniform between counties and allow for uniform analyses and comparisons. There also need to be mechanisms for evaluating costs, which are completely lacking under MHSOAC's proposed regulations.</p> <p>MIPO will first analyze the legal and practical deficiencies in the proposed tracking regulations for Prevention and Early Intervention programs, then suggest a way to fix them. MIPO does not address the tracking regulations relating to other aspects of the program, such as access and linkage, stigma and so forth-though they are just as bad. There is no way MHSOAC-- the "Oversight and Accountability" Commission--will be able to perform any kind of meaningful oversight, or hold anyone accountable, using the regulations it has proposed.</p>			<p>possibility of greater uniformity of evaluation reporting categories, still taking into account the variability of counties' programs and priorities. The details about the evaluations and reporting regulations will be presented to the MHSOAC and discussed in the responses to public comments on the evaluation and reporting sections at the October 2014 MHSOAC meeting.</p> <p>4. <u>Costs</u>: Proposed PEI regulations require counties to report costs of all PEI programs as well as number of individuals served thus providing the basis to estimate cost per person.</p>
3750 and 3755	Commenter #3	<p><u>Comment 3.44</u></p> <p>A. The Prevention/Early Intervention tracking regulation fails to require counties to measure their programs against effective prototypes.</p> <p>The statutory requirement that PEI programs for the mentally ill and severely mentally ill follow "effective" or "successful" prototypes is discussed at length in MIPO Comment No.9.</p>	Reject	Retain existing language with no change	<p>1. Proposed PEI Regulations require counties to define, measure, and report applicable MHSA outcomes for all PEI programs and to use practices that have demonstrated their effectiveness to bring about intended outcomes for the intended population.</p> <p>2. Proposed PEI Regulations also require the County to explain how the practice's effectiveness has been demonstrated for the intended population and how the County will ensure fidelity to the evidence-based practice</p>

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		Logically, programs modelled on "other effective programs" should measure themselves against those evidence-based programs, following the readily-available road map those programs created when they proved themselves to be "evidence-based." MIPO's suggested standard incorporates this statutory requirement; MHSOAC's proposed regulation does not.			in implementing the program (§3755(d)(4)(A)). It follows logically that when a county uses an Evidence-Based Practice, which has demonstrated applicable intended outcomes for an intended population, the County would measure these outcomes. The same logic applies to the other allowable standards of practice evidence.
3750 and 3755	Commenter #3	<p><u>Comment 3.45</u> B. MHSOAC lacks legal authority to ignore six objective statutory measurements and misconstrue/misapply the seventh. Welfare & Institutions Code section 5840(d) is a roadmap for the tracking regulations MHSOAC should create-a road map MHSOAC has failed to follow. It contains six objective, easily measured outcomes. Ignoring these objective outcomes, MHSOAC's proposed regulation chooses the only subjective factor in section 5840(d): "prolonged suffering." MHSOAC's proposed regulation then demands that each county figure out its own way to measure "prolonged suffering" using additional vague and subjective factors, e.g., by "measuring reduced symptoms and/or improved recovery, including protective factors that may lead to improved mental emotional, and relational functioning." Measuring a subjective outcome with vague and subjective factors is a recipe for failure.</p> <p>MHSOAC's approach misconstrues the</p>	Reject	Retain existing language with no change	<ol style="list-style-type: none"> <u>Objective outcomes:</u> Proposed PEI Regulations do not "ignore six objective statutory requirements and misconstrue/misapply the seventh," but rather the regulations require counties to define, measure, and report on objective indicators for all WIC §5840(d) outcomes that apply to the county's programs, including in all instances the reduction of prolonged suffering, which is defined as direct mental health outcomes. <u>Reduction of prolonged suffering:</u> The Regulations define the reduction of prolonged suffering as objective direct mental health indicators for several reasons, including the point made in the comment: that suffering as a result of untreated mental illness is ubiquitous and takes so many forms that its subjective measurement not practical nor consistent. See responses to comments 3.41 on page 29 and 3.43 on page 23.

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		<p>tracking mechanism created by the statute, and renders it meaningless. The six "negative outcomes" that MHSOAC's proposed regulation ignores are <i>all</i> clear and objective measures of "suffering." Mentally ill people who attempt and commit suicide are suffering. The mentally ill who are jailed when instead they should be receiving treatment, suffer. Homeless people suffer. People separated from their children and the children themselves suffer, and so on. The marker MHSOAC has chosen to focus on, instead, is really not about suffering at all. It is about "prolonged" suffering, <i>i.e.</i>, suffering that has gone on too long; suffering over <i>time</i>. "Prolonged" suffering harkens back to the repeated emphasis in Proposition 63 on "timely" treatment for all who are, or are in danger of becoming, severely mentally ill.</p> <p>By creating a subjective and unworkable standard, MHSOAC has avoided creating any standard at all. This simply encourages counties to continue the waste and abuse of PEI program funds of the past ten years.</p>			
3750 and 3755	Commenter #3	<p><u>Comment 3.47</u> 2. The alternative standards proposed by MIPO are reasonable, less burdensome, and far more effective. The California Administrative Procedure Act requires agencies to consider "reasonable... alternatives that are proposed as less burdensome and equally effective in achieving the</p>	Reject	Retain existing language with no change	<ol style="list-style-type: none"> 1. Proposed PEI Regulations address all MHSA PEI required outcomes in a way that provides maximum flexibility to counties and local communities. 2. The two primary problems with the comment's suggested approach are: (a) the lack of differentiation between PEI and CSS; and (b) inflexibility and lack of recognition of the wide variety of local priorities that result from the required local decision-making process regarding a

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		<p>purposes of the regulation in a manner that ensures full compliance with the authorizing statute." Govt. Code § 11346.2(4)(A). MIPO's proposed alternative language follows the statutory directives that the agency has failed to acknowledge. It incorporates all of the "negative outcomes" the statute required be reduced, including "prolonged suffering, " which it achieves by measuring the objective markers for suffering over time. (MIPO has also added one standard marker that is included in most studies that evaluate the efficacy of programs for the severely mentally ill: the number and length of hospitalizations for mental illness.) MIPO's proposed regulation is much shorter than MHSOAC's proposal; it is far easier to understand and administer; and it is designed to create uniform data across counties, rather than allowing the counties individually to create their own measurement metrics.</p> <p>MIPO's proposed regulation also adds a primitive measure of cost per recipient, something that MHSOAC has ignored entirely. MHSOAC is obligated to "ensure that all funds are expended in the most cost effective manner and services are provided in accordance with recommended best practices. 1/ See MHSOAC Purpose And Intent Provisions, Section 3(e). The PEI budget is approximately \$317 million yearly. MHSOAC simply cannot effectively perform its oversight and accountability</p>			<p>County's use of PEI funds.</p> <ol style="list-style-type: none"> 3. The comment's proposed approach does not differentiate between programs that address intended outcomes for individuals at risk (Prevention), individuals with early onset (Early Intervention), and programs and strategies that address broad MHSA PEI goals to improve timely access and reduce the duration of untreated mental illness, including by reducing stigma and discrimination related to mental illness and to seeking mental health services. 4. The reduction of the number and length of hospitalizations applies to some but not most PEI programs. The comment's proposed approach does not acknowledge that not all PEI programs could or should address all the outcomes specified in WIC §5840(d). The comment's proposed approach to measure markers of suffering over time is far more subjective than the approach in Proposed PEI Regulations to measure the reduction of identified risk factors and symptoms of a mental illness. 5. Proposed PEI Regulations report both costs and numbers served, providing the basis to estimate cost per person.

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		obligations if it does not in some manner ensure costs per program recipient. Without this cost data, PEI funds will continue to be misspent.			
3750 and 3755	Commenter #3	<p><u>Comment 3.48</u> 3. MHSOAC should create tracking regulations that allow for meaningful cost and expenditure analyses and program comparisons between counties. MHSOAC's regulations for the remaining PEI components have similar problems. They measure process instead of progress-the number of clicks on a website, for example, rather than achieved outcomes. They are full of subjective and vague phrases and require counties to make up their own measuring instruments instead of specifying uniform practices. This will result in counties doing an enormous amount of work to create idiosyncratic data that will vary so much from PEI component to PEI component and from county to county that collectively, the data will be worthless. The problem is compounded by MHSOAC's decision to write elaborate, separate requirements for each component of the PEI program, no matter how small.</p> <p>MIPO proposes that MHSOAC address the remaining PEI components, which are all essentially education programs, with uniform, easily understood standards. Rather than demanding that each county determine its own manner of measurement, MHSOAC should</p>	Reject	Retain existing language with no change	<ol style="list-style-type: none"> 1. <u>Cost and expenditure analysis</u>: See responses to comments 3.43 on page 23 and 3.47 on page 27. 2. <u>Objective outcomes measurements</u>: PEI Regulations require specific outcome measures, in addition to program or process data, for all PEI programs. The outcome measures looks at the progress and improvement related to each PEI programs. 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 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. The measurements are tailored to the specific type of program. More detailed information on the evaluation and reporting sections is in the responses to the public comments to the sections that will be discussed at the October 2014 MHAOAC meeting.

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		impose a uniform methodology, so that data can be compared across counties. Finally, it is critical to have better financial data accounting requirements, so that cost analyses and comparisons can be done. Without such improvements, the data MHSOAC accumulates under its proposed regulations will be worthless.			
3750 and 3755	Commenter #3	<p><u>Comment 3.41</u> MIPO proposes striking MHSOAC's proposed regulation section 3750(a) through (c) and section 3755(c) and (d), and substituting MIPO proposed section 3755(c) through (g), set forth below:</p> <p>Section 3750. Prevention and Early Intervention Program Evaluation. (a) For each Early Intervention program the County shall 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 select, define, and measure appropriate indicators that are applicable to the program. (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 reduction in risk factors and/or increased protective factors that</p>	Reject	Retain existing language with no change	<ol style="list-style-type: none"> 1. The deletion of 3750(a) through (c) and 3755 (c) through (d) is based on an invalid argument that the MHSOAC has ignored two statutory requirements: "successful/effective prototypes" and "eight objective statutory outcomes". The proposed regulations do not ignore either of the requirements mentioned in the comment. See responses to comments 3.34 on page 10, 3.45 on page 25 and 3.48 on page 28. 2. <u>Effective practices</u>: See response to comment 3.34 on page 10 3. <u>Statutory outcomes</u>: PEI programs that intend outcomes for specific individuals are required by WIC §5840(d) to address seven specified negative outcomes, all as a consequence of untreated mental illness. Six of the listed negative outcomes – suicide, incarcerations, school failure or drop out, unemployment, homelessness, and removal of children from their homes – are potential consequences of untreated mental illness that are relevant to some but not all Prevention and Early Intervention Programs. The seventh, reduction of prolonged suffering, as defined in Proposed PEI Regulations is applicable to all PEI programs. Detailed information on the evaluation will be discussed in the Matrix for the October 2014 MHSOAC meeting. 4. The information in section 3755 that is suggested be deleted is necessary for the decision makers at the local level to decide on how to prioritize the use of PEI funds.

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		<p>may lead to improved mental, emotional, and relational functioning. The County shall select, define, and measure appropriate indicators that are applicable to the program</p> <p>(c) — For each 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.</p> <p>Section 3755. Prevention and Early Intervention Component of the Three-year Program and Expenditure Plan and Annual Update.</p> <p>(c) — For each Early Intervention program as defined in Section 3710, the County shall include a description of the program including but not limited to:</p> <p>(1) — Identification of the target population for the intended mental health outcomes including:</p> <p>(A) — Demographics including, but not limited to, age, race/ethnicity, gender, and if relevant, primary language spoken, military status, and lesbian, gay, bisexual, transgender, and/or questioning identification.</p> <p>(B) — The mental illness or illnesses for which there is early onset.</p>			

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		<p>(C) — Brief description of how each participant's early onset of a potentially serious mental illness will be determined.</p> <p>(2) — Identification of the type of problem(s) and need(s) for which the program will be directed and the activities to be included in the program that are intended to bring about mental health and related functional outcomes including reduction of the negative outcomes referenced in Welfare and Institutions Code Section 5840, subdivision (d) for individuals with early onset of potentially serious mental illness.</p> <p>(3) — The Mental Health Services Act negative outcomes as a consequence of untreated mental illness referenced in Welfare and Institutions Code Section 5840, subdivision (d) that the program is expected to affect, including the reduction of prolonged suffering as a consequence of untreated mental illness, as defined in Section 3750, subdivision (a).</p> <p>(A) — List the indicators that the County will use to measure reduction of prolonged suffering as referenced in Section 3750, subdivision(a).</p> <p>(B) — For any other specified Mental Health Services Act negative outcome as a consequence of untreated mental illness, as referenced in Section 3750, subdivision (c), list the indicators that the County will use to measure the intended reductions.</p> <p>(C) — Explain the evaluation methodology, including, how and when</p>			

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		<p>outcomes will be measured, how data will be collected and analyzed, and how the evaluation will reflect cultural competence.</p> <p>(4) — Specify how the Early Intervention program is likely to reduce the relevant Mental Health Services Act negative outcomes as referenced in Welfare and Institutions Code Section 5840, subdivision (d) by providing the following information:</p> <p>(A) — If the County used evidence-based standard or promising practice standard to determine the program's effectiveness as referenced in Section 3740, subdivisions (a)(1) and (a)(2), provide a brief description of or reference to the relevant evidence applicable to the specific intended outcome, explain how the practice's effectiveness has been demonstrated for the intended population, and explain how the County will ensure fidelity to the evidence-based practice in implementing the program.</p> <p>(B) — If the County used community and/or practice-based standard to determine the program's effectiveness as referenced in Section 3740, subdivision (a)(3), describe the evidence that the approach is likely to bring about Mental Health Services Act outcomes for the intended population.</p> <p>(d) — The Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include a description of the Prevention program including but not limited to the following</p>			

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		<p>information:</p> <p>(1) Identification of the target population for the intended mental health outcomes, including:</p> <p>(A) Participants' risk of a potentially serious mental illness, either based on individual risk or membership in a group or population with greater than average risk of a serious mental illness.</p> <p>(B) How the risk of a potentially serious mental illness will be defined and determined.</p> <p>(2) Specify the type of problem(s) and need(s) for which the Prevention program will be directed and the activities to be included in the program that are intended to bring about mental health and related functional outcomes including reduction of the negative outcomes referenced in Welfare and Institutions Code Section 5840, subdivision (d) for individuals with higher than average risk of potentially serious mental illness.</p> <p>(3) Specify any Mental Health Services Act negative outcomes as a consequence of untreated mental illness as referenced in Welfare and Institutions Code Section 5840, subdivision (d) that the program is expected to affect, including reduction of prolonged suffering, as defined in Section 3750, subdivision (b).</p> <p>(A) List the indicators that the County will use to measure reduction of prolonged suffering as referenced in Section 3750, subdivision (b).</p> <p>(B) If the County intends the program</p>			

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		<p>to reduce any other specified Mental Health Services Act negative outcome as a consequence of untreated mental illness as referenced in Section 3750, subdivision (c), list the indicators that the County will use to measure the intended reductions.</p> <p>(C) — Explain the evaluation methodology, including, how and when outcomes will be measured, how data will be collected and analyzed, and how the evaluation will reflect cultural competence.</p> <p>(4) — Specify how the Prevention program is likely to bring about reduction of relevant Mental Health Services Act negative outcomes referenced in Welfare and Institutions Code Section 5840, subdivision (d) for the intended population by providing the following information:</p> <p>(A) — If the County used evidence-based standard or promising practice standard to determine the program's effectiveness as referenced in Section 3740, subdivisions (a)(1) and (a)(2), provide a brief description of or reference to the relevant evidence applicable to the specific intended outcome, explain how the practice's effectiveness has been demonstrated for the intended population, and explain how the County will ensure fidelity to the evidence-based practice in implementing the program.</p> <p>(B) — If the County used community and/or practice-based standard to determine the program's effectiveness as referenced in Section 3740,</p>			

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		<p>subdivision (a)(3), describe the evidence that the approach is likely to bring about Mental Health Services Act outcomes for the intended population.</p> <p>Authority for the deletions: MHSOAC does not have authority to ignore the statutory requirement that PEI programs follow 'successful ' and 'effective" prototypes. MHSOAC does not have authority to choose the one subjective factor in eight objective statutory outcome measures as the one that counties must somehow quantify. Government Code section 11346.2(4)(A) requires agencies in adopting regulations to consider alternatives that are "less burdensome and equally effective in achieving the purposes of the regulation in a manner that ensures full compliance with the authorizing <i>statute</i>."</p> <p>Necessity for the deletions: Necessary for conformity to statute, which MHSOAC's proposed regulations alter and amend. Necessary for clarity, as MHSOACs proposed regulations are burdensome, incomprehensible, and impossible to administer in a consistent manner. Necessary for compliance with Government Code section 11346.2(4)(A), which requires agencies in adopting regulations to consider alternatives that are "less burdensome and equally effective in achieving the purposes of the regulation in a manner that ensures full compliance with the authorizing statute." Also necessary to</p>			

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		end the documented ten-year history of waste and misallocation of PEI funds.			
3755	Commenter #3	<p><u>Comment 3.42</u> MIPO proposes the following language to replace the provisions deleted from section 3755:</p> <p>Section 3755. Prevention and Early Intervention Component of the Three-year Program and Expenditure Plan and Annual Update. *****</p> <p><u>(c) For each Prevention and each Early Intervention program funded pursuant to Sections 3710 and 3720 of this Article, the County shall maintain and report:</u> <u>1) A description of the previous program (referred to herein as "prototype program") on which the county-approved program is modelled, together with source citations to all data, positive or negative, that addresses whether the prototype program is "effective" or "successful" as applicable, and as defined in Section 3200.246(e) and (f).</u> <u>2) A summary of the data showing that the prototype program is "effective" or "successful" as applicable, at reducing one or more identified statutory markers in Section 5840(d);</u> <u>3) A summary of all ways in which the county-funded program will vary from the prototype program.</u> <u>d) Every Prevention and every Early Intervention program as defined in Sections 3710 and 3720 shall maintain the same data following the same methodology as the prototype program</u></p>	Reject	<p>Change existing language indicated by underlined (new language) or strikethrough (delete existing language):</p> <p>3755(c)(4)(B) 3755(d)(4)(B) 3755(f)(3)(B) 3755(g)(3)(B).</p> <p>If the County used <u>the</u> community and/or practice-based standard to determine the program's effectiveness as referenced in Section 3740, subdivisions (a)(3), describe the evidence that the approach is likely to bring about <u>applicable</u> Mental Health Services Act outcomes for the intended population(s) and explain how the <u>County will ensure fidelity to the practice in implementing the program.</u></p>	<ol style="list-style-type: none"> <u>Recommended change</u>: The requirement to explain how the County will ensure fidelity to the community and/or practice-based standard should be added for consistency with the same requirement if the County uses evidence-based practice. Proposed PEI Regulations require the County to "provide a brief description of or reference to the relevant evidence applicable to the specific intended outcome, explain how the practice's effectiveness has been demonstrated for the intended population, and explain how the County will ensure fidelity to the evidence-based practice in implementing the program" (§3755(c)(4)(A)), consistent with suggestions contained in the comment. Proposed PEI Regulations require counties to define, measure, and report applicable MHSA outcomes for all PEI programs and to use practices that have demonstrated their effectiveness to bring about intended outcomes for the intended population. While the MHSA mandates the use of effective practices, it does not specify a standard or kind of evidence necessary to demonstrate effectiveness. See responses to comments 3.34 on page 10, and 3.44 on page 24. Applicable MHSA PEI outcomes (5840(d)) for each Prevention and each Early Intervention Program: See response to comment 3.41 on page 29. PEI services to severely mentally ill persons and hospitalizations for mental illness: See responses to comment 3.47 on page 27. <u>Diagnosis</u>: See response to comment 3.32 on page 5 <u>Cost data</u>: See response to comment 3.43 on page 23 <u>Aggregate data</u>: PEI programs are not sufficiently similar to yield useful aggregate data in all instances. Future development of county and statewide data systems will yield more consistent outcomes to create a

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		<p><u>on which it is modelled, so as to measure its success against that of the prototype program.</u></p> <p><u>e) Every Prevention and every Early Intervention program as defined in Sections 3710 and 3720 shall be required to provide the data described in Section 3750(c) prior to receiving PEI funding, and prior to receiving continued funding if the program is changed under Section 3745.</u></p> <p><u>f) In addition to the data required in subsection (e), all Prevention and Early Intervention programs created pursuant to Section 3710 and 3720 shall separately maintain the following data required by Section 5840(d) on each mentally ill/severely mentally ill program recipient for each calendar year:</u></p> <p><u>1) Number of suicide attempts and successful suicides, if any;</u></p> <p><u>2) The number and length of all incarcerations in days;</u></p> <p><u>3) For programs involving recipients still in school, whether the recipient drops out of school or is held back from graduating or progressing to the next grade;</u></p> <p><u>4) If the recipient is an adult, the number and approximate length in days of paying jobs held by the recipient during the year. Employment in MHS-funded job programs shall be separately stated;</u></p> <p><u>5) The number and length in days of each recipient's hospitalizations for mental illness, with a trip to the emergency room that did not result in a hospitalization counting as one day;</u></p> <p><u>6) The number of times, and</u></p>			<p>stronger basis for aggregate evaluation data, but there will never be complete uniformity of PEI programs.</p> <p>9. <u>Withholding Funding:</u> WIC §5791(c) provides for monthly distribution of MHS funds to the Counties. The suggestion is therefore inconsistent with the MHSA.</p>

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		<p><u>approximate number of days during which the recipient was homeless, ie, living without a roof overhead other than one provided night-by-night by homeless shelters or other ad hoc temporary housing arrangements;</u></p> <p><u>7) For programs involving mentally ill minors, the number of instances in which the minor was removed from the home, the reasons for the removal, and the length in days of each such removal from the home;</u></p> <p><u>8) The demographic and diagnostic data, including changes in diagnosis, required by Sections 3560.010(b)(5)(A)-(J) and</u></p> <p><u>9) The total program cost and the average cost per program recipient per day (total revenues from all sources per year divided by 365, then divided by the total number of days of service provided to all mentally ill/severely mentally persons actively receiving services from the program).</u></p> <p><u>g) The County shall also require all Prevention and all Early Intervention programs established under Sections 3710 and 3720 to provide the County at least yearly with aggregate data (program totals) of all the data required by Section 3750(f)(1)-(9). Demographic and diagnostic data shall be aggregated by census category and diagnosis: e.g., number of Hispanics in the program, number of persons with schizophrenia in the program, and so forth. Where the data required by Section 3750(f)(1)-(9) includes measurements of time, program totals shall aggregate the total number of</u></p>			

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		<p><u>days for each event, e.g., days of incarceration of program clients, days of hospitalization of program clients, and so forth. Each program shall additionally aggregate diagnostic data across calendar years by diagnosis, e.g., number of clients diagnosed with schizophrenia on admission, number of program clients diagnosed with bipolar I on a consistent date chosen by the County during the current calendar year, and so forth.</u></p> <p><u>h) In its Three-Year report, the County shall report:</u></p> <p><u>1) All data required by subsections (c), (d) and (g) for each Prevention and each Early Intervention program established under Sections 3710 and 3720;</u></p> <p><u>2) The county-aggregated totals for all data required by Section 3755(g) separately stated by type of program: e.g., number of suicides in all county Section 3710(b)(1) programs, number of schizophrenics in all county Section 3710(b)(2) programs, total days of incarceration of all program clients in county Section 3720(b) programs, total days of hospitalization of all program clients in Section 3720(c) programs, and so forth.</u></p> <p><u>3) Totals from Section (h)(2) shall also be aggregated to state county-wide totals across all programs: e.g., total suicides in all programs per year, total number of Hispanics served in all programs per year, total days of hospitalization in all programs per year, and so forth. Aggregate cost data shall</u></p>			

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		<p><u>also be averaged to determine a county-wide average cost per recipient.</u> <u>i) In its Yearly Report, the County shall report the yearly aggregate data required by Section 3750(g) for each program, and the yearly aggregated county totals required by Section 3750(h)(2) and (3)</u></p> <p>Authority/Reference for the proposed replacement subsections (c) through (i): Welfare & Institutions Code section 5840(d), which states: "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"; section 5840(c), which provides: "The program shall include mental health services <i>similar to those provided under other programs</i> effective in preventing mental illnesses from becoming severe, and shall also include components <i>similar to programs that have been successful</i> in reducing the duration of untreated severe mental illnesses and assisting people in quickly regaining productive lives" (emphasis added); MHPA Section 3(e), which states: "To ensure that all funds are expended in the most cost effective manner and services are provided in accordance with recommended best practices subject to local and state oversight to ensure accountability to taxpayers and to the public."</p>			

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		<p>Necessity for the proposed replacement subsections (c) through (i): Necessary for conformity to statute, which MHSOAC's proposed regulation expands, alters and amends. Also necessary for compliance with Government Code section 11346.2(4)(A), which requires agencies in adopting regulations to consider alternatives that are "less burdensome and equally effective in achieving the purposes of the regulation in a manner that ensures full compliance with the authorizing statute." Further necessary to end the documented ten year history of waste and misallocation of PEI funds.</p>			
3755	Commenter #33	<p><u>Comment 33.01</u> Stakeholder Engagement</p> <p>AB 1467 includes additional language to augment the stakeholder engagement provisions to require counties to, "demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation, and budget allocations." (W&I Sections 5847 and 5848). However, the proposed PEI Regulations do not include specific guidance on how counties can demonstrate adherence with new MHSOAC requirements for the stakeholder involvement.</p>	Reject	<p>Retain existing language in 3755; however, amend 3745(a) as follows:</p> <p>(a) If the County determines a need to make a substantial change to a program or strategy or target population of the program or strategy described in the County's most recent Three-Year Program and Expenditure Plan or Annual Update that was adopted by the local county board of</p>	<ol style="list-style-type: none"> 1. <u>Recommended change:</u> The changes to section 3745 is consistent with the comment regarding the statutory requirement in WIC §5848 of meaningful stakeholder involvement. As such if the County makes "substantial change" the County would be required to ensure meaningful stakeholder involvement per 5848. The new subdivision (b) uses the language that was in subdivision (a) and more clearly states that is the definition of "substantial change." 2. The specific suggestion made by the comment deals with the general requirements for the Community Program Planning process which is currently specified in the MHSOAC regulations, Title 9 California Code of Regulations § 3300 and is the responsibility of the Department of Health Care Services. 3. Proposed PEI Regulations require the County to describe and document that participants in the Community Program Planning process were informed about and understood the purpose and requirements of the Prevention and Early Intervention Component

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		<p>Recommendations: The proposed PEI regulations should require counties to demonstrate accountability to stakeholders, adherence to MHSA values and principles, compliance with the law, and transparency in decision-making by providing a description of the stakeholder process including date(s) of meeting(s) ,and any other planning activities conducted that demonstrates:</p> <ul style="list-style-type: none"> A. The required stakeholders were included. B. Partnership with constituents and stakeholders throughout the community program planning process. C. The methods and approaches used to engage stakeholders in a meaningful way in the development of mental health policy, program planning and implementation, monitoring, quality improvement, evaluation, and budget allocations. 		<p>supervisors as referenced in Welfare and Institutions Code Section 5847, the County shall comply with the requirements described in Section 3755.010 regarding a Prevention and Early Intervention Program Change Report <u>ensure that stakeholders contributed meaningfully to the planning process that resulted in the decision to make the change.</u></p> <p>(b) <u>“Substantial change” as used in this section means, change(s) to the essential elements of a program or strategy or change(s) to the intended outcomes or target population.</u></p>	<p>(§3755(b)(1)) and to explain how stakeholders were meaningfully involved in all phases of the process (§3755(b)(2)), consistent with the requirements of WIC §5848(a), thereby addressing the substance of the suggestion in the comment.</p>
3755(a) and (b)	Commenter #8	<p><u>Comment 8.56</u> (a) The requirements set forth in this section shall apply to the Annual Update for fiscal year 2015/16 and each Annual Update and/or Three-Year Program and</p>	Reject	Retain existing language with no change.	<p>1. <u>Stakeholder</u>: The term “stakeholder” is defined in MHSA regulations Title 9 California Code of Regulations §3200.270 and is defined broadly enough to include the individuals suggested in the comment. The general MHSA regulations including the regulations relating to</p>

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		<p>Expenditure Plan thereafter.</p> <p>The Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan or Annual Update shall include the following general information:</p> <p>(1) A description of how the County ensured that staff and stakeholders involved in the Community Program Planning process required by Title 9 California Code of Regulations, Section 3300, were informed about and understood the purpose and requirements of the Prevention and Early Intervention Component.</p> <p>(2) A description of the County's plan to involve community stakeholders <u>including police, sherrifs, judges, disctric attorneys, homeless shelters, correction and others</u> meaningfully in all phases of the Prevention and Early Intervention component of the Mental Health Services Act, including program planning and implementation, monitoring, quality improvement, evaluation, and budget allocations.</p> <p>(3) A brief description, with specific examples of how each program and/or strategy funded by Prevention and Early Intervention funds will reflect and be consistent with all Mental</p>			<p>Community Program Planning process are the responsibility of the Department of Health Care Services.</p> <p>2. <u>Meeting the criteria in 5600.3</u>: the suggestion is not applicable to all PEI programs and thus is not appropriate to add here. The substance of the suggestion is already included in subdivisions (c) and (d) of Section 3755. See response to comment 3.32 on page 5.</p>

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		<p>Health Services Act General Standards set forth in Title 9 California Code of Regulations, Section 3320.</p> <p>(4) <u>Steps taken to ensure those served meet the criteria delineated in 5600.3.</u></p>			
3755(b)(1) and (2)	Commenter #6	<p>Comment 6.10</p> <p>(b) The Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan or Annual Update shall include the following general information:</p> <p>(1) A description of how the County ensured that staff and stakeholders involved in the Community Program Planning process required by Title 9 California Code of Regulations, Section 3300, were informed about and understood the purpose and requirements of the Prevention and Early Intervention Component. Reaching and engaging stakeholders from racial and ethnic backgrounds across all age groups and any cultural brokers need assurance of their involvement.</p> <p>(2) A description of the County's plan to involve community stakeholders (see inclusion clause in #1 above) meaningfully in all phases of the Prevention and Early Intervention component of the Mental Health Services Act, including program planning and implementation, monitoring, quality improvement, evaluation, and budget allocations.</p>	Reject	Retain existing language with no change.	See responses to comments 8.56 on page 42 and 33.01 on page 41 regarding definition of "stakeholder" and the general MHSA regulations for Community Program Planning process.

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3755(c)(3)(C)	Commenter #36	<p><u>Comment 36.14</u> Sect 3755 (c), subdivision (3) (C)</p> <p>Recommendation: Add “established standards for” between “reflect” and “cultural competence.”</p> <p>Rationale: We should make use of available standards and tools designed to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health care organizations to implement culturally and linguistically appropriate services. The Enhanced CLAS Standards are one example (https://www.thinkculturalhealth.hhs.gov/Content/clas.asp).</p>	Reject	Retain existing language with no change	Cultural competency standard is defined in MHSA regulations (Title 9, California Code of Regulations §3200.100) and is part of the general regulations, which are the responsibility of the Department of Health Care Services.
3755(c)(4)	Commenter #8	<p><u>Comment 8.57</u> (4) Specify how the Early Intervention program is likely to reduce the relevant Mental Health Services Act negative outcomes as referenced in Welfare and Institutions Code Section 5840, subdivision (d) by providing the following information:</p> <p>(A) If For the County used evidence-based standard or promising practice standard to determine the program's effectiveness as referenced in Section 3740, subdivisions (a)(1) and (a)(2), provide a brief description of or reference to the relevant evidence applicable to the specific intended outcome, explain how the practice's</p>	Reject	Retain existing language with no change	<u>Allowing only evidence-based practice:</u> See responses to comment 3.34 on page 10

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		<p>effectiveness has been demonstrated for the intended population, and explain how the County will ensure fidelity to the evidence-based practice in implementing the program. (B) — If the County used community and/or practice-based standard to determine the program's effectiveness as referenced in Section 3740, subdivision (a)(3), describe the evidence that the approach is likely to bring about Mental Health Services Act outcomes for the intended population.</p>			
3755(c)(4)(A) and (B)	Commenter #6	<p><u>Comment 6.11</u> Here there may not be evidence other than anecdotal and what is based on cultural beliefs and practices pertinent to the particular culture. However, this then could be linked to an Innovation project that would demonstrate meaningful outcomes where, over a period of time and projects, evidence can be substantiated as standard.</p>	Reject	Retain existing language with no change	<ol style="list-style-type: none"> 1. It is not clear what the comment is suggesting other than using an Innovation project as a way to demonstrate meaningful outcomes that can be used to substantiate and provide additional evidence for the community and/or practice-based standard. The criteria for an Innovation Project includes “introducing a new application to the mental health system of a promising community-driven practice or an approach that has been successful in non-mental health contexts or settings” (WIC §5830(b)(2)(C)). Innovation funds provide the opportunity for a County to define and test a new or changed approach that has not yet demonstrated its effectiveness, while PEI requires evidence of effectiveness. A program that could be funded under PEI could not be funded under Innovation, although Innovation can explicitly develop and test new or changed PEI practices for which there is not yet sufficient evidence of effectiveness. 2. The PEI regulations require different type of “evidence” for “community and or practice-based standard” than for “evidence-based practice standard”. Regulations Section 3740 defines “community and or practice-based

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					standard “as a set of practices that communities have used and determined to yield positive results by community consensus over time, which may or may not have been measured empirically.” The practices and results refer to those that are likely to bring about the MHSA outcomes that are applicable to the particular program or strategy. See response to comment 3.34 on page 10.
3755(d)(4)	Commenter #8	<p><u>Comment 8.58</u> (4) Specify how the Prevention program is likely to bring about reduction of relevant Mental Health Services Act negative outcomes referenced in Welfare and Institutions Code Section 5840, subdivision (d) for the intended population by providing the following information:</p> <p>(A) If the County used evidence-based standard or promising practice standard to determine the program’s effectiveness as referenced in Section 3740, subdivisions (a)(1) and (a)(2), provide a brief description of or reference to the relevant evidence applicable to the specific intended outcome, explain how the practice’s effectiveness has been demonstrated for the intended population, and explain how the County will ensure fidelity to the evidence-based practice in implementing the program.</p> <p>(B) If the County used community and/or practice-based standard to determine the program’s effectiveness as</p>	Reject	Retain existing language with no change	<u>Allowing only evidence-based practice:</u> See responses to comment 3.34 on page 10

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		<p>referenced in Section 3740, subdivision (a)(3), describe the evidence that the approach is likely to bring about Mental Health Services Act outcomes for the intended population.</p>			
3755(f)	Commenter #8	<p><u>Comment 8.59</u> (Commenter changed the subdivision numbers)</p> <p>(f) The Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include a description of each Stigma and Discrimination Reduction program/approach, including but not limited:</p> <p>(1) <u>Steps taken to Identify people with mental illness or seeking mental health services</u> whom the campaign intends to influence.</p> <p>(2) Specify the methods and activities to be used to change attitudes, knowledge, and/or behavior regarding being diagnosed with mental illness, having mental illness and/or seeking mental health services, consistent with requirements in Section 3750, subdivision (e), including timeframes for measurement.</p> <p>(3) Specify how the proposed method is likely to bring about the selected outcomes by providing the following information:</p>	Reject	Retain existing language with no change	<ol style="list-style-type: none"> 1. <u>Stigma and discrimination</u>: Stigma and Discrimination Reduction program is defined in the regulations as 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). 2. MHSA does not specify any particular method by which 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. The suggestion would limit the anti-stigma efforts to address only internalized stigma and would be unduly restrictive and ineffective 3. <u>Allowing only evidence-based practice</u>: See responses to comment 3.34 on page 10

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		<p>(A) If the County used evidence-based standard or promising practice standard, to determine the program's effectiveness as referenced in Section 3740, subdivisions (a)(1) and (a)(2), explain how the practice's effectiveness has been demonstrated and explain how the County will ensure fidelity to the evidence-based practice in implementing the campaign.</p> <p>(B) If the County used community and/or practice-based standard to determine the program's effectiveness as referenced in Section 3740, subdivision (a)(3), describe the evidence that the approach is likely to bring about Mental Health Services Act outcomes.</p>			
3755(g)	Commenter #8	<p><u>Comment 8.60</u> (Commenter changed the subdivision numbers)</p> <p>(g) The Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include a description of each Suicide Prevention program/approach including but not limited:</p>	Reject	Retain existing language with no change	<ol style="list-style-type: none"> 1. <u>Measure suicide statistics</u>: Completed suicides data are one but not the only measure of an effective suicide prevention program. If such a program is offered, the County is required to measure changes in attitude, knowledge, or behavior as applicable to the program. Therefore the requirement in the proposed regulations is appropriately more comprehensive than the approach suggested. 2. <u>Allowing only evidence-based practice</u>: See responses to comment 3.34 on page 10

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		<p>(1) Specify the methods and activities to be used to change attitudes and behavior to prevent mental illness-related suicide.</p> <p>(2) Indicate how the County will measure changes in <u>number of suicides by people with mental illness, attitude, knowledge, and /or behavior related to reducing mental illness-related suicide consistent with requirements in Section 3750, subdivision (f) including timeframes for measurement.</u></p> <p>(3) Specify how the proposed method is likely to bring about suicide prevention outcomes selected by the County by providing the following information:</p> <p>(A) If the County used evidence-based standard or promising practice standard to determine the program's effectiveness as referenced in Section 3740, subdivisions (a)(1) and (a)(2), explain how the practice's effectiveness has been demonstrated and explain how the County will ensure fidelity to the evidence-based practice in implementing the campaign.</p> <p>(B) If the County used community and/or</p>			

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		<p>practice-based standard to determine the program's effectiveness as referenced in Section 3740, subdivision (a)(3), describe the evidence that the approach is likely to bring about Mental Health Services Act outcomes.</p>			
3755(i)	Commenter #8	<p><u>Comment 8.61</u> (i) The Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include for all programs referenced in subdivisions (c) through (g) of this section an explanation of how the program will be implemented to help Improve Access to Services for Underserved Populations, as required in Section 3735, subdivision (a)(2). (1) For each program, the County shall indicate the intended setting(s) and why the setting enhances access for specific, designated underserved populations with mental illness. If the County intends to locate the program in a mental health setting, explain why this choice enhances access to quality services and outcomes for the specific underserved population. (2) Indicate if the County intends to measure outcomes in addition to those required in Section 3750, subdivision (h_g) and, if so, what outcome and how will it be measured, including timeframes for measurement.</p>	Reject	Retain existing language with no change	<ol style="list-style-type: none"> 1. The addition of “with mental illness” is not necessary because Section 3735(a)(2) already requires the individual or family from underserved population to be in need of mental health services because of risk or presence of a mental illness. The suggestion would inappropriately exclude individuals at risk of a mental illness, which is incompatible with the statute’s reference to improve timely access to <i>services</i>, not timely access to <i>treatment</i>. Mental health services include but are not limited to treatment. 2. As noted in the Initial Statement of Reasons, research documents that many members of communities of color, who are significantly underserved by the public mental health system, are more likely to seek or accept mental health services in culturally appropriate settings. The suggestion to delete the requirement that the County explain how the mental health setting enhances access to quality mental services would undermine the requirement Section 3735(a)(2).

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3755(k)	Commenter #8	<p><u>Comment 8.62</u> (k) The Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include for all programs the following information for the fiscal year after the plan is submitted.</p> <p>(1) Estimated number of children, adults, and seniors <u>with mental illness</u> to be served in each Prevention program and each Early Intervention program.</p> <p>(2) The County may also include estimates of the number of individuals <u>with mental illness</u> who will be reached by Outreach for Increasing Recognition of Early Signs of Mental Illness program or strategy within a program, Suicide Prevention programs/approaches, and Stigma and Discrimination Reduction programs/approaches.</p>	Reject	Retain existing language with no change	Section 3755(k) includes Prevention Programs, which address outcomes for individuals with greater than average risk of developing a potentially serious mental illness. The suggested language would make the section internally inconsistent.
3755(l)(2)	Commenter #8	<p><u>Comment 8.63</u> (2) The County shall identify each program funded with Prevention and Early Intervention funds as a <u>Prevention and Early Intervention Program</u> Prevention program, an Early Intervention program, Outreach for Increasing Recognition of Early Signs of Mental Illness program, Stigma and Discrimination Reduction program/approach, or Suicide Prevention program/approach and shall estimate expected expenditures for each program. If a program includes more than one element, the County shall estimate the</p>	Reject	Retain existing language with no change	As stated in the Initial Statement of Reasons, it is important for local decision makers to have an estimate of the projected expenditures for each of the programs. There is no category for a combined Prevention and Early Intervention program. If a county combines these two programs, the county must report the expenditures for each separately.

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		percentage of funds dedicated to each element. (A) The County shall estimate the amount of Prevention and Early Intervention funds for Administration of the Prevention and Early Intervention Component.			
3755(n)	Commenter #8	<u>Comment 8.64</u> (n) The Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include an estimate of the amount of Prevention and Early Intervention funds voluntarily assigned by the County to California Mental Health Services Authority or any other organization in which counties are acting jointly <u>and steps taken to ensure those funds are spent only on programs allowed by the legislation and not ipads..</u>	Reject	Retain existing language with no change	<ol style="list-style-type: none"> 1. Proposed PEI Regulations require that the use of Prevention and Early Intervention funds shall be governed by the MHSA regulations. This requirement applies to the funds that are voluntarily assigned by the County to California Mental Health Services Authority or any other organization in which counties are acting jointly. 2. WIC §5847(b)(8) and (9) require certification by the county mental health director and the county auditor-controller that the county has complied with laws, regulations, and fiscal accountability requirements. 3. As emphasized in the Initial Statement of Reasons one of the purposes of these regulations taken as a whole is to ensure that the funds are spent only on allowable programs.
No specified section	Commenter #8	<u>Comment 8.01</u> The "Purpose and Intent" of the Mental Health Services Act is to "define serious mental illness among children, adults and seniors as a condition deserving priority attention". The proposed regulations don't do that.	Reject	Retain existing language with no change	See response to comment 3.31 on page 1.
No specified section	Commenter #8	<u>Comment 8.02</u> The purpose of Mental Health Services Oversight and Accountability Commission (MHSOAC) is "To ensure that all funds are expended in the most cost effective manner and services are provided in accordance with	No specific action suggested	No specific action suggested	See response to comment 3.43 on page 23.

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		recommended best practices, The proposed regulations don't do that.			
No specified section	Commenter #8	<u>Comment 8.03</u> The purpose of Prevention and Early Intervention funds specifically are to "prevent mental illnesses from becoming severe and disabling." (5840(a)) These regulations fail to see that happens and drive funds away from that goal.	Reject	Retain existing language with no change	The overall purpose of the PEI component, as the comment observes, is to prevent mental illness from becoming severe and disabling. Proposed PEI Regulations fulfill this purpose by requiring, as a program or strategy, all required elements of WIC §5840. See responses to comments 4.05, 10.05, 11.05, 12.05, 16.05, 17.05, 22.05, 24.05, 27.05, 28.05, 37.06, 43.05, 46.05, 62.05, 69.05, 70.06, 72.06 on page 17.
No specified section	Commenter #8	<u>Comment 8.05</u> The regulations change "shall" to "may" in many cases thereby freeing counties from an obligation to use the funds as directed by taxpayers.	No specific action suggested	No specific action suggested	N/A
No specified section	Commenter #8	<u>Comment 8.09</u> The regulations allow more activities than the legislation does and seems to drive funding toward organizations associated with the MHSOAC Commissioners. (See "Examples of county social service programs masquerading as mental illness programs in order to receive MHSA PEI Funds" and "Insider Dealing in MHSA PEI Programs.	No specific action suggested	No specific action suggested	N/A
No specified section	Commenter #8	<u>Comment 8.10</u> "A regulation cannot alter, amend, enlarge, or restrict a statute, or be inconsistent or in conflict with a statute." These regulations do alter, amend enlarge, restrict the statute and are in conflict with it. These regulations do.	No specific action suggested	No specific action suggested	See response to comments 4.05, 10.05, 11.05, 12.05, 16.05, 17.05, 22.05, 24.05, 27.05, 28.05, 37.06, 43.05, 46.05, 62.05, 69.05, 70.06, 72.06 on page 17.
No specified section	Commenter #8	<u>Comment 8.11</u> There is a long history of MHSOAC (and it's predecessor DMH) driving MHSA funds from their intended function of	No specific action suggested	No specific action suggested	N/A

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		helping people with 'serious mental illness' as statute requires and allowing the expenditure of funds on non-evidence based practices. These were well documented by the California State Auditor, Mental Illness Policy Org11 (attached) and the media . The California State Auditor found that, due to lack of oversight, "the State has little current assurance that the funds directed to counties for MHSA programs have been used effectively and appropriately."			
No specified section	Commenter #8	<u>Comment 8.12</u> MHSOAC and its predecessor regulatory agency (DMH) have a long history of using the regulatory process in ways that restricted the statute, were inconsistent with it, altered, amended, and enlarged it. See "Prevention and Early Intervention: How up to \$2 billion was diverted to programs that did not serve people with serious mental illness or falsely claimed they prevent mental illness" (attached) and "Proposed and/or enacted regulations and guidelines being relied on by counties that diverted funds to people without serious mental illness and left people with serious mental illness without services"	No specific action suggested	No specific action suggested	N/A
No specified section	Commenter #8	<u>Comment 8.16</u> Additions are needed to the proposed regulation to correct regulators omissions <u>The regulations fail to ensure funds are spent on the legislatively required population.</u> The purpose of the legislation to "define <i>serious mental illness</i> among children,	Reject	Retain existing language with no change	As stated in the Initial Statement of Reasons, all Proposed PEI Regulations' requirements for all PEI programs aim to prevent mental illness from becoming severe and disabling consistent with WIC §5840. See responses to comment 3.32 on page 5.

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		<p>adults and seniors as a condition deserving priority attention". PEI funds are specifically limited by the legislation to "prevent mental illnesses from becoming severe and disabling." i.e., serving people <i>with</i> mental illness.</p> <p>The definition of that population occurs in 5600.3 and is specifically referenced.²¹ The legislation is clear that services are intended for the 5%-9% with serious mental illness, not the "mental illnesses (that) are extremely common"</p> <p>In spite of this clear direction, the regulations fail to ensure that those being served are people with mental illness or serious mental illness. The regulations do not require counties to limit the funds to the population the legislation is intended to serve or report on diagnosis. The regulations do not ensure the oversight commission receives the diagnostic information they need to ensure this is happening. See "PEI Funds Must Serve People with Serious Mental Illness" (attached).</p>			
No specified section	Commenter #8	<p><u>Comment 8.18</u> <u>The regulators fail to cite relevant research on serious mental illness, the risk factors for serious mental illness, or research on how to prevent mental illness from becoming severe and disabling.</u></p> <p>To prevent the recurrence of known previous misspending and lack of oversight issues identified by the</p>	Reject	Retain existing language with no change	<ol style="list-style-type: none"> 1. Research documentation of the value and efficacy of prevention, defined as intervening at the point of manifestation of risk, to prevent the occurrence, in some instances, of a serious mental illness and the negative consequences of a serious mental illness, should one develop are included in the list of resources in the Initial Statement of Reasons. 2. Neither the PEI provisions of the MHSA (WIC §5840) nor Welfare and Institutions Code 5600.3 require a diagnoses for a PEI program. See responses to

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		<p>California State Auditor, the following provisions should be promulgated as regulations.</p> <ul style="list-style-type: none"> • <u>Unless otherwise noted, prevention funds may not be spent on 'preventing mental illness' or preventing serious mental illness'</u> • <u>Unless otherwise noted, PEI funds may only be spent on people with serious mental illness or people with mental illness if needed to prevent the mental illness from becoming severe and disabling).</u> • <u>Unless otherwise noted, PEI funds may not be targeted to reduce suicide, incarceration, school failure or dropout, unemployment, prolonged suffering, or homelessness, among individuals who have not already been diagnosed with mental illness.</u> 			<p>comments 25.02 on page 16.</p>
No specified section	Commenter #13	<p><u>Comment 13.01</u> I collected signatures for Prop. 63 and have been dismayed that despite the expenditure of billions of dollars, it is not keeping very severely mentally ill people out of jails and hospitals and off of our streets, and in less danger of suicide or becoming the perpetrator or victim of violence.</p> <p>Scrutinizing the descriptions of programs funded by the PEI part of the MHSA, I am appalled to discover that so many of them serve people with no mental illness and which are not proven to improve the lives of severely mentally ill people. (e.g.</p>	Reject	Retain existing language with no change	See responses to comment 8.18 on page 56.

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		<p>after-school programs for youth; senior peer counseling; parenting classes; anti-stigma campaigns). In addition, the outcomes we so hoped would be improved, e.g. numbers of incarcerations, hospitalizations, suicides, victimization, are not even measured.</p> <p>Please change the MHSA regulations so that services funded under PEI will be used ONLY for services to people with a severe mental illness or a mental illness that is in danger of it worsening. Remove regulations that allow funds to be spent for people without mental illness. MHSA funds are required to serve people with serious mental illness and not those without.</p>			
No specified section	Commenter #15	<p><u>Comment 15.01</u> We are California residents who are parents of a young adult son suffering with serious mental illness and who for years now have not been able to get the help we needed through programs in our current mental health system to make any sustained difference in helping our son. There is too much waste on programs that are not targeting to our most severely ill and families need more help. We simply are not able to help our sons or daughters without the support of our system and without proven programs that are aimed at helping our most severely and persistently ill. Following are our comments on the Proposed Prevention and Early Intervention Regulations being considered.</p>	No specific action suggested	No specific action suggested	N/A

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No specified section	Commenter #19	<p><u>Comment 19.01</u> The proposed regulations perpetuate the failure of voluntary treatment only programs like the Family Services Agency of San Francisco's Prevention and Recovery in Early Psychosis program. http://prepwellness.org/ It's failure resulted in the death of Yanira Serrano in unincorporated Half Moon Bay on June 3. https://www.youtube.com/watch?v=qE0coU579Tc</p>	No specific action suggested	No specific action suggested	N/A
No specified section	Commenter #21	<p><u>Comment 21.01</u> I live in Contra Costa County, have six relatives with mental illness (several in this county), and am a Board Member and active volunteer for NAMI CC (National Alliance on Mental Illness). Additionally, like other people in our NAMI CC affiliate, I spent many hours working on passing MHSA and looked forward to its passage .</p> <p>However, I am very aware and dismayed that many of the PEI programs in our county have little to do with the severely mentally ill. For example, we have programs that deal fostering positive teen behavior/averting gang affiliation, LGBT mental health counseling/programs, and parenting classes. None of those programs target the mentally ill or those who are at risk for mental illness. It is quite a travesty that the money is diverted to other causes, often indirectly dealing with mental health but not the severely mentally ill. Our affiliate has voiced</p>	Reject	Retain existing language with no change	See responses to comment 8.18 on page 56.

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		<p>concern to the County about using funds in this manner, but there have been no changes.</p> <p>Please amend the current regulation so that 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. Remove regulations that foster the diversion of funds to people without mental illness. Be sure that measuring outcomes of work is included. MHSA funds are required to serve people with serious mental illness and not those without, unless they are family members directly involved with their mentally ill loved ones.</p>			
No specified section	Commenter #60	<p><u>Comment 60.03</u> <i>Current MHSA PEI guidelines and proposed regulations no longer require 51% of PEI funds to target children, youth and families. Instead it is a County level decision as to whether or not to target this population. UACF strongly supports and recommends the original mandate to allocate 51% of PEI funds to target children, youth and families be retained.</i></p> <p>Widely accepted statistics show that half of all lifetime cases of diagnosable mental illnesses begin by age 14, and three-fourths by age 24, the preservation of funds for children and youth is critical and necessary to ensure effective</p>	Accept	<p><u>Add new section 3706:</u></p> <p>(a) <u>The County shall serve all ages in one or more program of the Prevention and Early Intervention Component.</u></p> <p>(b) <u>At least 51 percent of the PEI funds shall be used to serve individuals who are under 25 years of age.</u></p> <p>(c) <u>Programs that serve parents, caregivers, or family members with the goal of addressing MHSA</u></p>	<ol style="list-style-type: none"> 1. MHSOAC legal counsel is of the opinion that the suggested new section including requiring counties to spend at least 51% of PEI funds for children and transition-age youth and their families is legally permissible pursuant to the MHSOAC's authority to "implement" the PEI Component of the MHSA. Given the statistics regarding the occurrence of mental illness in children and youth, this requirement fits in the overall purpose of PEI to prevent mental illness from becoming severe and disabling. 2. <u>Recommended change:</u> Staff supports the suggestion to continue the requirement in the current PEI Guidelines that counties serve all age groups and spend at least 51% of their PEI funds for children and transition-age youth, and their families. Staff also recommends an exception for small counties.

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		<p>prevention efforts for children and their parents or other caregivers. By requiring that children and youth receive the necessary support, it increases the likelihood that mental health problems will be addressed early and optimally before they can evolve into full-blown mental illness and/or substance abuse.</p> <p>SAMHSA data estimates that 15 – 18% of school age children have a developmental or behavioral disability, while only half are identified before starting school. Providing support for children’s optimal social and emotional development will result in positive outcomes for individuals and society, including greater school success, improved relationships, diminished juvenile justice cases, and economic savings. Families, parents, caregivers, teachers, and others who care for and work with children must be better informed about the milestones of normal, healthy child development as well as be equipped to identify early warning signs and/or risk factors that indicate when assistance is necessary. Funding programs that educate, support, and empower parents and families are the key to that success.</p> <p>Extensive research has identified risk and protective factors that affect the vulnerability of children to mental health problems. Some of these risk factors include poverty, significant lack of providers, appropriate access to care and community supports. These health inequities cannot be eliminated by a</p>		<p><u>outcomes for children or youth at risk of or with early onset of a mental illness can be counted as meeting the requirement in (a) and (b).</u> <u>(d) Small Counties are excluded from the requirements in (a) and (b) above.</u></p>	<p>Below are the pros and cons of the suggested changes.</p> <p><u>Reasons supporting the 51%:</u> Some of the reasons to require counties to continue to reserve at least 51% of PEI funds for programs for children and youth are stated in the multiple comments in support of this change and include the following:</p> <ul style="list-style-type: none"> ▪ According to the U.S. Surgeon General’s 2001 report, children/youth and people of color in the United States disproportionately carry burdens and disability from mental illness. They have lower utilization of services, worse quality of care, and more serious consequences from untreated mental illness. ▪ A wide array of demonstrated successful prevention and early intervention approaches have demonstrated effectiveness with diverse children, youth, and their families, as documented by the Institute of Medicine in its groundbreaking 2009 report, <i>Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities</i>. ▪ As many as three million California children and youth can be expected to experience mental health problems in any given year, including an estimated 97% of youth in the California Youth Authority and 70% to 84% of the 80,000 California children in foster care. ▪ First break—an individual’s initial episode of severe mental illness—usually occurs in the late teens or early twenties. Effective approaches have been shown to make a significant, positive difference in both immediate and long-term outcomes. ▪ Suicide is the third leading cause of death for youth ages 15-24 and the sixth leading cause of death for 5-15 year olds. About 19% of young people contemplate or attempt suicide each year; the rate of youth suicide has nearly tripled since 1960, while the overall suicide rate has declined. The youth suicide rate

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		<p>mental health program alone but having prevention strategies in place to educate and inform communities as well as eliminate the stigma and shame of mental illness is a step in the right direction. Children’s mental health is the foundation on which they build their future lives. It is up to policy makers, in accord with parents, families, and communities to influence the outcome, to ensure that children have every opportunity to be successful, contributing members of their families and their communities and that the preservation of funds maintain intact.</p> <p>UACF urges the MHSOAC to adopt these recommendations on behalf of the mental health and well-being of children, youth, and families across California. Who speaks for our children if not us?</p>			<p>has increased most rapidly for African American boys.</p> <ul style="list-style-type: none"> ▪ Children with unaddressed risk or onset of a mental illness are highly likely to drop out of school, go to jail as adults, and suffer other negative outcomes. Stated positively, children whose risk or onset of a mental illness is identified and addressed early are likely to experience success in all of these areas and to make positive social contributions. <p>Childhood is a critical period for addressing the earliest appearance of emotional and behavioral problems that frequently lead to mental disorders that persist into adulthood and worsen. Child and adolescent prevention and early intervention programs have the potential to limit the economic burden of mental illness through a reduced need for mental health treatment and related services and the potential benefits of increased positive outcomes such as educational attainment and economic output, with net savings overall. According to the Little Hoover Commission, “Prevention offers the greatest opportunity to serve the most needs in the most cost-effective manner” and can avoid, reduce, or resolve many of the serious problems that affect children, youth, and their families. This approach offers the greatest possible benefit not only to children and their families, but also to California as a whole.</p> <p><u>Reason not to support 51%:</u> The following are some of the reasons not to require counties to reserve 51% of PEI funds for programs that serve children and youth under age 25:</p> <ul style="list-style-type: none"> ▪ The requirement would limit county flexibility to decide local PEI priorities. ▪ Older adults in particular suffer negative impacts of stigma and discrimination. People of all ages experience risk and early onset of potentially serious mental illness that is frequently not identified. People across the lifespan need access to PEI programs. <p>3. <u>All age groups:</u> Staff supports the continuation of the</p>

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					<p>current PEI Guideline requirement for counties to serve all age groups with PEI programs.</p> <p><u>Reason for all age group:</u> The main reason to support the requirement is that prevention and early intervention are important and viable ways to bring about MHSA PEI outcomes for individuals across the lifespan. For example, the highest suicide rate in 2011 was among individuals ages 45-64 and the second highest rate was for ages 85 and older, according to the American Foundation for Suicide Prevention. Depression is a significant burden for many older adults. Neurological disorders and substance abuse frequently co-occur, with devastating consequences. There is evidence that stigma and discrimination perpetuated against older adults with mental illness is a particular issue that creates access barriers, according to SAMHSA. Requiring counties to offer PEI programs for individuals across the lifespan recognizes and responds to the range of needs and potential benefits for individuals at all ages at risk of and with a mental illness.</p> <p><u>Reason for not requiring all age group:</u> The main reason not to continue this requirement is to maximize county flexibility to determine and respond to local priorities, and to provide the option to focus rather than disperse efforts to the population(s) in greatest need.</p> <p>4. <u>Small County Exemption:</u> Staff supports an exception to these two requirements (51% of PEI funds directed to individuals age 25 and younger and to serve all age groups) for counties with population less than 200,000.</p> <p><u>Reasons to support small county exemption:</u> The reason to provide this exception is that counties with a population under 200,000 need more flexibility in how to direct limited PEI funds among populations that are frequently less diverse. For example, a County with a particular concentration of older adults or with a specific</p>

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					<p>mental health priority area is less likely to be able to bring about intended outcomes with fewer resources to distribute.</p> <p><u>Reasons not to support small county exemption:</u> A reason not to make this exception is to extend the benefits described above to individuals in all counties and to create more consistency across California.</p>
No specified section	Commenter #23	<p>Comment 23.03 <u>Recommendation: Retain mandate for 51% of PEI funds to target Children, Youth, and Families.</u> Proposed regulations would no longer require 51% of PEI funds to target children, youth and families, instead making it a county-level decision as to whether or not to target this population. <u>We strongly recommend that the mandate to use 51% of PEI funds to target children, youth and families be retained.</u></p> <p>According to a 2011 publication by the MHSOAC, the requirement to target 51% of PEI funds to serve children, youth, and families was instated “because half of all mental disorders start by age 14 and three- fourths start by age 24.” This requirement resulted in at-risk children, youth, and young adult populations being the most frequently addressed by counties’ PEI plans according to a 2011 MHSOAC review. This dynamic of early onset of mental illness remains the case today. Targeting children, youth and families remains a critical strategy for successful prevention and early intervention approaches.</p>	Accept	Same as response to comment 60.03 on page 60.	See response to comment 60.03 on page 60.

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		The preservation of targeted funds for children, youth, and families is necessary to ensure counties continue to target this high-risk and high-priority population. By requiring that children and youth receive the necessary support, we increase the likelihood of detecting mental health problems as early as possible in our communities, and have a better chance at addressing more mental health issues before they evolve into severe mental illness and/or substance abuse, minimizing both the human and financial toll on our communities.			
No specified section	Commenter #23	<u>Comment 23.04</u> CFRA would again like to express our appreciation for the MHSOAC's work in drafting these proposed regulations and recognize the progress toward stronger data collection and reporting requirements, as well as increased responsiveness to clients, families and stakeholders. Thank you for your attention to our recommendations.	No specific action suggested	No specific action suggested	N/A
No specified section	Commenter #25	<u>Comment 25.05</u> NFP helps families stay together and remain healthy. When at-risk, previously abused individuals begin parenting without acknowledgment of their own abuse history and how it can negatively impact their own parenting styles, they are more likely to perpetuate this cycle of violence. NFP nursing support, mentoring and training has been successful in assisting them in methods in which to end the cycle of abuse and employ safer and more nurturing	Accept	<ol style="list-style-type: none"> 1. Focus on prevention: See response to comment 60.02 2. Focus on children and youth: See response to comment 60.03 	<ol style="list-style-type: none"> 1. <u>Focus on prevention</u>: See response to comment 60.02 on page 17 of the Matrix presented to the MHSOAC at the August 28, 2014 meeting. 2. <u>Focus on children and youth</u>: See response to comment 60.03 on page 60.

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		<p>parenting techniques beginning with their very first child.</p> <p>Early intervention research studies that support prenatal home visits to youth to provide support that includes mental health counseling have been shown to improve mother-child interactions, reduce child maltreatment, and enhance child development, such as a child's improved cognitive ability. When over 50% of all mental illnesses occur at or before the age of 14 years old, it is imperative the MHSA maintains the focus on youth and primary mental health disease prevention.</p>			
No specified section	Commenter #29	<p><u>Comment 29.01</u> I believe there is a tremendous need for the required continuation of Prevention and Early Intervention (PEI) programs. Counties should be required to continue the 'help-first' system. The 51% of PEI funding focused on children, youth and families should also continue as a requirement. Our children grow up to be adults, if we support them and their families with services while they are young, our youth stand a greater chance of becoming productive citizens. The cost to support them when they are older will be greatly reduced by providing service in their youth prior to failing. I am a parent of three children with a serious mental health illness that affects their daily activities. I have been both their advocate and worked as a family advocate supporting families, I now work to support and educate family advocates</p>	Accept	<ol style="list-style-type: none"> 1. Focus on prevention: See response to comment 60.02 2. Focus on children and youth: See response to comment 60.03 	<ol style="list-style-type: none"> 1. <u>Focus on prevention</u>: See response to comment 60.02 on page 17 of the Matrix presented to the MHSAOAC at the August 28, 2014 meeting. 2. <u>Focus on children and youth</u>: See response to comment 60.03 on page 60.

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		as they support children and families with children in the mental health system. Look to the future and ask “did I give the children a fighting chance to be the best adult they could be”?			
No specified section	Commenter #32	<p><u>Comment 32.01</u> The MHSA Partners is an informal group that meets monthly to share information and discuss emerging policy issues related to the MHSA. The MHSA Partners Forum represents a wide range of stakeholder constituencies, including client, family, and parent advocates, providers of mental health services, government partners, and advocates for ethnic and cultural communities that have been unserved, underserved, or inappropriately served in the public mental health system.</p> <p>California is one of the most diverse states in the country, with almost 60% of its population comprised of communities of color and over 100 different languages spoken. Under the Affordable Care Act (ACA), millions of Californians will gain access to health coverage with an overwhelming majority from communities of color. Decisions about when and how health and mental health data is collected and the development of strategies for making this information more accessible to patients and advocates is critical to ensuring equitable quality of care for all Californians.</p>	No specific action suggested	No specific action suggested	N/A

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No specified section	Commenter #32	<p data-bbox="575 151 1112 313"><u>Comment 32.09</u> <u>Support for retaining 51% of PEI funds to Target Children, Youth and Families and for the Continued Funding for Student Mental Health</u></p> <p data-bbox="575 354 1112 686">Proposed regulations no longer require 51% of PEI funds to target children, youth and families, instead making it a county-level decision as to whether or not to target this population. In addition, the proposed regulations do not reference the Student Mental Health Initiative making it unclear if this initiative will continue to be a part of the PEI programs.</p> <p data-bbox="575 719 1112 954"><u>We propose that the mandate to earmark 51% of PEI funds to target children, youth and families be retained. We also propose that funding for the Student Mental Health Initiative (SMHI) continue in order reach children and youth.</u></p> <p data-bbox="575 987 1112 1412">Given that half of all lifetime cases of diagnosable mental illnesses begin by age 14, and three- fourths by age 24, the preservation of funds for children and youth is critical and necessary to ensure effective prevention efforts for children and their parents or other caregivers. By requiring that children and youth receive the necessary support, it increases the likelihood that mental health problems will be addressed early and optimally before they can evolve into full-blown mental illness and/or substance abuse.</p>	Accept: 51% of PEI funds for children and youth	See response to comment 60.03 on page 60.	<ol data-bbox="1763 151 2542 345" style="list-style-type: none"> 1. <u>Focus on children and youth</u>: See response to comment 60.03 on page 60. 2. <u>Student Mental Health Initiative</u>: The Student Mental Health Initiative was a one-time limited funding initiative and is beyond the scope of Proposed PEI Regulations.

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		<p>Data from the federal Substance Abuse Mental Health Services Administration (SAMHSA) estimates that 15-18% of school age children have a developmental or behavioral disability, while only half are identified before starting school. Providing support for children's optimal social and emotional development will result in positive outcomes for individuals and society, including greater school success, improved relationships, diminished juvenile justice cases, and economic savings. Families, parents, caregivers, teachers, and others who care for and work with children must be better informed about the milestones of normal, healthy child development as well as be equipped to identify early warning signs and/or risk factors that indicate when assistance is necessary. Prevention programs are the key to that success.</p> <p>Extensive research has identified risk and protective factors that affect the vulnerability of children to mental health problems. Some of these risk factors include poverty, significant lack of providers, appropriate access to care, and community supports. These health inequities cannot be eliminated by mental health programs alone, but having prevention strategies in place to educate and inform communities as well as eliminate the stigma and shame of mental illness is a step in the right direction. Children's mental health is the</p>			

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		<p>foundation on which they build their future lives. It is up to policy makers, in accord with parents, families, and communities, to influence the outcome and to ensure that children have every opportunity to be successful, contributing members of their families and communities.</p> <p>Additionally, schools are where students spend the majority of their day and are ideal settings to provide mental health prevention and intervention strategies. Research demonstrates that prevention of the occurrence of adverse childhood can be appropriately addressed in school settings. School personnel are familiar with students and their family, behaviors, issues, as well as school-based and community resources. The learning environment provides the right context for prevention and intervention as strategies can be implemented on multi-tiered systems of support. Most importantly, prevention services can be taught at a universal level and reach all students. When this is done, the need for more costly and intrusive services is curtailed. Streamlined, continuous PEI programs are needed throughout the K-12 and higher educational systems. It is necessary for mental health to be promoted in all levels, including the higher education system.</p> <p>With the recent increase in school violence, it would be detrimental for California to lose the SMHI. This</p>			

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		<p>initiative began with the other PEI statewide efforts due in part to continued tragedies involving students on college and school grounds. All SMHI partners have built momentum in developing capacity to identify and address mental health issues among students. This momentum would be lost if the SMHI is not maintained as a PEI program.</p> <p>We applaud the MHSOAC's work in drafting these proposed regulations. It is clear from the Proposed that the MHSOAC recognizes the need that exists and is untreated in our communities, and is diligently working to design a system that goes beyond treating those already in care.</p>			
No specified section	Commenter #33	<p><u>Comment 33.03</u> Local Mental Health Boards AB 1467 includes additional language about the role of the local mental health boards. In providing leadership for the local stakeholder process, mental health boards (MHB) are instructed to conduct a public hearing on the Proposed three-year program, expenditure plan and annual updates at the close of the 30-day comment period. However, the proposed regulations guiding the PEI are silent about the role and responsibility of the local mental health board in implementing the local level stakeholder process and ensuring adherence to the changes introduced by AB 1467 for the stakeholder process. Recommendation: The proposed PEI Regulations should</p>	Reject	Retain existing language with no changes	<ol style="list-style-type: none"> 1. Funding for and details regarding how mental health boards fulfill their MHSA-specified responsibilities (WIC §5848(b)) as part of the Community Program Planning process are beyond the scope of the PEI Regulations. 2. Existing MHSA regulations that deal with the Community Program Planning process are under the responsibility of Department of Health Care Services.

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		<p>clearly outline and strengthen the role and responsibility of local mental health boards in providing local level oversight; and funding should be made available to support the appropriate performance of their role and functions, included but not limited to training for board members, stakeholder engagement and education, independent annual evaluation of their local mental health program (to assess unmet needs, gaps in the service system, quality of services, consumer satisfaction with the system), and an annual report of MHB activities and evaluation findings to both the local Board of Supervisors and the MHSOAC.</p> <p>Additionally, as conveners and facilitators of the local stakeholder process, the MHBs are responsible for ensuring that the quality local level stakeholder process is:</p> <ul style="list-style-type: none"> A. Inclusive of underrepresented and under-reached constituencies across the full age spectrum and by engaging all relevant community stakeholders from the broader communities. B. Robust in ensuring stakeholders are involved in planning, designing, implementing, evaluating, and decision-making; C. Transparent with discussions, negotiations or decisions made regarding PEI with the full participation of all relevant stakeholder groups and/or their 			

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		<p>representatives at every step of the way.</p> <p>Finally, sufficient funding should be afforded to develop, implement and evaluate MHB training programs in order to ensure that MHB members are adequately prepared to carry out their roles and responsibilities thus effectively leading all stages of the planning process.</p>			
No specified section	Commenter #35	<p><u>Comment 35.01</u> Targeting Services to Children and Youth: The proposed regulation remove the mandate that a minimum of 51% of PEI funds be allocated to target children, youth, and families.</p> <p>The current <i>MHSOAC Prevention and Early Intervention Programs Initial Statement of Reasons</i> emphasizes the importance of providing prevention and early intervention services to children, youth, and families. As stated in this MHSOAC document, an estimated 75-80% of children and youth who need mental health treatment don't receive it. (Kataoka S, et al. (2002). Unmet need for mental health care among U.S. children: Variation by ethnicity and insurance status. <i>American Journal of Psychiatry</i> 159(9), 1548-1555.) Widely accepted statistics demonstrate that half of all lifetime cases of diagnosable mental illnesses begin by age 14, and three- fourths by age 24. Therefore, the preservation of funds for children and</p>	Accept	See response to comment 60.03 on page 60.	<u>Focus on children and youth:</u> See response to comment 60.03 on page 60.

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		<p>youth is critical and necessary to ensure effective prevention efforts for children and their family members.</p> <p>The MHSAspecified purpose for PEI programs is to prevent mental illnesses from becoming severe and disabling (Welfare and Institutions Code Section 5840, subdivision (a)). Specific provisions of the MHSAs require counties to: Emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness: suicide, incarcerations, school failure or drop-out, prolonged suffering, unemployment, homelessness, and removal of children from their homes.</p> <p>Recommendation: The California Alliance strongly supports the original mandate to allocate a minimum of 51% of PEI funds to target children, youth and families and recommends that this mandate be retained.</p>			
No specified section	Commenter #40	<p><u>Comment 40.02</u> 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. Remove regulations that foster the diversion of funds to people without mental illness. MHSAs funds are required to serve people with serious mental illness and not those without.</p> <p>I encourage you to accept the changes</p>	Reject	Retain existing language with no change	See responses to comment 8.18 on page 56.

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		proposed by 1) Mary Ann Bernard on behalf of Mental Illness Policy Org. and the changes proposed by 2) Joy Torres a consumer of mental health services in California.			
No specified section	Commenter #44	<u>Comment 44.01</u> The CPA strongly supports strategies of accountability in the use of public mental health funds. The CPA also strongly supports the aims of prevention and early intervention especially in the woefully, historically underfunded public mental health system. Making people with mental illness wait until they have been in and out of the criminal justice system and hospitals does not make sense especially from a humanitarian perspective. This is a potential of prevention and early intervention programs.	No specific action suggested	No specific action suggested	N/A
No specified section	Commenter #44	<u>Comment 44.03</u> AGE GROUP TARGETING Generally, the CPA notes that the removal of the restriction that 51% of the funds be used for children and youth, which was contained in prior guidance, is concerning. According to the National Institute of Mental Health: "... the National Institute of Mental Health (NIMH) have found that half of all lifetime cases of mental illness begin by age 14, and that despite effective treatments, there are long delays - sometimes decades - between first onset of symptoms and when	Accept	See response to comment 60.03 on page 60.	<u>Focus on children and youth</u> : See response to comment 60.03 on page 60.

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		<p>people seek and receive treatment. The study also reveals that an untreated mental disorder can lead to a more severe, more difficult to treat illness, and to the development of co-occurring mental illnesses."</p> <p>The same studies also found that three-quarters of all mental illness manifests by age 24. These scientific findings would support an emphasis, although not exclusive, on children and youth in the use of Prevention and Early Intervention (PEI) funds and the targeting of programming. However, CPA would also acknowledge that tertiary prevention and early interventions would also be very useful in, for instance, geriatric populations. What this means is that as a matter of policy there should be equitable distribution of PEI program focus across all age groups. The 51% standard was at least an attempt to accomplish this. While acknowledging that counties wish more flexibility in the use of funds, in the absence of any recited standard in these regulations we think this issue requires more thought and work among stakeholders.</p>			
No specified section	Commenter #45	<p><u>Comment 45.01</u> I strongly encourage the MHSOAC (the Commission) to ensure that the PEI regulations and definitions identify and include programs (ideally peer-run) such as, (but not limited to) Crisis Interventions, Warm-Lines, etc. as viable – evidence based programs that facilitate</p>	Reject	Retain existing language with no change	Proposed PEI Regulations provide the County the option to include programs such as those described in the comment if there is evidence that they are likely to bring about the intended MHSA outcomes for the intended populations, using a range of allowable evidence. See response to comment 3.34 on page 10.

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		prevention and early interventions for consumers experiencing mental health challenges in the community. Similarly that these programs can serve to divert transitional aged youth (TAY) ages 16-25 years old, or others, experiencing a first onset of psychosis and/or extreme states from psychiatric emergency services (PES) and/or pharmaceutical interventions.			
No specified section	Commenter #47	<u>Comment 47.01</u> To whom it may concern..I feel it crucial the funds stay with youth and children. MY children needed Mental health services. Mental health service helped my 2 sons with medication & therapeutic services for Bi-polar & Severe depression my Sons are grown adults living successfully using the tools to live as productive grown adults in the community..	Accept	See response to comment 60.03 on page 60.	<u>Focus on children and youth:</u> See response to comment 60.03 on page 60.
No specified section	Commenter #51	<u>Comment 51.01</u> I feel deeply that prevention and early intervention programs for children are incredibly important. There are many parents like myself who believe that had there been early intervention and prevention programs available when our children first became ill that we may have been able to prevent that first break. By identifying the early signs we may have been able to prevent our child's failure within the education system and his/her becoming part of the mental health system. Please require these prevention and early intervention programs in Los Angeles County.	Accept	Prevention: See response to comment 60.02 Children and youth: See response to comment 60.03 on page 60.	<u>Prevention:</u> See response to comment 60.02 on page 17 of the Matrix presented to the MHSOAC at the August 28, 2014 meeting. <u>Focus on children and youth:</u> See response to comment 60.03 on page 60.

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No specified section	Commenter #52	<p><u>Comment 52.01</u> It is, in my opinion, vitally important that the 51% of PE&I funds remain available to children, youth and their families. So much money is spent on adult mental health; and though much is needed in adult services, I want to remind you that many of the adults receiving continuous care now may have benefited tremendously from early interventions when they were young children. So I ask you how much quality of life did these adults lose as a result of lack of services available to them at a younger age. How many of these adults missed the opportunity to succeed in school and careers due to obtaining services after a major break in their late teens and early twenties. Please think about it. If a child has the opportunity to be identified and serviced at a young age, how much better their will their quality of life be as they learn to manage their mental health at a young age? How much money will the counties and state save on hospitalizations and prison stays, and on stays in high level group homes if children are taught to manage their mental health? Please lets insist that counties use PEI funds to teach mental health awareness, mental health first aid and how to get help when there are possible needs. Insist that “good mental health” is made recognizable to all, as well as poor mental health. Please for the sake of the future of our state and country, help the children and the families.</p>	Accept	See response to comment 60.03 on page 60.	<u>Focus on children and youth:</u> See response to comment 60.03 on page 60.

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No specified section	Commenter #52	<u>Comment 52.02</u> Please ask the OAC to consider prodromal psychotic features as a needed training opportunity for parents and youth and should be funded by PE&I.	Reject	Retain existing language with no change	PEI Programs can and do include those with a focus on individuals experiencing the prodromal phase of first-episode psychotic disorders.
No specified section	Commenter #55	<u>Comment 55.01</u> I have found it very difficult to navigate the fractured systems that are in place to obtain educational help for my child. I am asking that the PEI funding be directed to “children’s programs”, especially in the underserved Counties. (Santa Clara, Imperial for example) Thank you for taking the time to read my humble request.	Accept	See response to comment 60.03 on page 60.	<u>Focus on children and youth</u> : See response to comment 60.03 on page 60.
No specified section	Commenter #59	<u>Comment 59.01</u> I implore you to make it a requirement for School districts to develop Prevention and Early Intervention programs, especially since the AB 3632 funding was given to School districts to support mental health services when needed for a student to receive a free and appropriate education. I am speaking as a mom, that would have loved to have services at the beginning of challenging behaviors than at the end, when so much more damage and needs have risen to crisis levels, when my sons were in school. PEI is a stop measure for families to realize their dreams, goals, and	1. Accept: Children and youth 2. Reject: Requirement for school districts	1. See response to comment 60.03 on page 60. 2. Retain existing language with no change	1. <u>Focus on children and youth</u> : See response to comment 60.03 on page 60. 2. Requirements for school districts are beyond the scope of PEI Regulations. WIC §5891 provides that the MHSA funds go directly to the counties. WIC §5848 requires the county’s Three-year Plan to be developed with local stakeholders, which include representatives from the education system. As such, it is up to the local stakeholders to decide whether PEI funds should go to or involve school districts.

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		<p>successes before they problems reach epic proportions.</p> <p>I most definitely support the 51% of funding to go to MH services for families with youth and to require school districts to have PEI in all of their schools.</p> <p>Thanking you in advance to do the right thing for the families of California,</p>			
No specified section	Commenter #63	<p><u>Comment 63.01</u> This brand new policy brief should speak more loudly and clearly to enhancing the focus on children. http://healthpolicy.ucla.edu/publications/Documents/PDF/2014/childmentalhealthbrief-july2014.pdf</p>	Accept	See response to comment 60.03 on page 60.	<u>Focus on children and youth:</u> See response to comment 60.03 on page 60.
No specified section	Commenter #65	<p><u>Comment 65.01</u> It seems that everytime a plan is in place it becomes sabatoge before given a chance to be corrected. Though not perfect it had a lot of potential to grow and to really serve the motto of help first vs fail first. The 51% PEI funding provided focus on children and youth and families and identified those children, youth and families with much needed resources.</p> <p>Instead of getting rid of such an early impact in the lives of many children, youth and families, we should continue building on this motto and prevent serious mental illness from becoming severe.</p>	Accept	See response to comment 60.03 on page 60.	<u>Focus on children and youth:</u> See response to comment 60.03 on page 60.

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No specified section	Commenter #68	<p><u>Comment 68.01</u> I'm am parent Ramila Sloane from India. My son had M H illness. Because of different culture and stigma all our family member had hard life. He needed home services like wraparound, parent mentor, parent partner. It was not available to our Ventura county. We have now, but very long wait. So he suffered and I suffered and his sibling suffered. I had to educate myself about word like IEP for his school education .</p> <p>I know now, how much early intervention needed. So now I'm serving my community by giving parents their voice so they can ask for services what they need for their children and youth what they deserves.</p> <p>But we need funding (money) so our children, youth can have support and move forward happily. And parents feel complies. Parents are becoming abusers because they can't help their children (who has mentally Ill) With proper tools and guidance they can do parenting job well.</p> <p>Thank you for understanding. So please conceder many different Sevices to our children, youth and families.</p> <p>For the success we need funding. So please help.</p>	Accept	See response to comment 60.03 on page 60.	<u>Focus on children and youth</u> : See response to comment 60.03 on page 60.

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		English is my second language so excuse my writing.			
No specified section	Commenter #74	<u>Comment 74.01</u> REMHDCO also signed and strongly supports the recommendations in the letter from the MHSA Community Partners dated July 23, 2014. Finally, REMHDCO is also submitting a separate letter to the Commission regarding the process of developing these proposed PEI regulations.	No specific action suggested	No specific action suggested	N/A
No specified section	Commenter #48	<u>Comment 48.01</u> I strongly urge MHSOAC to support UACF's recommendations to REQUIRE Prevention Programs in every county as well as REQUIRE that 51% of PEI funding be dedicated to the needs of children, youth, and families. It has never made sense to me that children must attain a "sufficient" level of illness or disability in order to access systems and obtain needed services. I know in our family, and many of the families with whom I've worked, a need for some kind of service was recognized by parents well before the child became ill enough to "qualify" for services. Without benefit of consistent dedicated funding for children's Prevention and Early Intervention services, children and their families will likely continue to experience delays in identification and treatment of mental health issues, and needless worsening of those mental health issues while they are waiting for "the system" to recognize the value of	Accept	<ol style="list-style-type: none"> 1. Children and youth focus: See response to comment 60.03 on page 60. 2. Require prevention: See response to comment 60.02 from the August 28, 2014 MHSOAC meeting 	<ol style="list-style-type: none"> 1. <u>Focus on children and youth</u>: See response to comment 60.03 on page 60. 2. <u>Prevention</u>: See response to comment 60.02 on page 17 of the Matrix presented at the August 28, 2014 MHSOAC meeting.

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		<p>prevention services for them.</p> <p>Please REQUIRE Prevention Programs in every county and REQUIRE that 51% of PEI funding be dedicated to the needs of children, youth, and families. Thank you.</p>			
No Specified Section	Commenter #3	<p><u>Comment 3.01</u> The “Informative Digest” In The NPR Fails to Acknowledge That PEI Funds Have Been Misallocated For Years Pursuant to Illegal “Policies” and Pseudo-Regulations.</p> <p>The fourth paragraph of the “Informative Digest” (at p. 12) states as follows:</p> <p style="padding-left: 40px;">Prior to its elimination on June 30, 2012, the California Department of Mental Health (DMH) had the authority to adopt regulations for all of the MHSAs components. Given the scale of each component on a sequential and/or passed-in approach. Accordingly, DMH Proposed regulations through a concurrent process as the MHSAs components were being developed. Regulations for the PEI component had not been adopted prior to June 30, 2012. In July 2012 the Department of Health Care Services (DHCS) was given authority, in consultation with the MHSOAS, to develop regulations as</p>	Reject	Retain existing language with no change	Not relevant to the proposed regulations.

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		<p>necessary to implement the MHSA. Then in June 2013, the MHSOAC was mandated to adopt regulations for the PEI component.</p> <p>This is inaccurate and misleading. Here are the facts regarding prior misuse of the regulatory process in the allocation and expenditure of PEI funds:</p> <ul style="list-style-type: none"> • Proposition 63, now the Mental Health Services Act (MHSA), was adopted by voters in November of 2004. Regulations governing allocations of most of the funding under MHSA have been in place for years. However, for nearly ten years, PEI funds – 20 percent of the total of MHSA funds and presently amounting to some \$317 million annually - have been allocated pursuant to “policies” that were really pseudo or underground regulations, and that were in many respects directly contrary to statute. • MHSOAC created a “policy” of allocating PEI funds “to focus in individuals <i>prior</i> to diagnosis of a mental illness,” which was devised to “jump start prevention in California.” As our comments will show, this “policy” is directly contrary to MHSA, which requires, at minimum, a diagnosis of “mental illness” as a prerequisite to PEI funding. 			

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		<ul style="list-style-type: none"> <li data-bbox="620 154 1112 613">• These “policies”/underground regulations ignored what is arguably the most important mandate in the statute for the severely mentally ill, the group Proposition 63 was enacted to help: the need for programs to prevent or intervene early when the severely mentally ill relapse. Instead, the “policies” allowed expenditures on people who are not and will never be mentally ill, much less severely mentally ill, in violation of law. <li data-bbox="620 625 1112 922">• In June of 2010, MHSOAC Proposed proposed PEI regulations based on the existing “policies,” as shown by meeting minutes and documents from the time. At some point, these June Proposed, mislabeled as “regulations,” were uploaded to the Internet. <li data-bbox="620 933 1112 1421">• In October or 2010, DMH proposed PEI regulations that MHSOAC had Proposed, but then allowed them to lapse. However, many counties, individuals and advocacy organizations were convinced that these lapsed proposed regulations (hereinafter “the pseudo-regulations”), which until very recently appeared in a Google search using “PEI,” “California” and “regulation,” were actually valid regulations. It also appears that MHSOAC treated 			

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		<p>them as such. Though MIPO repeatedly demanded that the pseudo-regulations be taken off the internet as early as November 2012, this was only done recently, sometime during or after November 2012.</p> <ul style="list-style-type: none"> • During the 10 years since MHSA was enacted, MHSOAC continued to enforce the existing “policies” and pseudo-regulations, ignoring the statutory mandate for relapse prevention programs for the severely mentally ill and prohibiting use of PEI funds for individuals who had a mental illness diagnosis. • Only when the California State Auditor criticized the MHSOAC for proceeding under “policies” rather than duly-enacted regulations and ordered the MHSOAC to propose regulations by January 2014 did the agency re-commence the regulatory process. • In summary, MHSOAC has been allocating hundreds of millions of dollars every year pursuant to “policies” and pseudo-regulations that not only ignored, but actually reversed an important mandate in the statute it is charged with overseeing. It took specific directive from the State Auditor to get MHSOAC to do what should have been done years ago. 			

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No Specified Section	Commenter #3	<p><u>Comment 3.02</u> The MHSOAC In The Informative Digest (And Elsewhere) Repeatedly Ignores And Changes Essential Language Contained in the MHSA.</p> <p>The MHSOAC's Informative Digest includes statements of purpose that are inaccurate because they both ignore and change essential statutory language in the MHSA. This is a pattern that is repeated throughout MHSOAC's proposed regulations, resulting in proposed regulations that are inconsistent with the MHSA. The offending statements in the Informative Digest, at page 3, read as follows:</p> <p style="padding-left: 40px;">8. Include components similar to programs that have been successful in assisting people in quickly regaining productive lives (Welfare and Institutions Code Section 5840, subdivision (c)),</p> <p>The MHSA goals for PEI are the earliest possible identification and initiation of services for individuals with risk or onset of a potentially serious mental illness, as well as various strategies to link individuals to treatment and encourage them to make use of available services. MHSA PEI provisions ass to public mental health a positive, proactive help first approach with the potential to reduce the need for more costly</p>	Reject	Retain existing language with no change	<ol style="list-style-type: none"> 1. A review of the regulations as a whole and the Initial Statement of Reasons clearly show that the proposed regulations are consistent in implementing the PEI provisions of the MHSA (WIC §5840). 2. These same arguments have been repeated several times by this commenter and the MHSOAC has responded multiple times. See responses listed in the Matrix presented at the August 28, 2014 MHSOAC meeting. 3. Focus on untreated severe mental illness: See response to comment 3.33 on page 9 4. Severe mental illness and serious mental illness: See responses to comment 3.31 on page 1 5. Risk of a potentially severe mental illness: Proposed PEI Regulations clearly specify that a Prevention Program must show evidence of its capacity to bring about MHSA outcomes for "individuals and members of groups or populations whose risk of developing a serious mental illness is significantly higher than average" (§3720(b)), not for anyone in the general public who is theoretically at risk. Proposed PEI Regulations do not permit broad, general community wellness as an intended outcome for any PEI program, though it might be a positive added value. See responses to comments 25.02 on page 16.

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		<p>later onset or crisis oriented mental health treatments and increase the likelihood of positive outcomes.</p> <p>As occurs in the statement quoted above, the MHSOAC omits a key portion of cited statute, creating the implication that programs that help anyone “quickly regain productive lives” are eligible for PEI funding. In fact, the statutory language omitted by the MHSOAC makes it clear that eligible program must be aimed at helping those who suffer from untreated severe mental illness, Here is what the statute provides:</p> <p style="padding-left: 40px;">The program...shall also include components similar to programs that have been successful in <i>reducing the duration of untreated severe mental illnesses</i> and assisting people in quickly regaining productive lives.</p> <p>Welf. & Inst. Code § 5840 (c) (emphasis added).</p> <p>Along the same lines, MHSOAC’s proposed regulations frequently decouple the term “severe” from the term “mental illness” when it is inappropriate to do so. The proposed regulations also treat the terms “mental health,” “risk of onset of potentially serious mental illness,” and “severe mental illness,” as if they are equivalent. They most emphatically are not.</p>			

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		<p>The MHSA is a remarkably well-Proposed statute, whose Proposers used the terms “mental illness,” “serious mental illness,” and “severe mental illness” very precisely. MHSOAC uses interchangeably terms of art that represent a continuum, from trivial conditions to the most severe. Using them interchangeably, as MHSOAC frequently does, can and has resulted in misallocation of millions of dollars, in violation of statute.</p> <p>For example, at one end of the continuum is “mental health,” which very roughly could be interpreted as “stay sober and eat your veggies.” The next term in the continuum, coined by MHSOAC, is “<i>risk of onset of potentially serious mental illness.</i>” This term is meaningless, as we are all at “risk” of onset of a “potentially” serious mental illness. MHSOAC has used this term for years to justify allocating money to people who are not and never will be mentally ill.</p> <p>The next term, “mental illness,” is well-defined but now amounts to little, as recognized in the first sentence in MHSA Section 2, Findings and Declarations: “Mental illnesses are extremely common; they affect almost every family in California.” According to the federal agencies whose statistics are cited in sections 2 and 3 of MHSA, about 18% to 25% of the population is “mentally ill” at</p>			

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		<p>any given time. This is essentially because the mental “health” industry has pathologized normalcy. For example, people experiencing extreme grief over the loss of a family member or beloved pet are now diagnosed as “mentally ill.”</p> <p>Next on the continuum is “serious mental illness.” When that term is used in the MHSA, it is generally referring to the statistics on the NIMH/SAMHSA websites that also use this term. (See, e.g., Findings and Declarations; Purpose and Intent at sections 2(a) and 3). As NIMH/SAMHSA/MHSA define it, “serious mental illness” affects between 5% and 7-9% of the population. See MHSA Section 2(a). These are “serious” conditions, but not necessarily “severe” ones.</p> <p>Finally, the term “severe mental illness” – the term used repeatedly in the PEI portions of the MHSA – incorporates by reference the definition of those who are sufficiently disabled by mental illness to qualify for welfare benefits. This is a more restrictive term than “serious mental illness” referenced above. People who are “severely mentally ill” are very sick indeed.</p> <p>In these proposed regulations and elsewhere, MHSOAC conflates these precisely-defined and very different conditions. For example, after reciting, correctly that PEI provisions were intended to prevent “mental illness” from</p>			

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		<p>becoming “severe mental illness” (see p.2 of the Statement of Reasons), MHSOAC then excludes reference to “untreated severe mental illness” from the Informative Digest section cited above. By doing so, MHSOAC implies that the MHSA authorizes funding to help the general population “in quickly regaining production lives,” no matter what afflicts them – which it emphatically does not. MHSOAC also asserts, contrary to the clear intent of the MHSA, that the PEI provisions encompass “risk of onset of a <i>potentially</i> serious mental illness.” Clearly, this is not what the statute says, nor what the voters intended.</p> <p>Rather, as the Findings and Declarations, Purposes and Intent provisions at Sections 2 and 3 of the MHSA make clear, The PEI provisions that fund care and treatment were drafted and intended to prevent “mental illness” from becoming “severe mental illness,” and to prevent /intervene early in relapses into severe mental illness, i.e., “reduc[e] the duration of untreated severe mental illnesses and assist[] people in quickly regaining productive lives.”</p>			
No Specified Section	Commenter #4, 5, 10, 11, 12, 16, 17, 22, 24, 27, 28, 37, 43, 46, 62, 69, 70	<p><u>Comment 4.08, 5.06, 10.07, 11.07, 12.07, 16.07, 17.07, 22.07, 24.07, 27.07, 28.08, 37.08, 43.07, 46.07, 62.07, 69.07, 70.01</u></p> <p>We appreciate the Mental Health</p>	No specific action suggested	No specific action suggested	N/A

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		<p>Services Oversight and Accountability Commission (MHSOAC) for its transparent and productive stakeholder process to develop county Prevention and Early Intervention (PEI) programs evaluation regulations. A continued partnership between the MHSOAC and counties is essential to provide meaningful information to policymakers that demonstrate the value of these programs to Californians, while helping counties to continuously improve services.</p>			
No Specified Section	Commenter #8	<p><u>Comment 8.13</u> The "Policy Statement Overview and Anticipated Benefits of Proposal" in the "Notice of Proposed Rulemaking" shows MHSOAC misunderstands Proposition 63. This is causing the promulgation of regulations inconsistent with the legislation. That section claims, "The broad objective of these regulations is to facilitate the transformation of the mental health system from what has traditionally been seen as a fail first system to a help-first system. There is no language in the legislation to support the claim that MHSA funds are to be used to transform the system. Using funds to transform the system does "alter, amend, and conflict" with statute.</p>	Reject	Retain existing language with no change	<ol style="list-style-type: none"> 1. Proposed PEI Regulations and accompanying Initial Statement of Reasons do not claim or suggest that the MHSA states that its intention is to transform the mental health system. The observation is that implementing the changes in practice that the MHSA mandates inherently and obviously transforms the system from its state and focus before the passage of Proposition 63. 2. Before Proposition 63, the public mental health system did not include prevention and early intervention services. Today, 20% of MHSA funds are dedicated to prevention and early intervention. If a dedicated funding stream with resulting programs for prevention and early intervention, including linkages to earlier access to treatment for severe mental illness, were the only change brought about by the implementation of the MHSA – and it certainly is not – the resulting change would accurately be described as a transformation. 3. The fact that the MHSA intends to move the mental health system in the direction of prevention and early intervention is clearly indicated by WIC §5892(a)(4), which states, "The expenditure for prevention and early intervention may be increased in any county in which the department determines that the increase will decrease the need and cost for additional services to severely

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					<p>mentally ill persons in that county by an amount at least commensurate with the proposed increase.”</p> <p>4. Other changes mandated by and being brought about by the MHSA are too numerous to list. Transformation is profound change; the fact that California voters who passed Proposition 63 intended to bring about change and that resulting change in the public mental health system is occurring is without question.</p> <p>5. Diverse stakeholders have very different ideas about the specifics of the changes that the MHSA requires and envisions, resulting in a complicated, often slow, and ultimately enriching process reflected in these comments and responses.</p> <p>6. Proposed PEI Regulations will move the public mental health system in the direction of measuring and communicating the changes that are occurring through the MHSA PEI component. See response to comment 8.14 below on page 93.</p>
No Specified Section	Commenter #8	<p><u>Comment 8.14</u> The legislation specifically states the purpose of the funding is to expand already existing programs, not to provide for "transformation of the mental health system". The Findings and Declaration Paragraph (e) lists pre-existing programs the funds are supposed to expand. Findings and Declarations Paragraph (f) specifically states "By expanding programs that have demonstrated their effectiveness, California can save lives and money." Findings and Declaration Paragraph (g) says the goal is" To provide an equitable way to fund these expanded services". There is no mention in the Findings and Declarations of 'transformation'. There is extensive reference to funding programs</p>	Reject	Retain existing language with no change	<p>1. Expanding existing program models that have demonstrated their effectiveness is a key goal of the MHSA (Section 2, Finding and Declarations (f)) and Section 3, Purpose and Intend (c)). Making such program models widely available as well as other MHSA priorities and mandates such as establishing a program to prevent mental illnesses from becoming severe and disabling (WIC §5840(a)), providing timely access for underserved populations (WIC §5840(a)), reducing stigma and discrimination related to mental illness or to seeking mental health services (WIC §5840(b)(3)(4)), reducing the duration of untreated mental illness by identifying individuals with mental illness earlier in onset and linking them to treatment (WIC §5840(b)(2) and (c)), providing “programs, including prevention, that emphasize client-centered, family focused and community-based services that are culturally and linguistically competent and are provided in an integrated services system” (Section 2, Findings and Declarations</p>

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		that already exist.			(e)), and involving stakeholders including people with serious mental illness involved in meaningfully on mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation, and budget allocations – as well as numerous other provisions – all, collectively, constitute a transformation of California’s pre-MHSA public mental health system. See response to comment 8.13 on page 92.
No Specified Section	Commenter #8	<p><u>Comment 8.15</u> Likewise the "Purpose and Intent" of the Legislation is "To expand the kinds of successful, innovative service programs for children, adults and seniors begun in California...". It goes on to say "These programs have already demonstrated their effectiveness in providing outreach and integrated services, including medically necessary psychiatric services, and other services, to individuals most severely affected by or at risk of serious mental illness." (emphasis added). Again, there is no call in the legislation to 'transform' the system. The clear goal of voters was to expand existing, proven systems of care.</p> <p>This is stated explicitly within the PEI provisions of MHSA, i.e., taxpayers directed officials to fund existing programs. There is no direction to 'transform' the system. "The (PEI) program shall include mental health services similar to those provided under other programs effective in preventing mental illnesses from becoming severe, and shall also include components similar to programs that have been successful in reducing the</p>	Reject	Retain existing language with no change	<ol style="list-style-type: none"> 1. Transformation: See Responses to comments 8.13 on page 92 and 8.14 on page 93. 2. Medically necessary psychiatric services: See responses to comments 3.31 on page 1 3. Programs that have demonstrated their success: See response to comment 3.34 on page 10.

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		duration of untreated severe mental illnesses and assisting people in quickly regaining productive lives."			
No Section Specified	Commenter #37	<u>Comment 37.01</u> San Joaquin County is pleased that the Proposed Prevention and Early Intervention (PEI) regulations developed by the MHSOCAC promote the measurement of PEI efforts across the state. Focusing on continuous program and outcomes improvement assures that the MHSA funding is used efficiently and effectively to provide quality services.	No specific action suggested	No specific action suggested	N/A
No Specified Section	Commenter #39	<u>Comment 39.01</u> Proposed regulations were difficult to find. They should be (but are not) easily accessible on your website and should have been included with today's meeting documents. How can we comment on what we have not seen or read? I did eventually find it through a search engine online, but it was very difficult to locate the most recent vision.	No specific action suggested	No specific action suggested	The proposed regulations: (1) were published in the Notice Registry; (2) are posted on the MHSOAC's website under "laws and regulations" tab; (3) the notice of proposed rulemaking and the link to the MHSOAC website were sent to the hundreds of people who are signed up to receive notices from the MHSOAC; and (4) the regulations were emailed and mailed to anyone who specifically requested to receive notice of proposed regulations.
No Specified Section	Commenter #23, 41, 49, 53, 54, 58, 67, H1, H5, H8	<u>Comments: 23.01, 41.01, 49.01, 53.01, 54.01, 58.01, 67.01, H1.01, H5.02, H8.01 Listed Below:</u> <u>Comment 23.01</u> Family Resource Centers (FRC) use an integrated community approach to deliver comprehensive, prevention-oriented services including health, mental health, school readiness, child abuse prevention, family economic success, and more. PEI represents one of the few funding streams in our social services landscape that explicitly	Accept	1. Prevention: see response to comment 60.02 in the August 28, 2014 MHSOAC meeting. 2. Child-family focus: see response to comment 66.03 on page 60.	1. Prevention: See response to comment 60.02 from the August 28, 2014 MHSOAC meeting. 2. Child-family focus: See response to comment 60.03 on page 60.

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		<p>dedicates resources to prevention. Too often individuals and families must wait until a problem becomes a crisis to receive services, multiplying both the human and financial costs. PEI represents a critical component of the MHSA vision to transform California's mental health system from a "fail first" to a "help first" model.</p> <p>CFRA is extremely pleased that the Mental Health Services Oversight and Accountability Commission (MHSOAC) has Proposed regulations that protect the integrity of PEI and recognize the need to better understand, track, and meet the needs of unserved, underserved, and inappropriately served communities.</p> <p>There are, however, two key areas in which the proposed regulations should be modified to ensure continued successful implementation of PEI; 1) Require counties to offer at least one Prevention Program, and 2) Retain the mandate that counties dedicate 51% of PEI funds to target children, youth and families.</p> <p><u>Comment 41.01</u> As a resident of Sacramento County, I believe there is a tremendous need for the required continuation of prevention and early intervention programs. Counties should be required to continue the 'help-first' system vs the 'fail-first' system. The 51% of PEI funding focused</p>			

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		<p>on children, youth and families should also continue as a requirement in order to continue to support the 'help-first' mind set. This focused delivery of PEI programs to community members will continue to identify children early, provide resources earlier and ultimately children, youth and families will experience better outcomes.</p> <p><u>Comment 49.01</u> As the parent of a youth with schizoaffective disorder, I spent years advocating for my son, educating myself and learning to navigate fractured systems. If I knew then what I know now or If I had had the benefit of a prevention and early intervention program in my county, I could have saved my son years of hardship. I support the requirement of Prevention Programs in counties and the requirement that 51% of PEI funds be spent to address the needs of children, youth and families.</p> <p>Please consider carefully the UACF recommendations that I am in full support of.</p> <p><u>Comment 53.01</u> I support the requirement of Prevention Programs in counties and the requirement that 51% of PEI funds be spent to address the needs of children, youth and families.</p> <p><u>Comment 54.01</u> I believe there is a tremendous need for</p>			

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		<p>the required continuation of prevention and early intervention programs. Counties should be required to continue the 'help-first' system vs the 'fail-first' system. The 51% of PEI funding focused on children, youth and families should also continue as a requirement in order to continue to support the 'help-first' mind set. This focused delivery of PEI programs to community members will continue to identify children early, provide resources earlier and ultimately children, youth and families will experience better outcomes.”</p> <p><u>Comment 58.01</u> I urge the Commission to support the recommendations of United Advocates for Children and Families. Prevention and Early Intervention go hand in hand when addressing the mental health needs of youth and their families in our state. We ask that you reinstate the directive that 51% of PEI be reserved for children and families. Our strength lies in our ability to promote/insure early intervention for our children, thus preventing life-long emotional disabilities, and the ensuing ripple effect experienced by the family, the community and our state. Awareness of the importance of Prevention and Early Intervention programs are at an all time high, and to divert the funds needed to implement these programs can only be considered as short-sighted.</p>			

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		<p><u>Comment 67.01</u> I strongly encourage and support the requirement of Prevention and Early Intervention Programs in all counties, particularly those counties that are historically underserved and support the requirement that 51% of PEI funds be spent to address the needs of children and their families.</p> <p><u>Comment H1.01</u> Good morning. I just wanted to say that my name is Kendra White, again. I am representing my family -- my entire family. We all have some sort of mental illness. It's hereditary; we have seizures and OCD and a lot of other things.</p> <p>I am here because I was misdiagnosed when I was nine - I started having my seizures - and I have been an active part of the community. I'm thirty-six now. I just started taking medication last year for my illness.</p> <p>So, I was not even aware that there was things wrong with me, and there were a lot of things that I was forced to face by myself because no one -- they misdiagnosed me when I was younger. And no one told me that I needed help or most of my relationships, friends or otherwise, didn't work out because of a lot of things that were going on within me that I didn't understand or know about.</p> <p>So, I'm here to support families like mine and UACF and their recommendations</p>			

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		<p>that they already put in. I just wanted to say, too, that the prevention part is really important - early prevention - because if you don't help people, you're going to end up with a lot of people like me who were misdiagnosed and aren't able to get the services that they need and are just not even represented.</p> <p>I'm very smart. I am an active person in the community, like I stated a few minutes ago, but I could have been more active. There were things that I could have prevented in my life, like going to jail for a day because of an outburst that I didn't understand how to control, or letting things build up in my life because no one told me that there was something wrong with me.</p> <p>And a lot of people look regular, but they do have issues. And mental illness is not something that you can just see on the outside sometimes. So, please, take that into consideration. Early prevention really will help you with a lot of people who just simply don't look sick.</p> <p><u>Comment H5.02</u> We also ask that you include children, youth, and families in your language. The current regulations do not include the provision that fifty-one percent of PEI funds be spent to address the needs of children and youth, and we are recommending that your additional -- your original policy direction reserves that fifty-one percent to be reinstated and</p>			

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		<p>written into the guidelines, ensuring that all counties have funds directed to California's most vulnerable population.</p> <p>We found that most counties are already currently implementing both prevention and early intervention programs, and have money set aside for that mandate for children and youth. So, we don't feel that we're asking for additional programs or additional funds. We're just asking that you secure the programs and preserve what is already in place.</p> <p>We ask that you preserve the true purpose of the MHSA and to protect the future of our children. Thank you</p> <p><u>Comment H8.01</u> Good morning. My name is Monica Nepomuceno. I'm here representing the Department of Education, and I would just like to ask you to please consider, on behalf of the K-12 students, to include the fifty-one percent that has been allotted for the prevention and early intervention programs.</p> <p>As has been said before, there are a lot of students in the K-12 system who have been misdiagnosed and misappropriately placed in special education because their needs are not being served. They are not being identified. And so, again, on behalf of all K-12 students and the CDE, I hope that you will consider integrating that language back into the PEI Regulations. Thank you.</p>			

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No Specified Section	Commenter #72	<p><u>Comment 72.01</u> As the Secretary/Treasurer of County Behavioral Health Directors Association of California (CBHDA), and the Behavioral Health Director of the Orange County Health Care Agency, which represents the public behavioral health authority for the County of Orange, I would like to register our support for the CBHDA July 2, 2014 letter. Counties appreciated the opportunity to work through CBHDA to provide input on the initial proposed regulations (as presented in November 2013). The subsequent revisions substantially improve the approach to defining and measuring the impact of Prevention and Early Intervention (PEI) services along the behavioral health service continuum.</p>	No specific action suggested	No specific action suggested	N/A
No Specified Section	H9	<p><u>Comment H9.01</u> Chair Van Horn, Members of the Commission, my name is Robert Oakes. I represent the California Behavioral Health Directors Association, and we wrote a letter in support of the PEI Regulations with six recommended changes that would be necessary for us to support it.</p> <p>We represent the fifty-eight-county behavior health directors - the programs that they administer through the MHSA, and I invite any questions or concerns you may have to ask us. I also have one of the chairs of our MHSA Committee here, who is available to talk with you, as well. Thank you.</p>	No specific action suggested	No specific action suggested	N/A