Joy Torres
(CONTACT DELETED)

July 21, 2014

Lauren Quintero
Mental Health Service Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814
Lauren.Quintero@mhsoac.ca.gov

Re: Prevention and Early Intervention Regulations

Dear Ms. Quintero:

I am a California resident who has been a consumer of mental health services. I am submitting proposed changes to the MHSA PEI regulations referred to MHSOAC's Notice of Proposed Rulemaking (5/14/14).

Please confirm receipt of this document. Thank you.

I would like the entire document, including attachments entered in the record and to receive a response to each of the comments I am making—as opposed to an overall response. As a person with lived experience I also hope the MHSOAC will provide me reasonable accommodation and let me know how to improve the comments or if I wasn't clear or if it needs to make minor changes in order to incorporate these in the final regulations.

The purpose of most of the comments is to ensure that those taxpayers intended to serve and are legislatively required to be served are in fact served and that funds are not diverted to ineligible populations or non-evidence based practices. Thank you.

Sincerely,

Joy Torres

Attached:
Overall Comments to Regs,
Research relied on
Attachments detailing past problems with MHSA PEI Spending and Regulatory Process that are integral to my proposed changes.

COMMENTS BY JOY TORRES, A CALIFORNIA RESIDENT AND CONSUMER OF MENTAL HEATLH SERVICES TO PREVENTION AND EARLY INTERVENTION REGULATIONS PROPOSED BY MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION
July 21, 2014

*"This measure will provide mental health services to **people who need it most**." (emphasis added) –Darrell Steinberg March 23, 2004*[1]

"As I've said before, we can't prevent certain mental illnesses, such as schizophrenia and bipolar disorder, but we can prevent them from becoming severe and disabling." –Darrel Steinberg. 4/13/2004[2]

"And (voters) didn't want (Proposition 63) to fund all mental health, only people that had severe mental illness." Rusty Selix[3]

Overview

- 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"[4]. The proposed regulations don't do that.

- 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 recommended best practices…."[5] The proposed regulations don't do that.

- 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.

- Prevention and Early Intervention programs "shall include mental health services **similar to those provided under other programs** effective in preventing mental illnesses from becoming severe, and shall also include components **similar to programs that have been successful** in reducing the duration of untreated severe mental illnesses" (emphasis added) [6] These regulations intentionally drive funds from "effective" "successful" programs to programs that are neither effective, nor successful.

- The regulations change "shall" to "may" in many cases thereby freeing counties from an obligation to use the funds as directed by taxpayers.

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[1] "Campaign for Mental Health" a blog by Darrell Steinberg to pass Proposition 63. The quote is from the very first post after turning in the signatures needed to put the initiative on the ballot. Available at http://campaignformentalhealth.typepad.com/darrell/2004/03/campaignturns__1.html Accessed 7/19/13.
[2] Official Weblog of the Campaign for Mental Health, April 13, 2004. Created by Darrel Steinberg to get voters to pass MHSA. Available at http://digital.library.ucla.edu/websites/2004_996_010/darrell/2004/04/index.html Accessed 6/20/13
[3] "History of Mental Health in California" 4/5/10. UCLA Health Services Research Center Rusty Selix interview available at http://www.mhac.org/pdf/Rusty-Selix-Interview.pdf
[4] Purpose and Intent (a) available at http://www.mhsoac.ca.gov/docs/MHSA_AsRevisedSept2013_ForPosting_120613.pdf
[5] Uncodified Code Section 3, subdivision (e) "Purpose and Intent" of the MHSA) available at http://www.mhsoac.ca.gov/docs/MHSA_AsRevisedSept2013_ForPosting_120613.pdf
[6] 5840(c)

- The proposed regulations bifurcate prevention and early intervention programs into two separate entities and sever them from the statutory requirement that the components "prevent mental illnesses from becoming severe and disabling." This bifurcation makes the regulations needlessly cumbersome and difficult to understand and drives funds from their intended purpose

- The regulators fail to "require reports on the achievement of performance outcomes"[7] (i.e, measure 'progress', like number of suicides, number of people homeless, number incarcerated) and instead rely solely on "process" indicators (like how many people clicked on a web site, amount of money spent, etc.)

- The regulations redefined 'evidence based" to allow the funding of services that don't have evidence of efficacy. This encourages the diversion of PEI funds to programs that should be funded with INN funds.

- 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"[8] and "Insider Dealing in MHSA PEI Programs.[9]

- "A regulation cannot alter, amend, enlarge, or restrict a statute, or be inconsistent or in conflict with a statute."[10]These regulations do alter, amend enlarge, restrict the statute and are in conflict with it. These regulations do.

Background

There is a long history of MHSOAC (and it's predecessor DMH) driving MHSA funds from their intended function of 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 Org[11] (attached) and the media[12]. 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."[13]

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"

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[7] 5848 (c)

[8] Available at http://mentalillnesspolicy.org/states/california/mhsa/county-by-county-mhsa-misspending.pdf and part of the "MHSA: 10 Year Bait and Switch" Report attached as an integral part of my comments.

[9] Available at http://mentalillnesspolicy.org/states/california/mhsa/mhsa_insider_dealing.html and part of the "MHSA: 10 Year Bait and Switch" Report attached as an integral part of my comments.

[10] California Office of Administrative Law (OAL): "How to participate in rulemaking process" available at http://www.oal.ca.gov/res/docs/pdf/HowToParticipate.pdf).

[11] Mental Illness Policy Org. "California's Mental Health Service Act A Ten Year $10 Billion Bait and Switch" August 15, 2013. Available at http://mentalillnesspolicy.org/states/california/mhsa/mhsa.prop63.baitswitch.fullreport.pdf and attached as an integral part of my comments.

[12] Ex. Hannah Dreier ,Associated Press. California Mental Health Dollars Bypass Mentally Ill , July 28, 2012. One version of article available at http://www.dailynews.com/20120728/california-mental-health-spending-often-bypasses-the-mentally-ill

[13] California State Auditor. "Mental Health Services Act" Available at http://mentalillnesspolicy.org/states/california/mhsa/state-auditor-mhsa-report.pdf (Accessed 6/14)

(attached).[14]

The "Policy Statement Overview and Anticipated Benefits of Proposal" in the "Notice of Proposed Rulemaking"[15] 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. [16]

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.

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"[17]. 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 that already exist.

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…"[18]. 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.[19]

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 duration of untreated severe mental illnesses and assisting people in quickly regaining productive lives."

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 *serious mental illness* among children, adults and seniors as a condition deserving priority attention"[20] . PEI funds are specifically limited by the legislation to "prevent mental illnesses from becoming severe and disabling." i.e, serving people *with* mental illness.

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[14] These are part of the "Bait and Switch" Report at http://mentalillnesspolicy.org/states/california/mhsa/mhsa.prop63.baitswitch.fullreport.pdf that is attached.
[15] Available at http://www.mhsoac.ca.gov/Laws_Regs/docs/PEI_Notice.pdf
[16] On Page 3 of 12 of Notice of Proposed Rulemaking. June 6, 2014.
[17] 5840 (c).
[18] Uncodified "Purpose and Intent", Paragraph (c), available at
[19] Taxpayers did set aside funds for programs not yet proven to help people with serious mental illness. But those are limited to funding for Innovative Programs.
[20] Purpose and Intent (a) available at http://www.mhsoac.ca.gov/docs/MHSA_AsRevisedSept2013_ForPosting_120613.pdf

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"[22]

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).

The regulations fail to ensure the funds achieve legislatively mandated goals.

The Findings and Declarations from which all the other provisions of the act derive, state that the object of the legislation is to address the fact that

> "Many people left untreated or with insufficient care see their mental illness worsen. …(and) many become homeless and are subject to frequent hospitalizations or jail."

These goals are also specifically stated in PEI Section.

The program shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness: (1) Suicide. (2) Incarcerations. (3) School failure or dropout. (4) Unemployment. (5) Prolonged suffering. (6) Homelessness. (7) Removal of children from their homes.(5840 (d))

In spite of this clear direction, the regulations fail to require counties to measure rates of homelessness, rates of hospitalizations, or number of people incarcerated who have serious mental illness. Rather than focusing on the *outcomes* the regulations focus exclusively on the *process. As a result, regulators will have no idea if the programs are serving the intended target or not, and therefore can not determine if they were successful or not. They can only determine that money was spent. The regulators have disingenuously chosen to measure process, rather than progress. A county with increasing rates of suicide, homelessness, arrest, incarceration, school drop out, will not be called to account for their failure.*

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.

To prevent the recurrence of known previous misspending and lack of oversight issues identified by the California State Auditor, the following provisions should be promulgated as regulations.

- Unless otherwise noted, prevention funds may not be spent on 'preventing mental illness' or

[21] 5840 (b) 2.

[22] Uncodified Findings and Declarations (a). There is little controversy as to who has "serious" mental illness. Proposition 63 and virtually all government agencies and non profits use roughly 5-9% of the population because they all rely on the National Institute of Mental Health (NIMH) the pre-eminent research arm of the US Government that addresses these issues. 5-9% is also supported by other research.[22] NIMH estimates overall 5% have "Serious Mental Illness" and breaks it down by diagnosis as follows:

Schizophrenia (NIMH defines *all* schizophrenia as "severe")	1.1% of the population
The subset of major depression called "severe, major depression"	2.0% of the population
The subset of bipolar disorder classified as "severe"	2.2% of the population
Total "severe" mental illness by diagnosis:	**5.3% of the population**

The above are overall figures. Within certain age groups NIMH research shows up to 8% have serious mental illness. This accounts for the 5-9% figure used in the legislation.

preventing serious mental illness'[23]

- 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). [24]
- 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[25]

Umbrella comments

The PEI Section of legislation specifically says counties "shall establish **a** program designed to prevent mental illness from becoming severe and disabling."(emphasis added). The requirement is singular, not plural. In spite of this clear direction the draft regulations make components optional The artificial bifurcation of Prevention and Early Intervention Programs into two components (a) prevention and (b) early intervention, as proposed in the draft regulations is contrary to legislation. It complicates, confuses, and will likely end up diverting funds rather than helping to see they are spent appropriately. The legislation is clear that there shall be ""a" program, not multiple ((5840(a)). In addition 5840 (a), 5840 (b) and 5840 (c) all start by describing "The Program" not multiple programs.

Following are my concerns about the specific regulations being proposed.
THE ATTACHMENTS ARE AN INTEGRAL PART OF MY COMMENTS AND SHOULD BE INCLUDED IN THE RECORD. THANK YOU.

[23] 5840(a) defines the program as preventing mental illness from becoming severe and disabling, **not** "preventing mental illness". This is intentional. As the author of the legislation, Senator Darrel Steinberg eloquently stated when campaigning for Prop 63:"*As I've said before, we can't prevent certain mental illnesses, such as schizophrenia and bipolar disorder, but we can prevent them from becoming severe and disabling.*" –Darrel Steinberg. 4/13/2004 (Official Weblog of the Campaign for Mental Health, April 13, 2004. Created by Darrel Steinberg to get voters to pass MHSA. Available at http://digital.library.ucla.edu/websites/2004_996_010/darrell/2004/04/index.html Accessed 6/20/13) For mental disorders, we do not know the cause, we lack a biomarker that is 100 percent accurate for diagnosis" (Insel 2014). In 2003, the President's New Freedom Commission declared, "Preventing mental illnesses remains a promise of the future. (President's New Freedom Commission on Mental Health 2003). Nothing has changed since then. The well-respected Institute of Medicine conducted a study of efforts to prevent mental illness in the military and released their report in 2014. (Institute of Medicine 2014). The Wall St. Journal subhead summed it up best, "Study Fails to Find Evidence That Programs for Soldiers and Families Prevent Psychological Disorders" (Wang 2014) Presumably, to justify this diversion, regulators cite "Muñoz RF et al (2012). Major depression can be prevented. American Psychologist 67(4), 285-295." That is not research is a paper on what the Institute on Medicine (IOM) purportedly said. We do not know how to prevent mental illness. Expending funds to prevent mental illness is contrary to legislation, not evidence-based, and therefore not cost-effective; all of which are required by the legislation.

[24] The findings and declarations, purpose and intent, and 5840(a) and 5840(c) clearly establish MHSA and PEI in particular is intended to help those with mental illness or serious mental illness, not those without. Exceptions are noted.

[25] 5840(d) clearly limits expenditures to reducing these outcomes in people with 'untreated mental illness'. I have found numerous examples of counties using the funds to reduce these outcomes in people who do not have a mental illness. MHSOAC has an obligation to issue regs to insure that practice stops.

Bibliography of Research Relied on and Works Cited

Amador, Xavier, PhD. "Anosognosia and serious mental illness." Edited by Available at http://ssnsc.blogspot.com/2011/03/anosognosia-1-of-2.html. *National Alliance on Mental Illness Conference.* 2011.

American Foundation for Suicide Prevention. *AFSP: Facts and Figures.* 2010. http://www.afsp.org/index.cfm?page_id=04EA1254-BD31-1FA3-C549D77E6CA6AA37 (accessed March 24, 2013).

—. *Suicide: Facts and Figures.* 2010. https://www.afsp.org/understanding-suicide/facts-and-figures (accessed April 15, 2013).

American Psychiatric Association. *Diagnositic and Statistical Manual, 5th Edition.* Arlington, VA: American Psychiatric Association, 2013.

Antypa, N, Serretti, and A. "Family history of a mood disorder indicates a more severe bipolar disorder." *Journal of Affective Disorders* 156 (Marcy 2014): 178-86.

APA. "Practice Guideline for the Treatment of Patients With Schizophrenia." Edited by L., M.D. Dixon, D., M.D. Perkins and C., Ph.D. Calmes. Translated by Available at http://psychiatryonline.org/content.aspx?bookid=28&sectionid=1682213 (Accessed 3/14). Washington, DC: American Psychiatric Association, 2009.

Branan, Brad. "The Public Eye: $3 million in state contracts yanked from Sacramento mental health group Read more here: http://www.sacbee.com/2012/11/11/4976722/3-million-in-state-contracts-yanked.html#storylink=cpy." *Sacramento Bee*, November 11, 2012.

Broad Institute. *Genetic variants for schizophrenia, bipolar disorder identified.* Stanley Center for Psychiatric Research. September 19, 2011. http://www.broadinstitute.org/news/3048 (accessed April 19, 2013).

—. *Genetics of Bipolar and schizophrenia.* Stanley Center for Psychiatric Research. http://www.broadinstitute.org/science/programs/psychiatric-disease/stanley-center-psychiatric-research/genetics-bipolar-and-schizo (accessed April 19, 2013).

Brown, Jerry. *Governor Budget Summary 2014-2015.* January 10, 2014. http://www.calnewsroom.com/wp-content/uploads/2014/01/FullBudgetSummary.pdf (accessed June 20, 2014).

Bureau of Justice Statistics . *State Court Caseload Statistics.* US Department of Justice, Washington, DC: Office of Justice Programs.

California Department of Mental Health. " California Code of Regulations Title 9. Rehabilitative and Developmental Services Division 1. Department of Mental Health Chapter 14. Mental Health Services Act Article 2. ." 2005.

California DHCS. "Violence and Mental Illness: The Facts." *California Department of Health Care Services.* http://www.dhcs.ca.gov/services/MH/Documents/ViolenceandMentalIllnessTheFacts.pdf (accessed March 8, 2014).

California Mental Health Services Authority. *California Mental Health Services Authority Launches Statewide Suicide Prevention Campaign.* Dec 12, 2012. http://www.prweb.com/releases/prweb2012/12/prweb10229719.htm (accessed 12 28, 2013).

California State Auditor. "Mental Health Services Act." Sacramento, CA, 2013.

CDC. *Number and rate of discharges from short-stay hospitals.* 2010. http://www.cdc.gov/nchs/data/nhds/2average/2010ave2_firstlist.pdf (accessed June 20, 2014).

Center for Disease Control. *Suicide: Facts at a Glance.* 2010. http://www.cdc.gov/ViolencePrevention/pdf/Suicide_DataSheet-a.pdf (accessed March 24, 13).

Centers for Disease Control and Prevention. "Mental Illness Surveillance Among Adults in the United States." U.S. Department of Health and Human Services. September 9, 2011. http://www.cdc.gov/mmwr/pdf/other/su6003.pdf (accessed March 30, 2013).

Cochrane Collaborative. "Consumer-providers of care for adult clients of statutory mental health services." *Cochrane Database of Systematic Reviews.* no. 3. Edited by V. Pitt, D. Lowe, S.: Prictor.

M. Hill, SE. Hetrick, R. Ryan and L. Berends. Translated by Abstract at http://www.ncbi.nlm.nih.gov/pubmed/23543537 (Accessed 3/14). John Wiley & Sons, 2013.
Douglas F. Levinson, M.D., and M.D., Walter E. Nichols. *Major Depression and Genetics.* http://depressiongenetics.stanford.edu/mddandgenes.html (accessed 2 26, 2014).
Douglas KS, Guy LS, Hart SD. "Psychosis as a risk factor for violence to others: a meta-analysis." *Psychological Bulletin*, 2009: 679–706.
Follman, Mark. "Mass Shootings: Maybe What We Need Is a Better Mental-Health Policy." *Mother Jones News*, November 9, 2013.
Fortugno F, Katsakou C, Bremner S, Kiejna A, Kjellin L, Nawka P, Raboch J, Kallert T, Priebe S. "Symptoms associated with victimization in patients with schizophrenia and related disorders." Edited by Available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3602443/. *PLoS One*, March 2013.
Glaze, Lauren E, and Erica Parks. *Correctional Populations in the United States, 2011.* Office of Justice Programs, U.S. Department of Justice, Washington, DC: Bureau of Justice Statistics, 2011.
Glaze, Lauren E, and Erika Parks. "Correctional Populations in the United States, 2011." Survey, Bureau of Justice Statistics, U.S. Department of Justice, Office of Justice Programs, Washington, 2012.
Goldberg, TE, JD Ragland, EF Torrey, JM Gold, LB Bigelow, and DR Weinberger. "Neuropsychological assessment of monozygotic twins discordant for schizophrenia." *Archive of General Psychiatry* 47, no. 11 (November 1990): 1066-72.
Goldberg, TE: Green, ME. "Neurocognitive functioning in patients with schizophrenia: an overview." In *Psychopharmacology: The Fifth Generation of Progress*, by Kenneth L. Davis, Dennis Charney, Joseph T. Coyle and Charles Nemeroff, 657-669. Philadelphia, PA: Lippincott, Williams, & Wilkins, 2002.
Green, MF. "Cognitive impairment and functional outcome in schizophrenia and bipolar disorder." *Journal of Clinical Psychiatry* 67 (2006): 36-42.
Grob, Gerald N. "Public Policy and Mental Illnesses: Jimmy Carter's Presidential Commission on Mental Health ." *Milbank Quarterly* 83, no. 3 (October 2005): 425-456.
Hardin, Herschel. "Uncivil Liberties: Far from respecting civil liberties, legal obstacles to treating the mentally ill limit or destroy the liberty of the person." *Vancouver Sun*, July 22, 1993.
Heggarty, Michael, Director of Behavioral Health. *ASSISTED OUTPATIENT TREATMENT (W&I CODE 5345) (AB 1421) "LAURA'S LAW".* Powerpoint, Grass Valley, CA: Nevada County Department of Behavioral Health, November 15, 2011, 37.
Henry J. Steadman, PhD, et al. "Violence by People Discharged From Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhoods." Edited by Available at. *Arch Gen Psychiatry*, May 1998: 393-401.
Hiday, Virginia Aldigé, Ph.D., Marvin S., M.D. Swartz, Jeffrey W., Ph.D. Swanson, and Randy, H. Ryan, Psy.D. Borum. "Criminal Victimization of Persons With Severe Mental Illness." *Psychiatric Services*, January 1, 1999.
Hubert, Cynthia, Phillip Reese, and Jim Sanders. "Nevada busses hundreds of mentally ill patients to cities around country." *Sacramento Bee*, April 14, 2013: 1.
Insel, Dr. Thomas. *NIMH Director's Blog: Making the Connection.* March 22, 2013. http://www.nimh.nih.gov/about/director/2013/making-the-connection.shtml?utm_source=govdelivery&utm_medium=email&utm_campaign=govdelivery (accessed April 5, 2013).
Insel, Dr. Tom. "Blog of Dr. Tom Insel, Director of NIMH." *NIMH.* July 31, 2013. http://www.nimh.nih.gov/about/director/2013/getting-serious-about-mental-illnesses.shtml (accessed Feb 28, 2014).
Insel, Thomas. "Keynote Address." *Mental Health and Violence: Opportunities for Prevention and Early Intervention .* Edited by Available at http://iom.edu/Activities/Global/ViolenceForum/2014-FEB-26/Day%201/Welcome%20and%20Morning%20Presentations/4-Insel-Video.aspx (Accessed 3/14). Washington, DC: Insitute of Medicine, February 26, 2014.
Insel, Tom. *Director's Blog.* June 20, 2014. http://www.nimh.nih.gov/about/director/2014/aids-a-cautionary-tale.shtml (accessed June 21, 2014).

Institute of Medicine. *Improving the Quality of Health Care for Mental and Substance-Use Conditions.* Edited by Available at http://www.nap.edu/catalog/11470.html (Accessed 3/14). Washington, DC: National Academies Press, 2006.
—. "Mental Health and Violence: Opportunities for Prevention and Early Intervention - A Workshop." *Evidence for Violence Prevention Across the Lifespan and Around the World A Workshop of the Forum on Global Violence Prevention.* Edited by Proceedings and Videos. Washington, DC: IOM, January 23-24, 2013.
—. "Mental Health and Violence: Opportunities for Prevention and Early Intervention - A Workshop." Edited by Available at http://iom.edu/Activities/Global/ViolenceForum/2014-FEB-26/Day%201/Panel%201/19-Bernstein-Video.aspx (accessed 6/14). Washington, DC: National Academy of Sciences, February 26, 2014.
—. *Preventing Psychological Disorders in Service Members and Their Families: An Assessment of Programs.* Edited by Marc Meisnere, and Kenneth E. Warner Laura Aiuppa Denning. Washington, DC: National Academies Press, 2014.
—. *Preventing, Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possiblities.* Edited by Mary Ellen O'connel and Thomas Boat Kenneth Warner. Washington, DC: National Academis Press, 2009.
—. *Reduing Risk for Mental Disorders: Frontiers for Preventative Intervention Researh.* Edited by Patricia J. Mrazek and Robert J. Haggerty. Washington, DC: National Acadamy of Sciences, 1994.
J. John, Mann MD, Apter MD Alan, and et. al. "Suicide Prevention Strategies A Systematic Review." *The Journal of the American Medical Association (JAMA)* (American Medical Association) 294, no. 16 (October 2005): 2064-2074.
Jacobson, Joy. "Violence and Nursing." *American Journal of Nursing*, Februrary 2007: 25-26.
Jaffe, DJ. "Kognito At-Risk for College Students certified by SAMHSA as effective way to identify mentally ill students in spite of lack of evidence." *Mental Ilness Policy Org SAMHSA Subsite.* 2013. http://mentalillnesspolicy.org/samhsa/kognitounproven.html (accessed May 15, 2014).
—. "Letter to Governor Brown." *Mental Illness Policy Org.* August 29, 2013. http://mentalillnesspolicy.org/states/california/mhsa/govjerrybrownltr.html (accessed June 15, 2014).
—. "Mental Health First Aid is Unproven yet SAMHSA Subsidized." *Mental Illness Policy Org.* Mental Illness Policy Org. 2013. http://mentalillnesspolicy.org/samhsa/mental-health-first-aid-fails.html (accessed March 18, 2014).
—. "Teen Screen certified by SAMHSA in spite of zero research." *Mental Illness Policy Org.* 2013. http://mentalillnesspolicy.org/samhsa/teenscreenunproven.html (accessed May 12, 2014).
—. "Proposition 63 never promised to pay for gardens Read more here: http://www.sacbee.com/2012/08/10/4714373/hmong-gardens-and-prop-63.html#storylink=cpy." *The Sacramento Bee*, August 10, 2012.
—. "WRAP is Certified as 'evidence based' by SAMHSA, but is it?" *Mental Illness Policy Org.* 2013. http://mentalillnesspolicy.org/samhsa/wrapunproven.html (accessed March 17, 2014).
James, Doris J., and Lauren E. Glaze. *Mental Health Problems of Prison and Jail Inmates.* U.S. Department of Justice Office of Justice Programs. September 2006. http://bjs.gov/content/pub/pdf/mhppji.pdf (accessed March 10, 2014).
Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. "Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication." *Archive of General Psychiatry*, June 2005: 593-602.
Kessler, Ronald C., Patricia A. Berglund, and Martha L. Bruce. "The Prevalence and Correlates of Untreated Serious Mental Illness." Edited by Available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1089274/pdf/hsresearch00007-0020.pdf. *Health Services Research* 36 (2001): 987-1007.
Kessler, Ronald, Ph.D, et al. "Individual and Societal Effects of Mental Disorders on Earnings in the United States: Results From the National Comorbidity Survey Replication." *American Journal of Psychiatry.* 5. Vol. 165. Press release at http://www.nih.gov/news/health/may2008/nimh-07.htm (Accessed March 25, 2013), June 1, 2008.
Lamb, Richard. "Taking Issue – Combating stigma by providing treatment." *Psychiatric Services* 50,

no. 6 (June 1999).
Large, Nielssen, Olav and Large, Matthew. "Rates of homicide during the first episode of psychoses and after treatmen." *Schizophrenia Bulletin*, July 2010: 702-712.
Marilyn Lewis Lanza, Robert Zeiss, Jill Rierdan. "Violence against Psychiatric Nurses: sensitive research as science and intervention." *Mental Health Nursing*, 2006: 71-84.
Martin, Fred. "Outdated CA mental health law serves no one." *San Francisco Chronicle*, June 5, 2012.
Matejkowski, Jason C. MSW, Sara W. MSW Cullen, and Phyllis L. PhD Solomon. "Characteristics of Persons With Severe Mental Illness Who Have Been Incarcerated for Murder ." Edited by Available at http://www.jaapl.org/content/36/1/74.full. *J Am Acad Psychiatry Law* (American Academy of Psychiatry and the Law) 36, no. 1 (March 2008): 74-86.
Mental Illness Policy Org. "Research from the ten independent studies conducted over ten years on NYS Assisted Outpatient Treatment ." *Mental Illness Policy Org.* DJ Jaffe. 2013. http://mentalillnesspolicy.org/kendras-law/research/kendras-law-studies.html (accessed May 1, 2014).
Mental Illness Policy Org. "California's Mental Health Service Act: A Ten Year $10 Billion Bait and Switch." New York, NY, August, 2013.
Miller, Michael Craig. *What Causes Depression.* Harvard Health Publications, Harvard Medical School, Cambridge, MA: Harvard Univesity, 2013.
Mojtabai, Ramin MD, Mark Olfson, and Ronald C. PhD Kessler. "Barriers to Mental Health Treatment: Results from the National Comorbidity Survey Replication." *Psychological Medicine* (Cambridge University Press) 41, no. 8 (August 2011): 1751-1761.
NAMI California. "MHSA County Programs 2012: Services Promoting Recovery and Reducing Homelessness, Hospitalization, and Incarceration." Available at http://www.namicalifornia.org/uploads/eng/mhsa%20full%20report.pdf, May, 2012.
National Advisory Mental Health Council Behavioral Science Task Force . "Basic Behavioral Science Research for Mental Health: A National Investment ." National Institue of Mental Health, Rockville, MD, 1995.
National Advisory Mental Health Council. "Health Care Reform for Americans with Serious Mental Illness: Report of the National Advisory Mental Health Council ." *American Journal of Psychiatry* (American Psychiatric Association) 150, no. 10 (October 1993): 1447.
National Center for Health Statistics. *Health, United States 2011: With Special Feature on Socioeconomic Status and Health.* Edited by Table 130 available at http://www.cdc.gov/nchs/data/hus/hus11.pdf#130. MD Hyattsville. May 2012. http://www.cdc.gov/nchs/data/hus/hus11.pdf#130 (accessed April 15, 2013).
National Coalition for the Homeless. "Mental Illness and Homelessness." July 2009. http://www.nationalhomeless.org/factsheets/Mental_Illness.pdf.
National Institute of Mental Health. "Bipolar Disorder." *NIMH.* http://www.nimh.nih.gov/health/publications/bipolar-disorder/index.shtml (accessed February 14, 2014).
—. "Bipolar Disorder Among Adults (Statistics)." *NIMH.* http://www.nimh.nih.gov/statistics/1BIPOLAR_ADULT.shtml (accessed Februrary 28, 2014).
—. "Schizophrenia (Statistics)." *NIMH .* http://www.nimh.nih.gov/statistics/1SCHIZ.shtml (accessed Februrary 28, 2014).
—. "Schizophrenia Facts." *National Institute of Mental Heatlh .* March 20, 2012. http://www.nimh.nih.gov/health/publications/schizophrenia/index.shtml (accessed March 30, 2013).
National Institute of Mental Heatlh. "Major Depressive Disorder Among Adults (Statistics)." *NIMH.* http://www.nimh.nih.gov/statistics/1MDD_ADULT.shtml (accessed February 28, 2014).
National Law Center on Homelessness and Poverty. *Criminalization Crisis: The Criminalization of Homelessness in U.S. Cities.* November 2011. http://www.nlchp.org/view_report.cfm?id=366 (accessed April 5, 2013).
National Survey on Drug Use and Health. "State Estimates of Adult Mental Illness from the 2011 and 2012 National Surveys on Drug Use and Health." Substance Abuse and Mental Health Services Agency, Rockville, MD, Feb. 28, 2014.

Nurnberger JI, Jr. "Genetics of bipolar affective disorder." *Current Psychiatry Reports* 2 (April 2000): 147-157.
Padgett, D.K., and E.L. Struening. "Victimization and traumatic injuries among the homeless: Associations with alcohol, drug, and mental problems." *American Journal of Orthopsychiatry* 62 (1992): 525-534.
Peters, Amanda. "Lawyers Who Break the Law: What Congress Can Do to Prevent Mental Health Patient Advocates from Violating Federal Legislation." *Oregon Law Review* 89, no. 133 (2010): 133-174.
President's New Freedom Commission on Mental Health. *Achieving the Promise: Transforming Mental Health Care in America.* Edited by Ph.D. Michael F. Hogan. Rockville, MD, 2003.
Rabkin, J. "Criminal behavior of discharged mental patients: a critical appraisal of the research." *Psychological Bulletin* 86 (1979): 1-27.
Robert Keers, Ph.D., Ph.D. Simone Ullrich, Ph.D. Bianca L. DeStavola, and M.D. Jeremy W. Coid. "Association of Violence With Emergence of Persecutory Delusions in Untreated Schizophrenia." Edited by Abstract at http://ajp.psychiatryonline.org/article.aspx?articleID=1773703 (Accessed 3/14). *American Journal of Psychiatry* (American Psychiatric Association) 171, no. 3 (March 2014): 332-339.
Robins LN, Regier DA. *Psychiatric disorders in America: the Epidemiologic Catchment Area Study.* New York, NY: The Free Press, 1991.
Romney, Lee. "State mental hospitals remain violent, despite gains in safety." *Los Angeles Times*, October 9, 2013.
SAMHSA. "Results from the 2011 National Survey on Drug Use and Health: Mental Health Findings." Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration , Rockville, MD, 2012.
—. "SAMHSA's Definition and Guiding Principles of Recovery – Answering the Call for Feedback." Rockville, MD: Substance Abuse and Mental Health Services Administration, December 11, 2011.
—. "SAMHSA's Working Definition of Recovery Updated." *SAMHSA.* March 23, 2012. http://blog.samhsa.gov/2012/03/23/defintion-of-recovery-updated/#.U3YZFShJ-6k (accessed May 16, 2014).
—. "SAMHSA's Working Definition of Recovery Updated." Rockville, MD: Substance Abuse and Mental Health Services Administion, March 23, 2013.
—. "Violence and Mental Illness: The Facts." *SAMHSA's Resource Center to Promote Acceptance, Dignity and Social Inclusion Associated with Mental Health (ADS Center).* Substance Abuse and Mental Health Services Administration. http://www.promoteacceptance.samhsa.gov/publications/facts.aspx (accessed 8 2014, March).
Sanburn, Josh. "Inside the National Suicide Hotline: Preventing the Next Tragedy." *Time*, September 13, 2013.
Seena Fazel, Johan Zetterqvist, Henrik Larsson, Niklas Långström, Paul Lichtenstein. "Antipsychotics, mood stabilisers, and risk of violent crime." *Lancet*, May 2014.
Short, Tamsin B R, Stuart Thomas, Stefan Luebbers, Paul Mullen, and James R P Ogloff. "A case-linkage study of crime victimisation in schizophrenia-spectrum disorders over a period of deinstitutionalisation ." Edited by Available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3599537/. *BMC Psychiatry*, November 2013.
Swanson JW, Frisman LK, Robertson AG, Lin HJ, Trestman RL, Shelton DA, Parr K, Rodis E, Buchanan A, Swartz MS. "Costs of Criminal Justice Involvement Among Persons With Serious Mental Illness in Connecticut. ." *Psychiatric Services*, March 15, 2013.
Swanson, Jeffrey W., III Charles E. Holzer, Vijay K. Ganju, and Robert Tsutomu Jono. "Violence and Psychiatric Disorder in the Community: Evidence From the Epidemiologic Catchment Area Surveys." *Psychiatric Services* (American Psychiatric Association), July 1990.
Thorburn, K.M. "The corrections department: the forgotten branch of the mental health system." Edited by http://www.ncbi.nlm.nih.gov/pubmed/2732046. *Hawaii Medical Journal* 48, no. 3 (March 1989): 91-92.
Torrey, E. Fuller MD, Aaron (Sheriff) Kennard, Don (Sheriff) Eslinger, and Richard M.D. Lamb. *More Mentally Ill Persons Are in Jails and Prisons Than Hospitals.* A Survey of the States, Treatment

Advocacy Center, Arlington: Available at http://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf, 2010.
Torrey, E.F, and Aaron, Sheriff Eslinger, Don, Richard M.D., Sheriff Kennard. *More Mentally Ill in Jails than Hospitals: A Survey of the States.* Survey, Treatment Advocacy Center, 2010.
Torrey, E.F. *5000 suicides a year are likely caused by mental illness, mainly untreated mental illness.* . http://mentalillnesspolicy.org/consequences/suicide.html (accessed 4 15, 2013).
Torrey, EF. "Stigma and Violence: Isn't it Time to Connect the Dots." *Schizophrenia Bulletin*, june 2011.
—. *Violence and Mental Illness: A collection of studies.* 2010. http://mentalillnesspolicy.org/consequences/mental-illness-violence-stats.html (accessed 4 2013, April).
Torrey, F. *Suicide among people with bipolar and schizophrenia.* 2010. http://mentalillnesspolicy.org/consequences/suicide.html (accessed March 1, 2014).
Torrey, Fuller. *Schizophrenia and bipolar disorder are diseases of the brain .* 2010. http://mentalillnesspolicy.org/medical/schizophrenia-brain-studies.html (accessed February 22, 2014).
Treatment Advocacy Center. "The Shortage of Public Hospital Beds for Mentally Ill Persons." Survey, 2005.
Tsuang, MT. "Risk of suicide in the relatives of schizophrenics, manics, depressives, and controls. T." *Journal of Clinical Psychiatry* 44, no. 11 (November 1983): 398-400.
U.S. Census Bureau. *Table 348. Adults Under Correctional Supervision: 1980 to 2009.* Census Bureau, U.S. Department of Commerce, Washington, DC: U.S. Government, 2010.
U.S. Department of Housing and Urban Development. *2010 Annual Homeless Assessement Report to Congresss.* Office of Community Planning and Development. 2010. https://www.onecpd.info/resources/documents/2010HomelessAssessmentReport.pdf (accessed April 6, 2013).
U.S. Surgeon General. *Mental Health: A report of the U.S. Surgeon General.* Rockville, MD: Department of Heatlh and Human Services, 1999.
V.A. Hiday, M.S. Swartz, J.W. Swanson, R. Borum, H.R. Wagner. "Criminal Victimization of Persons With Severe Mental Illness." *Psychiatric Services* 50 (1999): 62-68.
Wahl, Otto. "Memorandum of the Resource Center to Address Discrimination and Stigma ." Hartford, CT, 2003.
Wang, Shirley. "Military's Mental-Health Efforts Are Ineffective, Report Finds." *Wall St. Journal*, February 10, 2014.

CHANGES TO REGS PROPOSED BY MS. TORRES:

Article 2. Definitions

Article 5. Reporting Requirements

Adopt Section 3510.010 as follows:

Section 3510.010. Prevention and Early Intervention Annual Revenue and Expenditure Report.

(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 Prevention and Early Intervention Program[1], Prevention Program, Early Intervention Program, Outreach for Increasing Recognition of Early Signs of Mental Illness Program/Approach, Stigma and Discrimination Reduction Program, ~~or~~ Suicide Prevention Program/Approach, 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.[2] If a program includes more than one element, the County shall estimate the percentage of funds dedicated to each element.

(B) Medi-Cal Federal Financial Participation

(C) 1991 Realignment

(D) Behavioral Health Subaccount

(E) Any other funding

(2) The amount of funding expended for Prevention and Early Intervention Component Administration by the following funding sources:

(A) Prevention and Early Intervention funds

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[1] Authority: 5840(a) says counties "shall establish a program designed to prevent mental illness from becoming severe and disabling."(emphasis added). 5840 (b) and 5840 (c) all start by describing "The Program" not multiple programs. The requirement is singular, not plural.
Statement of Necessity: The addition of this language allows counties to implement a Prevention and Early Intervention Program rather than requiring the bifurcation of Prevention and Early Intervention Programs into separate Prevention Programs and Early Intervention Programs. The artificial bifurcation of Prevention and Early Intervention Programs into two components (a) prevention and (b) early intervention, as proposed in the draft regulations is contrary to legislation. Any county that follows the legislation and implements a Prevention and Early Intervention Program would find themselves in violation of the regulations which prohibit that. Bifurcation complicates, confuses, and will likely end up diverting funds rather than helping to see they are spent appropriately. For purposes of our comments, I will add "Prevention and Early Intervention Program" wherever the proposed regulations say they have to be one or the other. That will give counties the option of following the legislation. However, our suggestion is that the regulators rewrite the regulations to eliminate the option of bifurcating.

[2] Authority 1 : 5840(c). Authority 2: Uncodified Code Section 3, subdivision (e) "Purpose and Intent" of the MHSA: "To ensure all funds are expended in the most cost effective manner". Note that I rely on this section for many of our proposed changes.
Statement of Necessity: These are mandated programs and therefore counties are required to allocate funds to them. Without requiring reporting on this, MHSOAC can not exercise their responsibilities pursuant to Uncodified Code Section 3, subdivision (e) "Purpose and Intent" of the MHSA:

(B) Medi-Cal Federal Financial Participation
(C) 1991 Realignment
(D) Behavioral Health Subaccount
(E) Any other funding

(3) The amount of funding expended for evaluation of the Prevention and Early Intervention Component by the following funding sources:
(A) Prevention and Early Intervention funds
(B) Medi-Cal Federal Financial Participation
(C) 1991 Realignment
(D) Behavioral Health Subaccount
(E) Any other funds

(4) 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.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5840, 5845, 5847, and 5899, Welfare and Institutions Code; Sections 2 and 3 of the Mental Health Services Act.

Adopt Section 3560 as follows:

Section 3560. Prevention and Early Intervention Reports.

(a) The County shall submit to the Mental Health Services Oversight and Accountability Commission the following Prevention and Early Intervention reports:
(1) The annual Prevention and Early Intervention report as specified in Section 3560.010.
(2) The Three- Year Evaluation Report as specified in Section 3560.020.

Adopt Section 3560.010 as follows:

Section 3560.010. Annual Prevention and Early Intervention Report.

(a) The requirements set forth in this section shall apply to the Annual Prevention and Early Intervention Report to be included in the Annual Update for fiscal year 2015/16 and each Annual Update and Three-Year Program and Expenditure Plan thereafter.
(b) The County shall report the following information annually as part of the Annual Update or Three- Year Program and Expenditure Plan. The report shall include the following information for the reporting period:
(1) For each Prevention and Early Intervention Program,[3] Prevention program and each Early Intervention program list:
(A) Unduplicated numbers of individuals served annually

~~1.~~(i) If a program ~~serves both individuals at risk. of~~prevents mental illness from becoming severe and disabling[4] (Prevention) and ~~individuals with early onset of~~ reduces

[3] See FN 1
[4] Authority 1: "Prevention" is defined at 5840(a) as "Preventing Mental Illness from becoming Severe and Disabling " R Authority 2; Uncodified "Purpose and Intent" paragraph (e), Regulators are required "to ensure that all funds are expended in the most cost effective manner and services are provided in accordance with recommended best practices…to ensure accountability to taxpayers and to the public."

the duration of untreated severe mental illness or provides "Access and linkage to medically necessary care provided by county mental health programs for children with severe mental illness, as defined in Section 5600.3, and for adults and seniors with severe mental illness, as defined in Section 5600.3, as early in the onset of these conditions as practicable. (Early Intervention)[5] ~~a potentially serious mental illness~~, the County shall report numbers served separately for each category.

~~2.~~(ii) If a program serves families the County shall report information for each individual family member served.

~~b.~~(2) For each Outreach for Increasing Recognition of Early Signs of Mental Illness program or strategy within a program, the County shall provide the number of potential responders engaged differentiated by type of settings as referenced in Section 3750, subdivision (d)(3)(A).

~~(2)~~(3) For Access and Linkage to Treatment Strategy the County shall provide:

~~i.~~(A) ~~Number~~ Number and diagnosis by category of mental illness[6] of individuals with serious mental illness referred to treatment, and the kind of treatment to which the individual was referred.

~~ii.~~(B) Number of individuals and diagnosis by category of those[7] who followed through on the referral and engaged in treatment, defined as the number of individuals who participated at least once in the program to which they were referred.

~~(A)~~(C) Duration of untreated mental illness as defined in Section 3750, subdivision (g)(3)(A).

~~iii.~~(D) How long the individual received services in the program to which the individual was referred.

~~c.~~(4) For Improve Timely Access to Services for Underserved Populations Strategy the County shall provide:

~~i.~~(A) Identify the specific underserved populations for whom the County intends to increase timely access to services.

Statement of Necessity: This change is needed because regulators (DMH and MHSOAC) have repeatedly in the past told counties to use PEI funds on people who don't have mental illness. (See Regulation originally proposed by DMH to be included in California Code of Regulations, Title 9. Rehabilitative and Developmental Services, Division 1. Department of Mental Health, Chapter 14. Mental Health Services Act Article 2. DEFINITIONS, Section 3200.251 which was shared with all counties, and letters sent by DMH to counties in October 2005, requiring counties to spend funds on those 'prior to diagnosis', i.e., without mental illness). In light of those communications it is critical that regulators correct the misperception and establish the funds are intended to help those with mental illness, not those without. Regulators can not change the meaning of legislation. PEI programs are limited to those with mental illness who risk having it become severe and disabling; and those with untreated serious mental illness. Allowing funds to be spent on those without mental illness ("at risk") is not authorized by the legislation. Nor is it supported by science. Regulators refer to "Muñoz RF et al (2012). Major depression can be prevented. American Psychologist 67(4), 285-291 to justify expenditure on risk factors. That report says " Specific factors include having first-degree relatives with a history of depression, having high symptoms of depression that do not cross the threshold for a clinical diagnosis, and exhibiting depressogenic behavioral patterns or cognitive styles." It does list some of the other factors MHSOAC likes to divert funds to (ex. poverty, exposure to violence, abuse, etc.) but they are NOT risks for major depression only for depression (which is outside the scope of MHSA which is for 'serious' mental illness. Other research is consistent with this. .

[5] Authority: 5840(c) defines early intervention as those that reduce the duration of untreated mental illness, i.e., get help to those with mental illness who have not received treatment. Authority 2: Also see uncodified "Findings and Declarations", paragraph c, "Untreated mental illness…." Authority 3: Uncodified "Purpose and Intent" paragraph (e). 5840(b)2 Authority 4: 5840(b)(2). Authority 3: Proposed Regulation 3720 (d) recognizes funds may be used for relapse prevention.
Statement of necessity: There is no requirement in MHSA to limit funds to 'early onset' if that is defined as 'early in life', nor is there a requirement to time-limit services to the period immediately after onset no matter when in life onset occurs. The legislation is quite specific that services can be ongoing. They are intended to prevent those who have mental illnesses (no matter when it occurred or how long ago it occurred) from having the mental illness become severe and disabling. For many, that will mean ongoing services.

[6] Authority 1: 5840(b)(2). Authority 2: Uncodified Purpose and Intent, paragraph (a). Authority 3: 5600.3
Statement of Necessity: Multiple media reports and findings of California State Auditor indicate that funds are being spent on people without mental illness. Ex. Massage chairs for government employees. In light of that, it is critical that regulators track who is being served to ensure they are adults and children with illnesses defined in the legislation and not others.

[7] See previous comment.

~~ii.~~(B) Number of referrals by diagnosis[8] of members of underserved populations to a Prevention program, an Early Intervention program and/or to treatment beyond early onset including kind of care that resulted from the outreach.

~~iii.~~(C) Number of ~~individuals~~ individuals, by diagnosis[9] who followed through on the referral, defined as the number of individuals who participated at least once in the program to which they were referred.

~~iv.~~(D) Interval between ~~onset of risk indicators and~~ [10]initial symptoms of a mental illness as self-reported or reported by a parent/family member or as identified by medical records and if applicable~~, entry~~, entry into treatment or services ~~of a Prevention program or an Early Intervention program.~~[11]

~~(B)~~(E) Interval between referral and engagement in services, including treatment.

~~v.~~ How long the individual received services in the program to which the individual was referred.

(5) For Program Similar to Other Programs Effective in Preventing Mental illness from Becoming Severe

(A) Identify the 'Similar Program"

(B) Provide number of people served by diagnosis

(C) Describe how county measures effectiveness in preventing mental illness from becoming severe, i.e., by reductions in outcomes described in 5840(d) (1-7) in people with mental illness.[12]

(6) For Program Successful in Reducing the Duration of Untreated Severe Mental illness

(A) Describe how the program reduces the duration of untreated serious mental illness

(B) Provide number of people with untreated mental illness or untreated severe mental illness served.[13]

(7) For Program that Assists People with Severe Mental Illness in Regaining Productive Lives

(A) Provide number of people served by severe mental illness diagnostic categories.

(B) Provide reductions in outcomes described in 5840(d) (1-7) in people with severe mental illness.[14]

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[8] See previous comment.

[9] See previous comment.

[10] Authority 1: 5840(a). MHSA and PEI funded services are limited to those with serious mental illness, those with mental illness who need services to prevent it from becoming severe and those with mental illness who need services to prevent the illness from going untreated. Authority 2: 5840 (c), Uncodified Section 3, Purpose and Intent paragraphs (a) and (b).
Statement of Necessity: There is no authority for serving people who do not have mental illness, i.e., are 'at-risk'. This proposed regulation would expand the program beyond that intended by voters. Further, there is no science that shows whether someone without mental illness, but allegedly 'at-risk' will develop a "serious mental illness" meeting the criteria of 5600.3 or just a run of the mill mental illness (ex. mild anxiety) that is outside the scope of the legislation. If regulators want to define specific 'risk factors' that lead to someone with mental illness developing a severe mental illness, those would include having a previous episode of severe mental illness being the first degree relative of someone with severe mental illness.

[11] There is no requirement in the legislation that the services be provided by a Prevention and Early Intervention program. Services may be provided by a hospital, psychiatrist, private physician, or others.

[12] Authority 1: 5840(c), a mandated program. Authority 2: Authority 2: Uncodified Code Section 3, subdivision (e) "Purpose and Intent" of the MHSA: "To ensure all funds are expended in the most cost effective manner".
Statement of Necessity. The legislation mandates provision of services to people with mental illness that are "similar to other programs effective in preventing mental illness from becoming severe", that are successful in "reducing the duration of untreated severe mental illness" and "assist people with severe mental illness in regaining productive lives" yet the regulators failed to issue any regulations requiring counties to do so or to provide information to regulators ensuring they do so. This is especially glaring in light of known previous misspending.

[13] See previous comment.

[14] See previous comment.

~~d.~~(8) For the information reported under subdivisions (1) through (47) of this section, disaggregate numbers served, number of potential responders engaged, and number of referrals for treatment and other services by:

~~(C)~~(A) The following age groups:

~~1.~~(i) 0-15 (children/youth);

~~2.~~(ii) 16-25 (transition age youth);

~~3.~~(iii) 26-59 (adult);

~~4.~~(iv) ages 60+ (older adults).

~~(D)~~(B) Race by the following categories:

~~5.~~(i) American Indian or Alaska Native

~~6.~~(ii) Asian

~~7.~~(iii) Black or African American

~~8.~~(iv) Native Hawaiian or other Pacific Islander

~~9.~~(v) White

~~10.~~(vi) Other

~~(E)~~(C) Ethnicity by the following categories:

~~11.~~(i) Hispanic or Latino as follows

~~a.~~(a) Caribbean

~~(a)~~(b) Central American

~~(b)~~(c) Mexican

~~(c)~~(d) South American

~~(d)~~(e) Other

~~12.~~(ii) Non-Hispanic or Non-Latino as follows

~~(e)~~(a) African

~~(f)~~(b) Cambodian

~~(g)~~(c) Chinese

~~a.~~(d) Eastern European

~~b.~~(e) European

~~(h)~~(f) Filipino

~~(i)~~(g) Japanese

~~(j)~~(h) Korean

~~(k)~~(i) Middle Eastern

~~(l)~~(j) Vietnamese

~~(m)~~(k) Other

~~(F)~~(D) Primary language spoken listed by threshold languages for the individual county

~~(G)~~(E) Sexual orientation,

~~(H)~~(F) Disability, if any,

~~(I)~~(G) Veteran status,

(H) Gender identity,

~~(J)~~(I) Diagnostic categories (i.e., psychotic illness, severe major depression, severe bipolar disorder, other)[15]

(J) Any other data the County considers relevant.

(9) Number of people with mental illness who

[15] There has been a major problem identified by the California State Auditor, Associated Press, and Mental Illness Policy Org of funds going to ineligible populations.

(a) committed suicide[16]

(b) were arrested and/or incarcerated and number served by AOT and Mental Health Courts[17]

~~ii.~~ (c) increase in units of housing for people with severe mental illness(or number of mentally ill housed) and number of mentally ill who remain homeless.[18]

~~e.~~(10) For Stigma and Discrimination Reduction Programs/Approaches and Suicide Prevention Programs/Approaches, the County ~~may~~ shall report number of suicides in the county, and if possible, number by people with mental illness, [19]available numbers of individuals with mental illness or seeking services [20] reached, including demographic and diagnostic breakdowns. An example would be the number of individuals with mental illness who received training and education or who clicked on a web site.

(11)For all programs and strategies, the County may report implementation challenges, successes, lessons learned, and relevant examples.

~~f.~~(12) For all programs, the county must report steps taken to ensure that people receiving services meet the criteria of having a mental illness for which services are needed to prevent it from becoming severe and disabling, or have a serious mental illness for which treatment is needed to reduce it's untreated duration.[21]

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[16] Authority: 5840(d)1
Statement of Necessity. In order to meet the Commissions obligation to taxpayers to ensure 'effective use of funds" regulators must measure outcomes, not merely process. The number of people who commit suicide and rates of suicide among people with mental illness is the best measure to determine if suicide funds have been used effectively. Regulators unwillingness to measure 'outcomes' prevents them from knowing if funds are being used effectively, if the intent of the voters is being met, and encourages diversions of funds to programs that do not reduce the indented outcome (reducing suicide by mentally ill).

[17] Authority: 5840 (d)(2).
Statement of Necessity: In order to meet the Commissions obligation to taxpayers to ensure 'effective use of funds" regulators must measure outcomes, not merely process. The number of people who become arrested among people with mental illness is the best measure to determine if funds designed to reduce incarceration have been used effectively. Rates of incarceration may also be used as a barometer, but they would lag arrest rates. AOT and Mental Health Courts are both evidenced based treatments proven to reduce incarceration, so their presence or absence should also be measured. Regulators unwillingness to measure 'outcomes' prevents them from knowing if funds are being used effectively, if the intent of the voters is being met, and encourages diversions of funds to programs that do not reduce the intended outcome (reducing arrest among severely mentally ill).

[18] Authority: 5840(d)(6).
Statement of Necessity: MHSOAC has an obligation to monitor progress "effective use of funds", not just process, i.e., "how much was spent" or number of people touched by communications. They must measure outcomes. Number housed and number who are homeless is the best barometer of whether funds are effectively and efficiently reducing "homelessness" that results from "untreated mental illness". Regulators unwillingness to measure 'outcomes' prevents them from knowing if funds are being used effectively, if the intent of the voters is being met, and encourages diversions of funds to programs that do not reduce the intended outcome (reducing homelessness among people with severe mental illness).

[19] The purpose of Suicide Reduction programs is to reduce suicide. It is impossible for MHSOAC to exercise their responsibility to see the funds are used effectively, if they don't measure the results of the spending.

[20] Authority: 5840 (b)(3) limits stigma programs to people with a diagnosis or are seeking services.

[21] Authority 1: Uncodified Purpose and Intent (a). The purpose of the legislation to "define *serious mental illness* among children, adults and seniors as a condition deserving priority attention" Authority 2: 5840(c) PEI funds are specifically limited by the legislation to "prevent mental illnesses from becoming severe and disabling." i.e., serving people *with* mental illness. Authority 3: 5600.3. Authority 4: Uncodified Findings and Declarations (a) limiting programs to serving the 5-9% with serious mental illness.
Statement of necessity: In spite of this clear direction, none of the regulations 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 that population or report on diagnosis. See "PEI Funds Must Serve People with Serious Mental Illness" (attached). This change is needed because regulators (DMH and MHSOAC) have repeatedly in the past told counties to use PEI funds on people who don't have mental illness. (See Regulation originally proposed by DMH to be included in California Code of Regulations, Title 9. Rehabilitative and Developmental Services, Division 1. Department of Mental Health, Chapter 14. Mental Health Services Act Article 2. DEFINITIONS, Section 3200.251 which was shared with all counties, and letters sent by DMH to counties in October 2005, requiring counties to spend funds on those 'prior to diagnosis', i.e., without mental illness). In light of those communications it is critical that regulators correct the misperception and establish the funds are intended to help those with mental illness, not those without.

There is little controversy as to who has "serious" mental illness. Proposition 63 and virtually all government agencies and non profits use roughly 5-9% of the population because they all rely on the National Institute of Mental Health (NIMH)[21] the pre-eminent

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5840 and 5847, Welfare and Institutions Code; Sections 2 and 3 of MENTAL HEALTH SERVICES ACT.

Adopt Section 3560.020 as follows:

Section 3560.020. Three-Year Evaluation Report.

•(a) The County shall submit the Three-Year Evaluation Report to the Mental Health Services Oversight and Accountability Commission every three years as part of the Three-Year Program and Expenditure Plan. The Three-Year Evaluation Report answers questions about the impacts of Prevention and Early Intervention component programs on individuals with ~~risk~~ mental illness [22] or early onset of serious mental illness and on the mental health and related systems.

~~c~~(1) The Three-Year Evaluation Report is due to the Mental Health Services Oversight and Accountability Commission on or before December 30, 2018 as part of the Three-Year Program and Expenditure Plan for fiscal years 2017/18 through 2019/20. The Three-Year Evaluation Report shall be due no later than December 30th every three years thereafter and shall report on the evaluation(s) for the three fiscal years prior to the due date.

•(b) The Three-Year Evaluation Report shall describe the evaluation of each Prevention and Early Intervention Program or Component program and strategy, including approaches used to select recipients, outcomes and indicators, collect data, and determine results, and how often the data were collected.[23]

•(c) The Three-Year Evaluation Report shall provide results and analysis of results for all required evaluations set forth in Section 3750.

•(d) The County may also include in the Three-Year Evaluation Report any additional evaluation data on selected outcomes and indicators, including evaluation results related to the impact of Prevention and Early Intervention Component programs on mental health and related systems.

~~(a)~~(e) The County may report any other available evaluation results in the County's Annual Updates.

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research arm of the US Government that addresses these issues. 5-9% is also supported by other research.[21] NIMH estimates overall 5% have "Serious Mental Illness" and breaks it down by diagnosis as follows:

Schizophrenia (NIMH defines *all* schizophrenia as "severe")	1.1% of the population[21]
The subset of major depression called "severe, major depression"	2.0% of the population[21]
The subset of bipolar disorder classified as "severe"	2.2% of the population[21]
Total "severe" mental illness by diagnosis:	5.3% of the population[21]

The above are overall figures. Within certain age groups NIMH research shows up to 8% have serious mental illness. This accounts for the 5-9% figure used in the legislation.[21]

Regulators can not change the meaning of legislation. PEI programs are limited to those with mental illness who risk having it become severe and disabling; and those with untreated serious mental illness. Allowing funds to be spent on those without mental illness ("at risk") is not authorized by the legislation. Nor is it supported by science (available on request).

[22] Authority: 5840: The entire legislation and specifically 5840, limit services to those with mental illness primarily severe mental illness.

Statement of Necessity: Allowing the use of funds to those 'at-risk' will lead to a diversion of funds, especially absent direction on what the risk factors for serious mental illness are (primarily genetics, possibly in-utero infections during third trimester of pregnancy).

[23] MHSAOAC should provide the outcome indicators, ex. reduced rates of suicide, reduced rates of homelessness, reduced rates of incarceration, rather than allowing counties to create their own, since they will likely use process indicators rather than progress indicators. I are deeply disappointed by the Commissions failure to require these simple and clear rates to be reported. The result is that almost 10 years after inception of MHSA, we still do not have evidence programs work and there is evidence that homelessness, suicide, incarceration of people with severe mental illness is on rise. Meanwhile MHSA funded PR firms tout the 'success' of the programs.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5840 and 5847, Welfare and Institutions Code; Sections 2 and 3 of Mental Health Services Act.

Article 7. Prevention and Early Intervention

Adopt Section 3700 as follows:

Section 3700. Rule of General Application.

(a) The use of Prevention and Early Intervention funds shall be governed by the provisions specified in this Article and Articles 1 through 5, unless otherwise specified.

Adopt Section 3705 as follows:

Section 3705. Prevention and Early Intervention ~~Component~~ Program General Requirements.

(a) The County shall include in its Prevention and Early Intervention Program or[24] Components:
(1) Evidence based programs that "Prevent Mental Illness from becoming Severe and Disabling[25]
(2) Evidence-based programs that reduce the duration of untreated severe mental illness,[26]
~~(1)~~ ~~At least one~~All Early Intervention programs as defined in Section 3710.[27]

~~o~~(3) At least one Outreach for Increasing Recognition of Early Signs of Mental Illness program or strategy as defined in Section 3715.
~~(2)~~(4) The strategies defined in Section 3735.

(b) The County ~~may~~ shall [28]include in its Prevention and Early Intervention Component:
(1) ~~One or more~~All[29] Prevention programs as defined in Section 3720.
~~o~~(2) The county may include ~~One~~one or more Stigma and Discrimination reduction programs/approached as defined in Section 3725.
~~(2)~~(3) The county may include ~~One~~one or more Suicide Prevention programs/approaches as defined in Section 3730.

[24] Authority 1: Again, the language in 5840 is clear that counties may institute a (singular) Prevention and Early intervention program. There is no requirement in the legislation for them to bifurcate the county program into the subcategories of "prevention" and 'early intervention. Authority 2: Uncodified "Findings and Declarations" paragraph (f) "By expanding programs that have demonstrated their effectiveness" See FN 1
[25] Authority 1: 5840 (a) "Prevention" is defined as "Preventing Mental Illness from becoming Severe and Disabling. Authority 2: Uncodified "Findings and Declarations" paragraph (f) "By expanding programs that have demonstrated their effectiveness" Statement of necessity: Failing to include the proposed language encourages counties to ignore providing legislatively mandated services.
[26] Authority: 5840(c) defines early intervention as those that reduce the duration of untreated mental illness, i.e., get help to those with mental illness who have not received treatment. Also see uncodified "Findings and Declarations", paragraph c, "Untreated mental illness…." Authority: Uncodified "Purpose and Intent" paragraph (e).
Statement of necessity: Failing to include the proposed language encourages counties to ignore providing legislatively mandated services.
[27] Authority: 5840: The programs defined in 3710 are mandatory ("shall include") and not optional ("may include")
Statement of necessity: Regulations must ensure compliance with the legislation and not be in contravention to it.
[28] See Previous comment
[29] See previous comment

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Section 5840, Welfare and Institutions Code.

Adopt Section 3710 as follows:

Section 3710. Early Intervention Program.

(a) The County shall offer ~~at least~~all ~~one~~ Early Intervention programs as defined in this section[30].

- "Early Intervention program" means ~~treatment and other services and interventions to address and promote recovery and related functional outcomes for a mental illness early in its emergence, including the applicable~~ programs that reduce negative outcomes listed in Welfare and Institutions Code Section 5840, subdivision (d) that result from untreated mental illness~~.~~; Access and linkage to medically necessary care for children with severe mental illness, as defined in Section 5600.3, and for adults and seniors with severe mental illness, as defined in Section 5600.3, as early in the onset of these conditions as practicable. Each program shall include services similar to those provided under other programs effective in preventing mental illnesses from becoming severe [31];
- ~~Early Intervention program services shall not exceed eighteen months, unless the individual receiving the service is identified as experiencing first onset of a serious mental illness or emotional disturbance with psychotic features, in which case early intervention services shall not exceed four years.~~[32]
- (b) Early Intervention program services may include services to parents, caregivers, and other family members of the person with early onset of a mental illness, as applicable.

(c) Early Intervention program ~~may~~ shall include efforts to prevent relapse in an individual ~~with~~ as early in onset[33] of a severe mental illness as practical. And

(2) Programs designed to intervene early in relapses into severe mental illness, as defined herein. Such programs shall be similar to programs that have been successful in reducing the duration of untreated severe mental illnesses and assisting people in quickly regaining productive lives. Each program shall emphasize strategies to reduce applicable negative outcomes in Welfare and Institutions Code 5840(d). An individual must have a diagnosis of severe mental illness as defined herein to qualify for programs that intervene early in relapses

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[30] See previous comment

[31] Authority: 5840 (b) 2. Authority: 5840(c) defines early intervention as those that reduce the duration of untreated mental illness, i.e., get help to those with mental illness who have not received treatment. Authority 2: Also see uncodified "Findings and Declarations", paragraph c, "Untreated mental illness…." Authority 3: Uncodified "Purpose and Intent" paragraph (e). 5840(b)2 Authority 4: 5840(b)(2).
Statement of necessity: There is no requirement in MHSA to limit funds to 'early onset' if that is defined as 'early in life', nor is there a requirement to time-limit services to the period immediately after onset no matter when in life onset occurs. The legislation is quite specific that services can be ongoing. They are intended to prevent those who have mental illnesses (no matter when it occurred or how long ago it occurred) from having the mental illness become severe and disabling. For many, that will mean ongoing services.
Statement of Necessity:

[32] Authority 1: 5840(b) (2) requires 'access' to care. There is no requirement the access be denied after a time period. Authority 2: 5840 (a) Requires programs to prevent mental illness from becoming severe and disabling. Many individuals need ongoing care to prevent their mental illness from becoming severe and disabling. There is no authority to withhold services from these individuals after a set time period or to force them out of the PEI funded programs into other programs.
Statement of Necessity: Without the removal of these time limits, the purpose of MHSA and PEI is defeated. People who need ongoing treatment to prevent their mental illness from becoming severe and disabling will be at risk of having it removed. This would cause the increase in outcomes that 5804(d) is supposed to prevent.

[33] Authority 5840(b)(2) limits programs to providing support "as early in the onset of these conditions as practicable ". It does not limit the provision of services to people with early onset (i.e., below age 18) as this regulation as written would require.
Statement of necessity: Regulators may not change the meaning of a voter initiative. Individuals who experience 'late onset' are entitled to services.

into severe mental illness [34]

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NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Section 5840, Welfare and Institutions Code.

Adopt Section 3715 as follows:

Section 3715. Outreach for Increasing Recognition of Early Signs of Mental Illness.

•(a) The County shall offer at least one Outreach for Increasing Recognition of Early Signs of Mental Illness program or strategy, defined as an element within a program, that provides outreach to potential responders as defined in this section.

•(b) "Outreach" is a process of engaging, encouraging, educating, and/or training, and learning from potential responders about ways to recognize and respond effectively to early signs of potentially severe and disabling mental illness.

•(c) "Potential responders" include, but are not limited ~~to,~~to,families, of people with serious mental illness ~~employers,~~ primary health care providers, school personnel, community service providers, peer providers, ~~cultural brokers,~~ law enforcement personnel, emergency medical service providers, people who provide services to individuals who are homeless, leaders of faith-based organizations, and others more likely than the general population to come into contact with those who have ~~in a position to identify~~ early signs of potentially severe and disabling mental illness, provide support, and/or refer individuals who need treatment or other mental health services.[35]

•(d) Outreach for Increasing Recognition of Early Signs of Mental Illness may include reaching out to individuals with signs and symptoms of a mental illness, so they can recognize and respond to their own symptoms.

•(e) Outreach for Increasing Recognition of Early Sings of Mental Illness may be a stand-alone program, a strategy within a Prevention and Early Intervention program, a strategy within a Prevention Program or ~~n~~ Early Intervention program, a strategy within another program funded by Prevention and Early Intervention funds, or a combination thereof.[36]

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Section 5840, Welfare and Institutions Code.

Adopt Section 3720 as follows: Section
3720. Prevention Program.

(a) The County ~~may offer one or more~~shall offer all the Prevention Programs ~~as~~ defined in this section.[37]

[34] Authority 1: 5840(c). Authority 2: 5840 (d). Authority 3: 5840(b)(2).
Statement of Necessity: The California auditor and media found lack of oversight and spending on programs outside the scope of the act, respectively. MHSOAC must issue regulations that limit spending to that allowed by the legislation.

[35] Authority 1: 5840. The purpose of PEI is to help people with mental illness. Authority 2: Uncodified Code Section 3, subdivision (e) "Purpose and Intent" of the MHSA: "To ensure all funds are expended in the most cost effective manner".
Statement of necessity: There is no evidence that 'cultural brokers' are more likely than others to cross paths with individuals who have mental illness. In order to ensure an efficient use of funds, outreach funds must be aimed at those more likely than others to come into contact with the target population.

[36] See Footnote 1.

[37] Authority 1: 5840(a). Authority 2: 5840(b) Authority 3: 5840(c). Authority 4 (5840(d). The legislation is clear that these programs "shall" be provided.

~~1.~~(b) "Prevention Program" means evidence-based interventions that prevents mental illness from becoming severe and disabling[38] ~~a set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors.~~[39] The goal of this program is to ~~bring about mental health~~prevent people with mental illness from having it become severe and disabling.[40] ~~including~~ It includes a reduction of the applicable negative outcomes listed in Welfare and Institutions Code Section 5840, subdivision (d) as a result of untreated mental illness ~~for individuals and members of groups or populations whose risk of developing a serious~~for people with mental illness [41]~~is significantly higher than average and, as applicable, their~~ . Preventing the progression of mental illness to serious mental illness may necessitate implementing programs for parents, caregivers, and other family members.

~~2.~~(c) "Risk factors for mental illness" means conditions or experiences that are associated with a higher than average risk of developing a potentially serious mental illness. Kinds of risk factors include, but are not limited to, biological including family history and neurological, and behavioral, ~~social/economic, and environmental.~~ [42]

~~a.~~(1) Examples of risk factors include, but are not limited to, a ~~serious chronic medical condition, adverse childhood experiences, experience of severe trauma, ongoing stress,~~ exposure to drugs or toxins ~~including~~ in the womb, ~~poverty, family conflict or domestic violence, experiences of racism and social inequality, prolonged isolation, having a previous mental illness,~~[43] a previous suicide attempt, or having a family member with a serious mental

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Statement of necessity. Making a mandatory program optional is contrary to the will of the voters who passed the act and the legislative language of the act and will result in the inefficient and ineffective expenditures of funds.

[38] Authority 1: "Prevention" is defined at 5840(a) as "Preventing Mental Illness from becoming Severe and Disabling " Regulators can not change the meaning. Authority 2; Uncodified "Purpose and Intent" paragraph (e), Regulators are required "to ensure that all funds are expended in the most cost effective manner and services are provided in accordance with recommended best practices…to ensure accountability to taxpayers and to the public."

Statement of Necessity: See previous notes concerning the expansion of the programs to those with 'risk factors".

[39] Authority 5840 which limits spending to mental illness

Statement of necessity: This is pop-psychology nonsense. The 'risk factors' for developing a serious mental illness is 80% genetic and there is nothing that can be done to change that. (Science available on request). Likewise 'protective factors' is an open-ended invitation to misspending like that highlighted by Associated Press whereby programs were using MHSA funds for yoga, zumba classes, car washes, gardens, hip-hop events and other programs that are not evidence based to help people with mental illness and are not 'protective factors'. If MHSOAC wants to require counties to fund alleged 'protective factors' then they should be narrowly defined based on the science of serious/severe mental illness, and not simply left as an open-ended invitation to misspending.

[40] Authority 5840 (a) defines prevention. There is no authority in MHSA to improve the mental health of people without mental illness.

[41] Authority 5840(d). It specifically requires efforts to reduce suicide, incarcerations and the other outcomes be limited to those that 'result from untreated mental illness'. There is no authority to expand this to those allegedly 'at risk' of mental illness, since there is no way to predict who will develop serious mental illness.

[42] Risk of severe mental illness is mainly associated with family history (genetics). Social and economic factors are not known causes of mental illness. Environmental factors may be in utero infections, but other environmental factors are not known to cause serious mental illness, although they may cause other mental illnesses (ex. mild anxiety). (Research available on request).

[43] This is one of the biggest failures of MHSOAC and it's predecessor: the total lack of understanding on the literature of serious mental illness. This regulation, as written, allows the expenditure of PEI funds to reduce stress, end poverty, end domestic violence, end discontented marriages, end racism, and end social inequality. There is no such authority in MHSA for that. "The largest known risk factor for bipolar disorder and schizophrenia is an inherited vulnerability" (Broad Institute n.d.) "Up to 80 percent of cases can be traced to inheritance" (Broad Institute 2011). Schizophrenia occurs in one percent of the general population, but it occurs in 10 percent of people who have a first-degree relative with the disorder, such as a parent, brother, or sister. (Broad Institute 2011). Children with a parent or sibling who has bipolar disorder are four to six times more likely to develop the illness, compared with children who do not have a family history of bipolar disorder. (Nurnberger JI 2000). They are also more likely to have more severe symptoms, including suicidal ideation, elevated depressive symptoms, and increased racing thoughts. (Antypa, Serretti and A. 2014) If someone has a parent or sibling with major depression, that person probably has a two or three times greater risk of developing depression compared with the average person. (Douglas F. Levinson and Walter E. Nichols n.d.) Other risk factors may include in utero infection during third trimester, and having a previous suicide attempt. Individuals who are first degree relatives of those who attempted or completed are at higher risk of suicide. Some claim that 80% of suicide is mental illness related, soar I am leaving suicide in. However, an effective use of suicide funds would be for means removal, i.e., nets under bridges, locks on guns and medicine cabinets. (Yip. Et al.

illness.

~~3.~~(d) Prevention program services ~~may~~ shall include relapse prevention for individuals ~~in recovery from a~~with serious mental illness.[44]

~~4. Prevention programs may include universal prevention efforts as defined below if there is evidence to suggest that the universal prevention effort is likely to bring about mental health and related functional outcomes for individuals and members of groups or populations whose risk of developing a serious mental illness is significantly higher than average.~~

~~(1) Universal prevention efforts mean efforts that target a population that has not been identified on the basis of risk.~~[45]

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Section 5840, Welfare and Institutions Code.

Adopt Section 3725 as follows:

Section 3725. Stigma and Discrimination Reduction Program/Approaches.

~~•~~(a) The County may offer one or more Stigma and Discrimination Reduction Programs/Approaches as defined in this section.

~~•~~(b) "Stigma and Discrimination Reduction Programs/Approaches" means the County's direct activ ities to reduce negative feelings, attitudes, beliefs, perceptions, stereotypes and/or ~~discrimination related~~discrimination r e l a t e d to being diagnosed with a mental illness, having a mental illness, or to seeking mental health services ~~and to increase acceptance, dignity, inclusion, and equity for individuals with mental illness, and members of their families~~.[46]

"Means restriction for suicide prevention" The Lancet, 2012, v. 379 n. 9834, p. 2393-2399) These other factors we struck may lead to poor mental health, but they are not a cause of serious mental illness. This regulation ensures funds are spent inefficiently. They led to the kind of misspending highlighted by the media and the state auditor.

[44] Authority: 5840. Authority 2: 5840(b)(2). These services 'shall' be provided.
Statement of Necessity: There is no provision in MHSA that allows regulators to limit PEI services to those 'in recovery'. While, arguably, services should be recovery-oriented, they are available to anyone who meets the criteria in 5840(b)(2).

[45] Authority: There is no authority within PEI to expend funds on people who do not have mental illness or serious mental illness. This practice of using PEI funds for advertising, PR firms, brochures, has diverted funds from its intended purpose of providing funds to stop mental illness from becoming severe and reducing the duration of untreated serious mental illness.
Statement of Necessity: Any public education efforts must be directed at those with high risk. In the past, to justify this waste MHSAOC has misquoted and misread reports by the Institute of Medicine. Their 1994 report discussed universal and selective interventions and declared found " (P)revention programs that currently exist are service programs and demonstrations that have not incorporated rigorous research methodologies. Even those that have an evaluation component usually have not used rigorous standards for assessment of effectiveness. Thus the nation is spending billions of dollars on programs whose effectiveness is not known." The report unequivocally stated that "Universal and selective interventions to prevent the onset of schizophrenia are not warranted at this time. Much more risk factor research is needed," (Institute of Medicine 1994). A 2009 IOM report that also looked at selective and universal prevention was "Preventing, Mental, Emotional, and Behavioral Disorders Among Young People" (Institute of Medicine 2009). But that report was not about preventing serious mental illness in adults, and does not suggest serious mental illness can be prevented. It focuses on preventing issues in children such as violence, aggression, and antisocial behavior, not mental illness. Regulators cite "Muñoz RF et al (2012). Major depression can be prevented. American Psychologist 67(4), 285-295. That report clearly states " universal approaches have not yielded significant results,". The "authority" MHSOAC uses to justify this waste is not there. MHSOAC should be reigning in, not empowering these practices.

[46] Authority: 5840(b)(3) limits the use of SDR funds to those "either being diagnosed with a mental illness or seeking mental health services."
Statement of Necessity: The regulation as proposed will divert funds to programs outside the scope of the legislation and thereby prevent individuals within the scope of the program from being served. Further there is evidence that while anti-stigma programs are profitable to mental health agencies (some run by MHSOAC Commissioners) they increase stigma. If stigma is a reason people don't

(1) Examples of Stigma and Discrimination Reduction Programs/Approaches include, ~~but~~ are ~~not~~ limited to programs targeted at those "either being diagnosed with a mental illness or seeking mental health services,~~,~~[47] and may include so-cial m-arketing cam-paigns, violence reduction initiatives such as services to facilitate 5150 interventions, guardianships, conservatorships and treatment under AB-1421, [48]speakers' bureaus and o-ther direct -contact approaches, targeted education and training, anti-stigma advocacy, web-based campaigns, efforts to combat multiple stigmas that have an impact on mental illness, and efforts to encourage self-acceptance as long as such programs are targeted at those "either being diagnosed with a mental illness or seeking mental health services.[49]~~for individuals with a mental illness.~~

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Section 5840, Welfare and Institutions Code.

Adopt Section 3730 as follows:

Section 3730. Suicide Prevention Programs and Approaches.

•(a) The County may offer one or more Suicide Prevention Programs/Approaches as defined in this section.

•(b) Suicide Prevention Programs/Approaches means organized activities that the County undertakes to prevent suicide as a consequence of mental illness. This category of program ~~s does not focus~~must focus on or have intended outcomes for ~~specific~~ individuals or populations ~~at risk of or~~ with serious mental illness.~~-~~[50]

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access care, then teaching people there is stigma makes them less likely to get care and more likely to deteriorate. "Repeated use of the term "stigma" in conjunction with "mental illness," …may establish stigma as an element of mental illness - as inevitable and intrinsic to psychiatric conditions." (Wahl 2003)

[47] See previous footnote.

[48] There is an extensive body of research showing that it is violence by the minority tars the majority. (Torrey 2011). By reducing violence, we reduce stigma. "Probably nothing contributes more to the stigmatization of mental illness than the commission of violent crimes by persons who are clearly severely mentally ill." (Lamb 1999). Also see Surgeon General's Report on Mental Health, 1999 and "Connect the Dots" by Dr. Fuller Torrey in Schizophrenia Bulletin June 7, 2011). Voluntary treatment, guardianships, conservatorships, hospitalization and treatment under AB-1421, reduce violence and therefore reduce stigma. It would therefore be an appropriate use of stigma funds to connect people with these services and provide them.

[49] See previous footnote.

[50] Authority: 5840(d)(1) limits funding of suicide programs to those that result from untreated mental illness
Statement of necessity: Again: There is no authority in MHSA that allows MHSOAC to divert suicide funds to people without mental illness, without serious mental illness, and in this MHSOCAC proposed regulation, without even the risk of mental illness.
Statement of Necessity. PEI Suicide funds are widely misspent in California and as a result indications are that suicide among mentally ill is rising, not declining. As with the concepts of 'risk factors' and 'prevention' MHSOAC demonstrates an unawareness of the literature. In 2012, the California mental health industry banded together to spend $32 million in public funds for a TV, radio, billboard, online, mobile and print advertising campaign targeted at the general public to reduce suicide. (California Mental Health Services Authority 2012).

But there is little scientific evidence media campaigns reduce suicide and mounting evidence they don't. The largest and most sound review of the issue was *Suicide Prevention Strategies: A systematic review*, was published in the Journal of the American Medical Association. (J. John, Alan and al. 2005). The authors found that "despite their popularity as a public health intervention, the effectiveness of public awareness and education campaigns in reducing suicidal behavior has seldom been systematically evaluated." As such, if funded at all, they should be funded with INN funds, not PEI. The report went on to note what the research does show: "Such public education and awareness campaigns, largely about depression, have no detectable effect on primary outcomes of decreasing suicidal acts or on intermediate measures, such as more treatment seeking or increased antidepressant use." By encouraging, rather than reigning in this practice MHSOAC fails to meet its requirement to see funds are spent effectively.

PEI funded suicide initiatives are often targeted at college students, a group least likely to commit suicide. The 2011 National Survey on Drug Use and Health is one of the premiere epidemiological surveys and found college students were less likely than other same

○(1) Suicide prevention activities that aim to reduce suicidality for specific individuals at risk of or with early onset of a potentially serious mental illness can be a focus of a Prevention and Early Intervention Program[51] or Prevention program pursuant to Section 3720 or a focus of an Early Intervention program pursuant to Section 3710.

•(c) Suicide Prevention programs and approaches pursuant to this section include, but are not limited to, ~~public and~~ [52]targeted information campaigns, suicide prevention networks, firearms removal, knives removal, dangerous medication removal, and other means removal programs; [53] outreach and support programs for those who have attempted suicide or are first degree relatives of those who attempted,[54] capacity building

programs, culturally specific approaches, screening programs, suicide prevention hotlines or web-based suicide prevention resources, and training and education aimed at high-risk populations[55].

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Section 5840, Welfare and Institutions Code.

Adopt Section 3735 as follows:

Section 3735. Prevention and Early Intervention Strategies.

•(a) The County shall include all of the following strategies as part of each program listed in Sections 3710 through 3730 of Article 7:

○(1) Be designed and implemented to help create Treatment or Access and Linkage to Treatment~~.~~ for

▪(A) ~~"Access and Linkage to Treatment" means connecting~~ children with severe mental illness, as defined in Welfare and Institutions Code Section 5600.3, and adults and seniors with severe mental illness, as defined in Welfare and Institutions Code Section 5600.3, as early in the onset of these conditions as practicable, to medically necessary care and

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aged adults to have serious thoughts of suicide (6.5 vs. 8.4 percent), make suicide plans (1.5 vs. 2.4 percent), or attempt suicide (0.8 vs. 1.8 percent). (SAMHSA 2012). The college targeted PR programs are no more effective than mass market anti-suicide PR campaigns. "Few such programs are evidence-based, reflect the current state of knowledge in suicide prevention, or evaluate effectiveness and safety for preventing suicidal behavior…A systematic review of studies published from 1980-1995 found that knowledge about suicide improved but there were both beneficial and harmful effects in terms of help-seeking, attitudes, and peer support."

[51] See footnote 1.

[52] Authority: 5840(d) limits funding of suicide programs to those that serve people with mental illness, not the public. See a previous footnote quoting suicide prevention research.
Statement of Necessity: There is also a substantial body of literature that shows suicide campaigns targeted to the public (or students) do not reduce suicide and may in fact increase it. See previous footnote detailing suicide prevention research.
Statement of necessity. See discussion of Institute of Medicine Findings in footnote related to proposed regulation 3720 (e).

[53] 5840(d)(1)
Statement of Necessity: "Means Removal" is one of the most evidence-based ways to reduce suicide in people with mental illness, especially those at highest-risk, i.e., those who have attempted it before. (Yip. Et al. "Means restriction for suicide prevention" The Lancet, 2012, v. 379 n. 9834, p. 2393-2399) It is far more successful than the other interventions listed. For example MHSA funds were recently thankfully approved for the installation of a net under the Golden Gate Bridge

[54] Authority 5840(d)(1)
Statement of Necessity: The suicide literature (previously quoted) is clear that those most likely to attempt or complete suicide are those who have previously attempted it, and those who are first degree relatives of those who previously attempted or completed. In order to ensure efficient and effective use of funds these individuals must be given priority attention.

[55] See previous Footnote.

treatment, including but not limited to care provided by county mental health programs.

- (B) Treatment, Access and Linkage to Treatment can be a stand-alone program, an element of a Prevention and Early Intervention program, Prevention Program or an element of an Early Intervention program, or a combination thereof.[56]

~~c~~ (2) Be designed, implemented, and promoted in ways that Improve Timely Access to Mental Health Services for Individuals and/or Families from Underserved Populations.

- (A) "Improving Timely Access to Services for Underserved Populations" means to increase the extent to which an individual or family from an underserved population as defined in Title 9 California Code of Regulations Section 3200.300 who needs mental health services because ~~of risk or~~[57] presence of a mental illness receives appropriate services as early in the onset as practicable, through program features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available, and cost of services.

- Programs shall provide services in convenient, accessible, acceptable, culturally appropriate settings such as primary healthcare, doctor's offices, shelters, homeless camps,[58] schools, family resource centers, community-based organizations, places of worship, and public settings ~~unless a mental health~~ when those settings are as good as or superior than mental health settings in improving ~~enhances access to quality services and~~ outcomes for underserved populations.[59]

~~c~~ (3) Be designed, implemented, and promoted using Strategies that are Non-Stigmatizing and Non-Discriminatory

- (A) "Strategies that are Non-Stigmatizing and Non-Discriminatory" means promoting, designing, and implementing programs in ways that reduce and circumvent stigma, including self- stigma, and discrimination related to being diagnosed with a mental illness, having a mental illness or seeking mental health services, and make services accessible, welcoming, and positive.
- (B) Non-Stigmatizing and Non-Discriminatory approaches include, but are not limited to, using ~~positive~~ accurate truthful messages concerning diagnosis and prognosis l[60] and approaches with a focus on evidence-based practices like the use of medication, substance use avoidance[61], recovery, wellness, and resilience; use of

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[56] See FN 1.

[57] Authority 1: 5840 (b)(2). Authority 2: Uncodified Findings and Declarations (a) limiting services to the 5%-9% with serious mental illness, rather than all people with mental health concerns.
Statement of Need: The words "at risk" do not appear in the legislation. PEI funded services may only go to those with mental illness, not those without. By adding the words 'at risk' regulators have intentionally broadened the scope of the act beyond that intended by voters. Voters narrowly and intentionally defined who may be helped. This is another example of regulators expanding the purpose of the act and encouraging diversion of funds. It is also unsupported by science since the risk factors for 'serious/severe' mental illness are primarily genetic.

[58] These are places where underserved priority populations with mental illness are often found.

[59] Authority 1. Uncodified Purpose and Intent, paragraph (c) suggests expanding 'culturally and linguistically competent approaches'. Authority 2: 5840 .
Statement of Necessity: There is no authority that requires counties to presume that services in a mental health setting are less 'culturally and linguistically competent' or less likely to improve outcomes than services delivered elsewhere. The regulation MHSOAC is proposing requires not only that services delivered in a mental health setting be as good as those delivered elsewhere, but that they must be better ("enhance") services. This prohibits counties from delivering equivalent services in the most efficient setting which is often a health center. The locations mentioned do not include some of the most important places where the underserved congregate: shelters and homeless camps.

[60] It would in itself be discriminatory to treat persons with mental illness differently than others by hiding truthful accurate information behind a regulation that only allows for positive messaging.

[61] Authority: 5840
Statement of need: The purpose of PEI is to help people recover, so a non-discriminatory practice must be to provide them the same information persons with other illnesses have, like info on medications and treatments that can facilitate recovery.

culturally appropriate language and concepts; efforts to acknowledge and combat multiple social stigmas that affect attitudes about mental illness and/or about seeking mental health services, including but not limited to race and sexual preference; co-locating mental health services with other life resources; promoting positive attitudes and understanding of recovery among mental health providers; inclusion and welcoming of family members; and employment of peers in a range of roles.

(C) Are similar to other programs in reducing the duration of untreated serious mental illness[62]

(D) Prevent mental illness from becoming severe and disabling. (5840)[63]

(4) Be designed to ensure only those who meet the inclusion criteria defined in 5600.3 are served.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Section 5840, Welfare and Institutions Code.

Adopt Section 3740 as follows: Section 3740. Effective Methods.

~~1.~~(a) For each program and each strategy in Article 7, the County shall use effective methods likely to bring about intended outcomes, based on ~~one of the following standards, or a combination of~~ the following standard~~s~~:

~~a.~~(1) Evidence-based practice standard: Evidence-based practice means activities for which there is scientific evidence consistently showing improved outcomes as defined in 5840(d)[64] ~~mental health outcomes~~ for ~~the intended population~~individuals who meet the criteria of 5600,3,[65] including, but not limited to, scientific peer-reviewed research using randomized clinical trials.

~~b. Promising practice standard: Promising practice means programs and activities for which there is research demonstrating effectiveness, including strong quantitative and qualitative data showing positive outcomes, but the research does not meet the standards used to establish evidence-based practices and does not have enough research or replication to support generalizable positive public health outcomes.~~[66]

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[62] Authority: 5840(c).

[63] Authority 1. 5840(a) Authority 2: 5840(c)

[64] Authority: 5840 (d)

Statement of Necessity: Programs that are evidence based to reduce other outcomes are not eligible for PEI funding. This is critical because counties have been allowed by regulators to use any program that has improved any soft outcome, like 'improved sense of self', versus the hard measures intended by voters. I.e., reducing homelessness, incarceration, hospitalization, suicide, etc.

[65] Authority 1: 5840 (d); Authority 2: 5840 (b) 2).

Statement of Necessity. As written the regulation makes it seem that as long as the practice improves outcomes for those for whom the practice was intended, it should be considered 'evidence based' for purposes of PEI funding. That is not true. The practice must be evidence based to help those the statue was intended to help, which may or may not be the same population that practice was intended to help. For example, a program that reduces substance abuse in non mentally ill would be considered 'evidence-based' and eligible for funding the way the regulation currently reads. But only those practices which are evidence-based to reduce substance abuse in the seriously mentally ill are intended to be eligible for any MHSA funding.

[66] Authority: 1: 5830, Innovative Programs. Authority 2. Uncodified Purpose and Intent paragraph (e) requiring services to be provided "in accordance with recommended best practices". Authority 3: 5840(c) limiting PEI programs to those "effective" and "successful"

Statement of Necessity: The legislation, is clear a replete that MHSA funds should be spent on evidenced based programs. ("best" practices, not 'good enough/iffy' practices). The reliance on "promising practice" standard and "community and/or practice" based standard has allowed multiple counties to divert funds to program that do not improve a meaningful outcome for people with serious mental illness. A list of PEI funded programs is available at http://www.namicalifornia.org/uploads/eng/mhsa%20full%20report.pdf.

~~c. Community and or practice-based evidence standard: Community and or practice-based evidence means a set of practices that communities have used and determined to yield positive results by community consensus over time, which may or may not have been measured empirically. Community and or practice-defined evidence takes a number of factors into consideration, including worldview and historical and social contexts of a given population or community, which are culturally rooted.~~[67]

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Section 5840, Welfare and Institutions Code.

Adopt Section 3745 as follows: Section 3745. Changed Program.

(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 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.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Section 5840, Welfare and Institutions Code.

Adopt Section 3750 as follows:

Section 3750. Prevention and Early Intervention Program Evaluation.

Programs on that list that fail to help the seriously ill include Teen Screen, Mental Health First Aid (MHFA), Wellness Recovery Action Plan (WRAP), and Kognito At Risk. For the science on these programs, see http://mentalillnesspolicy.org/samhsa/teenscreenunproven.html and http://mentalillnesspolicy.org/samhsa/mental-health-first-aid-fails.html and http://mentalillnesspolicy.org/samhsa/wrapunproven.html and http://mentalillnesspolicy.org/samhsa/kognitounproven.html respectively.
Other programs that lack evidence and are funded with PEI funds are in the report "Examples of county social service programs masquerading as mental illness programs in order to receive MHSA PEI Funds" available at http://mentalillnesspolicy.org/states/california/mhsa/county-by-county-mhsa-misspending.pdf and "Insider Dealing in MHSA PEI Funds" available at available at http://mentalillnesspolicy.org/states/california/mhsa/mhsa_insider_dealing.html.
Programs that can't meet the "Evidence Based Practice Standard may only be funded with INNOVATIVE funds, not PEI. Voters set aside 5% of funds for Innovative Programs that do not meet the criteria of being evidence based. That is the proper funding stream for non evidence based programs (or as regulators disingenuously call them "promising practice standards" or "Community and Practice based evidence" By dumbing down the definition of evidence based to include treatments that have 'consensus' violates the intent of voters and allows funding of non-evidence based programs with PEI funds that should be funded with INN funds. This will result in PEI funds failing to produce the outcomes intended and fewer being served. "Consensus" does not equal evidence. This is especially true since historically regulators have used this rubric to allow the funding of massage chairs, hip-hop car washes, gardens and other interventions which may have 'consensus' but are not evidence based. It is this type of bald attempt to divert funds that has caused MHSA programs to lose public support. In justification of this diversion regulators may be citing the American Psychological Association Presidential Task Force on Evidence-Based Practice. (2006). Evidence-Based Practice In Psychology. American Psychologist, 271-285. But psychologists are not M.Ds. The legislation is clear that it is to deliver 'medically necessary' care and only psychiatrists, not psychologists can arbitrate that. At the absolute minimum, all programs should be "independently" reviewed and proven to reduce a meaningful outcome (5840(d), in people with serious mental illness.

[67] See previous comment

- (a) For each Early Intervention program and Prevention and Early Intervention Program[68] 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 measure number of people with mental illness who committed suicide, number of people with severe mental illness who were provided housing, number of people with mental illness unhoused, and number of mentally ill arrested and/or incarcerated.[69] The County may select, define, and measure other 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 number of people with mental illness who committed suicide, number of people with severe mental illness who were provided housing, number of people with mental illness unhoused, and number of mentally ill incarcerated.[70] ~~reduction in risk factors and/or increased protective factors that may lead to improved mental, emotional, and relational functioning. The County shall select, define, and measure appropriate indicators that are applicable to the program~~[71]
- (c) For each Prevention and Early Intervention, [72]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.[73]
- (d) For Outreach for Increasing Recognition of Early Signs of Mental Illness as either a stand-alone program or a strategy within another program, referenced in Section ~~3715,~~3715, the County

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[68] See FN 1

[69] Authority 5840 (d).

Statement of Need: Even in the regulators own "Statement of Need" under which these proposed regulations were issued, regulators noted the requirement to "require reports on the achievement of performance outcomes" (i.e., measure 'progress', like number of suicides, number of people homeless, number incarcerated). Instead in the regulations proposed, regulators rely solely on "process" indicators (like how many people clicked on a web site, amount of money spent, etc.) We are simply at a lost to determine why regulators are going so far out of their way to not measure outcomes. We fear it is because many receive MHSA Funds for programs that do not improve outcomes and don't want the funding to stop. See "Insider Dealing in MHSA PEI Funds available at http://mentalillnesspolicy.org/states/california/mhsa/mhsa_insider_dealing.html

[70] See previous footnote.

[71] Authority 5840 (d) MHSOAC should issue regulations to define prolonged suffering, but these don't do that.

Statement of Need: These regulations allow for the use of funds to reduce 'risk factors' without defining them. 80% of 'risk factor' is genetic (See FN to Proposed Regulation 3720(c)(1)). Other 'risk-factors' are not known and are not actionable. MHSOAC has historically let counties define own non-scientific 'risk factors' (poverty, coming from a single mom home, etc.) and divert money to them. MHSOAC and counties regularly intentionally confuse 'association' with being a 'risk factor'. Ex. Poverty may be 'associated' with mental illness (as 90% of SMI are unemployed), but it is not poverty that puts the person at risk of mental illness, it is mental illness that puts the person at risk of poverty. Further, even if a factor were a cause of mental illness, the legislation is limited to those with severe/serious mental illness. MHSOAC must end the diversion of funds voters intended for people with mental illness to other albeit worthy social causes.

The regulations as written also allow/encourage the diversion of funds to "protective factors". This is undefined and unscientific. There is no mention of "protective factors" in the legislation. If by "protective factors" regulators mean encouraging people to take medications, preventing them from using substances (both of which can prevent mental illness from becoming severe and disabling) regulators should say so. They should not allow counties to say something is a protective factor, when no such factors exist. The legislation requires programs to have "demonstrated their effectiveness". The likely impact of this regulation will be for counties to declare bad grades, poverty, and divorce as risk factors for serious mental illness when that is unsupported by the research.

[72] SE FN 1

[73] This is unclear. The counties must be required to measure the outcomes, i.e., reduced homelessness, suicide, incarceration, etc. That must be mandatory. It is allowable for the county to supplement that info with other information, but I am not sure why a regulation is needed to say that they may do that. If there are other indicators MHSOAC wants used, they should specify them rather than open it up to a free for all.

shall track:

(1) The number of people who had their early signs of mental illness identified

(2) The success of referring those people to services[74]

~~(1)~~(3) The number of potential responders.

~~(2)~~(4) The type of potential responders.

~~(3)~~(5) The setting in which the potential responders were engaged.

~~•~~(A) Settings providing opportunities to identify early signs of mental illness include, but are not limited to, psychiatric hospitals, jails, prisons, [75]family resource centers, senior centers, schools, cultural organizations, churches, faith-based organizations, primary health care, recreation centers, libraries, public transit facilities, support groups, law enforcement departments, residences, shelters, and clinics.

•(e) If the County chooses to offer a Stigma and Discrimination Reduction Program/Approach referenced in Section 3725, the County shall select and use a validated method to measure one or more of the following:

~~○~~(1) Changes in attitudes, knowledge, and/or behavior in people with mental illness or seeking services[76] related to mental illness that are applicable to the specific program/approach.

~~(4)~~(2) Changes in attitudes, knowledge, and/or behavior related to seeking mental health services in people with mental illness or seeking services[77].

~~•~~ ~~If the County chooses to offer a~~For the Suicide Prevention Program/Approach referenced in Section 3730, the County shall select ~~and~~ and measure how many individuals committed suicide and if possible the number with mental illness.[78] ~~use a validated method to measure changes in attitudes, knowledge, and/or behavior regarding suicide related to mental illness that are applicable to the specific program/approach.~~

•(f) For each strategy or program to provide Access and Linkage to Treatment the County shall track:

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[74] Authority: 5840(b)(1).
Statement of Necessity: These additions are needed to measure outcomes. I.e., did the "Outreach for Increasing Recognition of Early Signs of mental illness" succeed or not. Once again, regulators have proposed regulations that measure process, not progress, i.e., how many people were trained to recognize symptoms but not whether they did or not. MHSOAC must be especially vigilant with the regulations because so many of the organizations associated with the commissioners are the ones to benefit from the expenditures.

[75] Authority: 5840(b)(1)
Statement of Necessity. 1. As the strongest predictor for having a serious mental illness is being the first degree relative of someone with severe mental illness, then these activities should be conducted where persons with mental illness are, so they can recognize it in their relatives. 2. Relatives of the ill are likely to be visiting them in mental health clinics, hospitals, jails, shelters and prisons, so it makes sense to do outreach where these relatives are. 3. Those who work in the settings are the people most likely to come into contact with relatives, so they should be trained to identify the illness. (Ex. guards trained to identify early signs of mental illness in relatives of the incarcerated mentally ill who are there on visiting day). 4. The problem with the regulation as written is that it suggests Outreach in places where persons with mental illness are NOT disproportionately represented and is therefore not efficient.

[76] Authority 5840(b)(3)
Statement of Necessity. The legislation requires stigma funds be aimed at those with mental illness or seeking services. The purpose is to change their attitudes, not the public's. Measuring public attitudes is not related to the desired outcome or allowed by legislation. Put another way, there is no evidence that voters wanted to tax themselves so government could create PSAs telling them how to think. Yet many counties are spend PEI funds on that activity through CalMHSA and their own efforts. The measurement of successful spending is the measure among people with serious mental illness, not among those without.

[77] See previous comment

[78] Authority 1: Uncodified finding and declarations paragraph (c). Authority 2: 5840 (d) 1.
Statement of necessity. See FN for Proposed Regulation 3750(b). To determine if a program is effective, MHSA must measure results, not process. There is also an extensive body of literature (available on request) that the types of suicide programs MHSOAC is encouraging (programs aimed at public vs. those at high risk, public relations, etc.), especially those funded via CalMHSA are not effective at reducing the number of people who commit suicide and can in fact increase it.

~~(5)~~(1) Number of referrals to treatment, and kind of treatment to which person was referred.

~~o~~(2) Number of persons who followed through on the referral and engaged in treatment, defined as the number of individuals who participated at least once in the program to which the person was referred.

~~▪~~(A) The County may use a methodologically sound sampling method to satisfy this requirement.

~~(6)~~(3) Duration of untreated mental illness.

~~▪~~(A) Duration of untreated mental illness shall be measured by the interval from onset of symptoms of mental illness, based on available medical records or if medical records are not available, on self-report or report of a parent or family member, until initiation of treatment.

~~o~~(4) How long the person received services in the program to which the person was referred.

(A) The County may use a methodologically sound sampling method to satisfy this requirement.

•(g) For each strategy to Improve Timely Access to Services for Underserved Populations the County shall measure:

~~o~~(1) Number of referrals of members of underserved populations to a ~~Prevention~~ program, ~~an Early Intervention~~[79] program, and/or treatment (beyond early onset) including the kind of care.

~~o~~(2) Number of persons who followed through on the referral and engaged in treatment, defined as the number of individuals who participated at least once in the program to which the person was referred.

~~(B)~~(A) The County may use a methodologically sound sampling method to satisfy this requirement.

~~(7)~~(3) Timeliness of care.

(A) Timeliness of care for individuals from underserved populations with a mental illness is measured by the interval from onset of symptoms of a mental illness, based on available medical records, or if not available, on self-report or report of a parent or family member, until initiation of treatment.

~~▪~~(B) Timeliness of care for individuals from underserved populations with ~~risk factors for a~~ mental illness is measured by the duration between onset of indicators of ~~risk of~~ [80] mental illness and initial receipt of services.

~~(8)~~(4) How long the person received services in the program to which the person was referred.

(A) The County may use a methodologically sound sampling method to satisfy this requirement.

•(h) The County shall design the evaluations to be culturally appropriate and shall include the perspective of diverse people with lived experience of mental illness, including their family members, as applicable.

•—In addition, to the required evaluations listed in this section, the County may also, as relevant and applicable, define and measure the impact of programs funded by Prevention and Early Intervention funds on the mental health and related systems, including, but not limited to education, physical

healthcare, law enforcement ~~and justice~~, courts and corrections, reductions in arrest, social services, homeless shelters and other services, and community supports specific to age, racial, ethnic, and cultural groups. Examples of system outcomes include, but are not limited to, increased provision of services to people with serious mental illness by ethnic and cultural

[79] There is no requirement the referral be to a PEI program. In fact, the purpose is to refer people to 'medically necessary care'. That can be provided by PEI or non-PEI funded programs.

[80] Again: There is no way to predict serious mental illness. Services are allowed once someone shows signs of mental illness, not alleged risk factors that purport to indicate future mental illness.

community organizations, hours of operation, integration of services including co-location, involvement of clients and families in key decisions, identification and response to co-occurring substance-use disorders, staff knowledge and application of recovery principles, collaboration with diverse community partners, or funds leveraged.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5840 and 5847, Welfare and Institutions Code; Sections 2 and 3 of Mental Health Services Act.

Adopt Section 3755 as follows:

Section 3755. Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update.

(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 Expenditure Plan thereafter.

The Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan or Annual Update shall include the following general information:

(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.

2 A description of the County's plan to involve community stakeholders including police, sheriffs, judges, district attorneys, homeless shelters, corrections and others[81] 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.

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 Health Services Act General Standards set forth in Title 9 California Code of Regulations, Section 3320.

(4) Steps taken to ensure those served meet the criteria delineated in 5600.3.[82]

(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:

(1) Identification of the target population for the intended mental health outcomes including:

(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.

(A)(B) The mental illness or illnesses for which there is early onset.

(C) Brief description of how each participant's early onset of a potentially serious mental illness will be determined.

(2) Identification of the type of problem(s) and need(s) for which the program will be

[81] Authorities/References: 5846, 5840(d)(2), 5847, Title 9 CCR 3320
Statement of Necessity: The purpose of PEI is to reduce the outcomes defined in 5840(d), yet no attempt has ever been made to engage law enforcement, judges, correctional associations, shelter workers, who are primary stakeholders in the goal of decreasing arrest, incarceration and homelessness in formulating PEI plans. As a result, MHSA programs have not been fulfilling their mission of reducing rates of incarceration, and homelessness. Specifically mentioning criminal justice and shelter workers will help return MHSA to its mandated purposes and help develop strategies designed to improve outcomes listed in 5840(d).

[82] Authority: 5840(b)3
Statement of necessity: The California State Auditor, media, and Mental Illness Policy Org all uncovered examples of inappropriate expenditures driven by a failure of Planning Councils to understand the legislative restriction on how funds may be spent. For example, many have joined together to divert funds meant to help persons with mental illness to public relations for the program and mental health directors, IPads for county commissioners, and other expenses outside the scope of the legislation.

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.

~~c~~(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).

- (A) List the indicators that the County will use to measure reduction of prolonged suffering as referenced in Section 3750, subdivision(a).
- (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.
- (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.

~~c~~(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:

~~(B) If~~ For the ~~County used~~ evidence-based standard ~~or promising practice standard~~ [83] ~~to determine~~

(A) ~~the program's effectiveness as r~~ referenced in Section 3740, subdivisions (a)(1) ~~and (a)(2),~~ [84] 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.

- (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.~~ [85]

•(b) 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 information:

~~c~~(1) Identification of the target population for the intended mental health outcomes, including:

- (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.

~~(C)~~(B) How the risk of a potentially serious mental illness will be defined and determined.

~~c~~(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

[83] See comments in proposed Reg 3740 (a)(2-3)
[84] See FN comment in Section 3740 (a)(2-3)
[85] See FN comment in Section 3740 (a)(2-3)

Welfare and Institutions Code Section 5840, subdivision (d) for individuals with higher than average risk of potentially serious mental illness.

- (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).
  - (A) List the indicators that the County will use to measure reduction of prolonged suffering as referenced in Section 3750, subdivision (b).
  - (B) If the County intends the program 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.
  - (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.
- (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:
  - (D)(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~~),[86] 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.
  - ~~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.~~[87]

- (c) The Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include a description of each Outreach for Increasing Recognition of Early Signs of Mental Illness program or strategy within a program, including but not limited to:
  - (1) Identify the types and settings of potential responders the program intends to reach.
    - (A) Describe briefly the potential responder's setting, as referenced in Section 3750, subdivisions (d)(3)(A), and the opportunity the potential responders will have to identify diverse individuals with signs and symptoms of potentially serious mental illness.
  - (2) Specify the methods to be used to reach out and engage potential responders and the methods to be used for potential responders and public mental health service providers to learn together about how to identify and respond supportively to signs and symptoms of potentially serious mental illness.

- (d) 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

[86] See FN comment in Section 3740 (a)(2-3)
[87] See FN comment in Section 3740 (a)(2-3). This should be done with INN funds, not PEI.

program/approach, including but not limited:

~~o~~(1) Steps taken to Identify people with mental illness or seeking mental health services whom the campaign intends to influence.[88]

~~o~~(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.

~~o~~(3) Specify how the proposed method is likely to bring about the selected outcomes by providing the following information:

~~(E) 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.[89]

~~▪(A) 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.~~[90]

•(e) 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:

~~o~~(1) Specify the methods and activities to be used to change attitudes and behavior to prevent mental illness-related suicide.

~~o~~(2) Indicate how the County will measure changes in number of suicides by people with mental illness. [91]~~attitude, knowledge, and /or behavior related to reducing mental illness-related suicide consistent with requirements in Section 3750, subdivision (f) including timeframes for measurement.~~

~~o~~(3) Specify how the proposed method is likely to bring about suicide prevention outcomes selected by the County by providing the following information:

~~▪(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),~~[92]
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.

~~▪ 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.~~[93]

•(f) 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 create Access and Linkage to Treatment for individuals with serious mental illness as referenced in Section 3735, subdivision (a)(1).

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[88] Authority5840(b)(3)
Statement of Necessity: The campaigns are required to be targeted to people with mental illness or seeking services, not all others. There has been monumental waste in this area.

[89] See FN comment in Section 3740 (a)(2-3)

[90] See FN comment in Section 3740 (a)(2-3)

[91] The purpose is to reduce the number of suicides and attempts. It is critical counties measure outcomes, not just process.

[92] See FN comment in Section 3740 (a)(2-3)

[93] See FN comment in Section 3740 (a)(2-3)

~~o~~(1) Explain how individuals will be identified as needing assessment or treatment for a serious mental illness or serious emotional disturbance that is beyond the scope of an Early Intervention program.

~~o~~(2) Explain how individuals, and, as applicable, their parents, caregivers, or other family members, will be linked to county mental health services, a primary care provider, or other mental health treatment.

~~o~~(3) Explain how the program will follow up with the referral to support engagement in treatment.

~~o~~(4) Indicate if the County intends to measure outcomes in addition to those required in Section 3750, subdivision (g).

~~•~~(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).

~~o~~(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.~~

~~o~~(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.

~~•~~(j) 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 use Strategies that are Non-Stigmatizing and Non- Discriminatory, including a description of the specific strategies to be employed and the reasons the County believes they will be successful and meet intended outcomes.

~~•~~(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.

~~o~~(1) Estimated number of children, adults, and seniors with mental illness to be served in each Prevention program and each Early Intervention program.

~~o~~(2) The County may also include estimates of the number of individuals with mental illness who will be reached by Outreach for Increasing Recognition of Early Signs of Mental Illness program or strategy within a program, Suicide Prevention programs/approached, and Stigma and Discrimination Reduction programs/approaches.

~~•~~(l) The Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include projected expenditures for each program and strategy funded with Prevention and Early Intervention funds by fiscal year

(1) Projected expenditures shall be broken down by the following sources of funding:

(A) Estimated total mental health expenditures

(B) Prevention and Early Intervention funds

(C) Medi-Cal Federal Financial Participation

(D) 1991 Realignment

(E) Behavioral Subaccount

(F) Any other funding

(2) The County shall identify each program funded with Prevention and Early Intervention funds as a Prevention and Early Intervention[94] 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 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.

(m) The Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include the previous fiscal years' unexpended Prevention and Early Intervention funds and the amount of those funds which will be used to pay for the programs listed in the Annual Update and/or Three-year Program and Expenditure Plan.

(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 and steps taken to ensure those funds are spent only on programs allowed by the legislation and not ipads[95].

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5840 and 5847, Welfare and Institutions Code.

Adopt Section 3755.010 as follows:

Section 3755.010. Prevention and Early Intervention Program Change Report.

(a) If the County determines a need to make a substantial change to a program, strategy, or target population as described in Section 3745, the County shall in the next Three-Year Program and Expenditure Plan or Annual Update, whichever is closest in time to the planned change, include the following information:

(1) A brief summary of the program as initially set forth in the originally adopted Three-Year Program and Expenditure Plan or Annual Update.

(2) A description of the change including the resulting changes in the intended outcomes and the planned evaluation.

(3) Explanation for the change including, stakeholder involvement in the decision and, if any, evaluation data supporting the change.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5840 and 5847, Welfare and Institutions Code.

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[94] See FN 1

[95] Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5840 and 5847, Welfare and Institutions Code. Statement of Necessity. CalMHSA has spent PEI funds ineffectively and outside the scope of the legislation. See "Examples of statewide misspending within California's Mental Health Services Act Prevention and Early Intervention (PEI) Programs and/or Innovation Programs" available at http://mentalillnesspolicy.org/states/california/mhsa/statewide-mhsa-misspending.pdf. Much of the expenditures seem to be PR for MHSA, rather than services that help people with serious mental illness. CalMHSA even bought Ipads for county directors, in spite of the fact that there is no evidence that buying ipads for commissioners reduces stigma in people with mental illness. (See last page, last paragraph at http://calmhsa.org/wp-content/uploads/2012/06/CalMHSA-Budget-Package-2012-2013-FINAL.pdf

California's Mental Health Service Act
A Ten Year $10 Billion Bait and Switch

An investigation by Mental Illness Policy Org and Individual Californians
August 15, 2013

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Executive Director
Mental Illness Policy Org

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Appendices

Note to Reporters and Good Government Groups:

Most of the problems we found in MHSA accrued to the benefit of community based providers of voluntary "mental health" and social services. Hence, they tend to support what we identified as a major problem: the diversion of funds from people with serious mental illness to those with any mental health problem or social service need. The trade associations for these organizations (MHA, CCCMHA, CalMHSA, etc.) are not likely to find fault with the programs. This, combined with the over $11 million the Oversight Commission has allocated to PR efforts explains why this problem has gone largely (not completely) unreported.

For that reason, we would suggest you contact experts in *serious* mental illness, versus mental health or social services when attempting to get other perspectives on this report. Experts who do deal with people with serious mental illness (ex: schizophrenia and bipolar disorder) include prison and jail officials; homeless shelter workers and doctors; psychiatric inpatient doctors and nurses; hospitalized, incarcerated or homeless patients; and perhaps most importantly, mothers of children with serious mental illness who have been shut out of care due to the diversion of funds. We have provided contacts for a few of these at the end.

About Mental Illness Policy Org:

Mental Illness Policy Org is an independent, non-profit think tank dedicated exclusively to the study of serious mental illness, not mental health. We provide media, policymakers, and advocates with science based solutions to seemingly intractable problems like violence, incarceration, involuntary commitment and the need for more hospital beds. We have been credited as the driving force behind the adoption of Kendra's Law in New York and multiple other advancements in the treatment and care of the most seriously ill. We became interested in California because passage of Prop 63--specifically intended to help the most seriously ill, made it the only state with enough money to make a major improvement in how the most seriously ill were treated. Over time, reports came to our office that the funds were being diverted to other purposes. As documented in this report, we investigated and found the reports to be true.

California's Mental Health Service Act
A Ten Year $10 Billion Bait and Switch

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August 2013

Executive Summary

Background

In November, 2004 voters enacted a 1% tax on millionaires (Prop 63) to establish the Mental Health Services Act (MHSA) fund solely to help people with **serious mental illnesses**.[1] $10 billion has been raised since inception. Voters also created a Mental Health Services Oversight and Accountability Commission (MHSOAC a/k/a "Oversight Commission") to see the program stuck to its purpose of helping people with serious mental illness.

Primary Findings

Many people with serious mental illness are receiving critical treatment as a result of Prop 63 but billions are being diverted to other purposes:

- $1-2 Billion of Prevention and Early Intervention (PEI) Funds was intentionally diverted to social service programs masquerading as mental illness programs or falsely claim they prevent serious mental illness.
- $2.5 billion of the "Full Service Partnership (FSP) funds were spent without oversight of whether the recipients had schizophrenia, bipolar disorder, or the other serious mental illnesses that made them eligible for MHSA funds.
- $23 million went to organizations directly associated with Oversight Commissioners.
- $11 million is going to PR firms that make the Oversight Commissioners look good and hide the failure of MHSA to accomplish its mission
- $9 million is going to organizations working prevent the seriously ill from receiving treatment until after they become violent.
- Up to $32 million was diverted to TV shows, radio shows, PSAs and other initiatives designed to reach the public without mental illness. Some feature the Senate President Pro Tem.

Additional Findings

- County Behavioral Health Directors chaired meetings that allowed "stakeholder input" to trump the legislative language and voter intent to spend the funds on those with serious mental illness.
- No attempt is made to ensure programs receiving MHSA funds serve people with serious mental illness.[2]
- MHSA funds are being lavished on studies, reports, and consultants that generate jobs for those who get the contracts, but not services for people with serious mental illness.[3]
- Millions were diverted to programs intended to 'improve the wellness' of all Californians, rather than provide treatment to Californians with serious mental illnesses.[4]
- Funds failed to expand the capacity of proven existing programs as the legislation required.
- The most important programs to help the most seriously ill (like Laura's Law) are going unfunded.
- The Oversight Commission evaluated counties based on what they said they were going to do rather than on what they did.
- A series of amendments and related legislation introduced by legislators made it less likely MHSA funds will ever reach people with serious mental illness.[5]

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[1] The purpose was to "To define serious mental illness among children, adults and seniors as a condition deserving priority attention. "See the bill as originally passed http://mentalillnesspolicy.org/states/california/prop63text.pdf and as amended in 2012 http://mentalillnesspolicy.org//states/california/mhsa/MHSA_Amend-AB1467_July2012.pdf

[2] Many of the outcome reports are at http://www.mhsoac.ca.gov/Evaluations/CSS-Outcomes.aspx . They do not include any info on the diagnosis of people served.

[3] Ex. The Oversight Commission put out an RFP for an evaluation to evaluate the evaluations. Neither the original evaluations or the evaluation of the evaluations require evaluation of whether the people being served were seriously mentally ill individuals eligible for services. http://mhsoac.ca.gov/Evaluations/docs/Contracts/RFP_MHSOAC012-015.pdf

[4] The Oversight Commission itself created an eight page glossy insert for papers throughout the state headlined, "Mental Illness: It Affects Everyone, even though the legislation is not intended to affect everyone. See http://issuu.com/news_review/docs/2013-01-03_mentalillness (accessed 6/23/12).

[5] Most notably, AB-100 took $863 million out of the MHSA fund and directed it to fund programs courts had mandated the state to fund. AB 1467 (July 2012) essentially disconnected Innovative Funds (5% of total MHSA funds) from a connection with serious mental illness.

This report will document each of these findings.

Who is responsible for the failure:

The Oversight Commission

The problems with MHSA are not 'under the radar,' they are caused by the radar operators. The Oversight Commissioners have become cheerleaders for mission creep and cronyism rather than careful stewards of public funds. The Oversight Commissioners receive funds for their programs, approve distribution of the funds, hire outside evaluators to prove they are doing a good job and PR firms to convince the public all is well.

County Behavioral Health Directors

County behavioral directors--thirty-four of whom recently voted themselves MHSA-funded IPads[6]—have led and let the stakeholder process circumvent the language of the law and intent of the voters. They are funding anything brought to them by stakeholders, rather than limiting funding to serious mental illness programs.

California's non-profit mental 'health' and social service industries

California's non-profit mental health and social service industries provide an important safety net for many Californians. But in a gold-rush like attempt to garner funds for their own programs, they threw those with serious mental illness under the bus. Non-profits and associations like Disability Rights California, NAMI California, Mental Health America of California, each of which receive over $3 million and have representation on the Oversight Commission put their own parochial needs ahead of those of people with serious mental illness.

Senate President Pro-Tem Darrell Steinberg and the Legislature

Many of the citizens who contributed information to this report told us the Senate leader's heart is in the right place and he can be part of the solution. Unfortunately, when we look at the facts, we are forced to conclude that since passage, the Senate President Pro-Tem Steinberg has been part of the problem. He introduced and the legislature passed numerous bills that subverted the intent of voters to use the funds to help the most seriously ill. SB 1467 ensured fewer Innovation Funds reached persons with mental illness.[7] Provisions he inserted in AB-100 diverted $836 million of MHSA funds to fund pre-existing state obligations[8]. His opposition to SB 664 made it harder for counties to implement Laura's Law. His opposition to AB-1265 guaranteed mentally ill prisoners would go untreated upon end of their sentence. SB-364 as proposed made it more dangerous for parents to call authorities to help mentally ill loved ones. We would love to see the Senator resume a leadership role in improving services for people with serious mental illnesses. Recommendations on how to do so are attached.

Conclusion: It is undeniable that some people with serious mental Illness are being helped by MHSA, but u**nmitigated mission creep has left many of the most seriously mentally ill seriously underserved.** There is an unregulated feeding frenzy going on and Prop 63 is on its way to becoming a **"Ten Year, $10 Billion Bait and Switch."**

Someone should go to jail.

[6] Through CalMHSA, a Joint Power Authority funded with MHSA Prevention funds.

[7] See Appendix C. How Senate President Pro-Tem Exempted an additional 5% of MHSA funds (Innovative Services Funds) from helping persons with serious mental illness.

[8] There is a "non-supplantation" clause of Prop 63 (5891) that required the maintenance of funding for previously existing programs so MHSA funds can result in incremental activity. AB-100 used MHSA funds to pay for programs California was already under court order to pay or was otherwise funding. Put another way, $836 million of MHSA funds were used to lower the budget deficit.

Recommendations

1. Focus Programs on those voters intended: people with the most serious mental illnesses

- Require counties to report and monitor MHSA expenditures *by diagnosis*.
- Eliminate all regulations and guidance that diverted MHSA funds to people without mental illness and inform counties they are no longer operative.
- Eliminate funding of programs that falsely claim they prevent serious mental illness
- Eliminate funding of programs that refuse to accept people with serious mental illness
- Define "Underserved Populations" by diagnosis and severity of their mental illness.
- Eliminate spending on PR, TV shows, PSAs ("Universal Prevention Activities") and spend the money saved on helping people with serious mental illness
- Expand programs that existed prior to Prop 63 that successfully treated people with serious mental illness.
- Require Prevention and Early Intervention (PEI) funds to be spent, as legislatively required, on 'preventing mental illness from becoming severe and disabling", not 'preventing mental illness' (since no one knows how to prevent serious mental illnesses like schizophrenia and bipolar disorder.)
- Eliminate funding of organizations that do not believe mental illness exists or lobby--even with non-MHSA funds--against treatment for those who are so sick they do not recognize their need for treatment.
- Eliminate the ability of County Behavioral Health Directors to lead or follow a stakeholder process that perverts and circumvents intent of legislation. (i.e., use science based rules rather than mob rules to distribute funds)

2. Overhaul the Oversight Commission

- Individuals responsible for distributing or receiving MHSA funds should not be allowed on oversight committees because they have a conflict of interest.
- Prohibit Insider Dealing: No funds should go to programs associated now, or within the last five years with board members of the Oversight Commission.
- Increase percentage of criminal justice representatives on Oversight Commission because they know what community services are needed to prevent arrest and incarceration of the most seriously ill
- Increase representation from inpatient psychiatric hospitals on oversight commission as they know what community services are needed to prevent rehospitalization of the most seriously ill

3. Use legislative and legal process to further voter intent, rather than divert funds to non related programs

- Pass legislation to clarify that individuals under Laura's Law are eligible for MHSA supported services.
- Amend MHSA to allow funding for people with serious mental illness paroled from state prisons
- Overturn AB 1467 which severed Innovative Funds from helping people with serious mental illness
- Refer illegal expenditures to Attorney General

Unmitigated Mission Creep: MHSA fails to stick to the mission of serving individuals with serious mental illness

When campaigning for Proposition 63, Senator Steinberg and mental health trade association head, Rusty Selix promised voters the funds would help people with **serious** mental illness.

> *"This measure will provide mental health services to **people who need it most**." (emphasis added) –Darrell Steinberg March 23, 2004*[1]

> *"And (voters) didn't want (Proposition 63) to fund all mental health, only people that had severe mental illness." Rusty Selix*[2]

Proposition 63 Findings and Declarations differentiated between mental illnesses and serious mental illnesses

> *"Mental illnesses are extremely common; they affect almost every family in California. They affect people from every background and occur at any age. **In any year, between 5% and 7% of adults have a serious mental illness as do a similar percentage of children — between 5% and 9%.** Therefore, more than two million children, adults and seniors in California are affected by a potentially disabling mental illness every year.*

Proposition 63 made clear it was to help get services to people with serious mental illnesses:

> *Purpose and intent: To "define **serious mental illness** among children, adults and seniors as a condition deserving **priority** attention…to reduce the long-term adverse impact on individuals, families and state and local budgets resulting from **untreated serious mental illness…**To expand…programs have already demonstrated their effectiveness in providing …**medically necessary psychiatric services**, and other services, to individuals **most severely affected** by or at risk of **serious mental illness."***

There is little controversy as to who has "serious" mental illness. Proposition 63 and virtually all government agencies and non profits use roughly 5-9% of the population because they all rely on the National Institute of Mental Health (NIMH)[3] the pre-eminent research arm of the US Government that addresses these issues. 5-9% is also supported by other research.[4] NIMH estimates overall 5% have "Serious Mental Illness" and breaks it down by diagnosis as follows:

Schizophrenia (NIMH defines *all* schizophrenia as "severe")	1.1% of the population[5]
The subset of major depression called "severe, major depression"	2.0% of the population[6]
The subset of bipolar disorder classified as "severe"	2.2% of the population[7]
Total "severe" mental illness by diagnosis:	**5.3% of the population**[8]

The above are overall figures. Within certain age groups NIMH research shows up to 8% have serious mental illness. This accounts for the 5-9% figure used in the legislation.[9]

In spite of the above, MHSA funds are being used on people who may have any type of mental health problem rather than those with serious mental illness as required by the legislation. Worthy and unworthy social service programs started masquerading as mental health programs to make them eligible for funding. Tutoring, unemployment, bullying initiatives,

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[1] "Campaign for Mental Health" a blog by Darrell Steinberg to pass Proposition 63. The quote is from the very first post after turning in the signatures needed to put the initiative on the ballot. Available at http://campaignformentalhealth.typepad.com/darrell/2004/03/campaign_turns__1.html Accessed 7/19/13.

[2] "History of Mental Health in California" 4/5/10. UCLA Health Services Research Center Rusty Selix interview available at http://www.mhac.org/pdf/Rusty-Selix-Interview.pdf

[3] http://www.nimh.nih.gov

[4] 1. United States Public Health Service Office of the Surgeon General (2001). *Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General.* Rockville, MD: Department of Health and Human Services, U.S. Public Health Service. 2. Department of Health and Human Services: Substance Abuse and Mental Health Services Administration (2002). *National Household Survey on Drug Abuse: Volume I. Summary of National Findings; Prevalence and Treatment of Mental Health Problems*. 3. Kessler, R. C., Berglund, P. A., Bruce, M. L., Koch, J. R., Laska, E. M., Leaf, P. J. et al. (2001). The prevalence and correlates of untreated serious mental illness. *Health Services Research, 36,* 987-1007.

[5] NIMH, Schizophrenia. "Schizophrenia is a chronic, severe, and disabling mental disorder characterized by deficits in thought processes, perceptions, and emotional responsiveness. http://www.nimh.nih.gov/statistics/1SCHIZ.shtml

[6] "2.0% of U.S. Population is are classified as "severe"", NIMH" Major Depressive Disorder Among Adults" http://www.nimh.nih.gov/statistics/1MDD_ADULT.shtml

[7] NIMH "Bipolar Disorder Among Adults" "2.2% of U.S. adult population are classified as "severe"". http://www.nimh.nih.gov/statistics/1BIPOLAR_ADULT.shtml

[8] "Prevalence of Serious Mental Illness Among U.S. Adults by Age, Sex, and Race in 2008 (NSDUH)" at http://www.nimh.nih.gov/statistics/SMI_AASR.shtml

[9] California's definitions can be found at 5600.3

crime reduction, bad marriages, prostitution, were all defined as mental health issues eligible for funding.

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.

Case Study: Monterrey attempted to use MHSA PEI funds as intended: to prevent those *with* mental illness from having it become 'severe and disabling'. The Oversight Commission stopped them:

> "To be consistent with this (Prevention) definition, MHSA-funded PEI programs *cannot serve people with a mental health diagnosis*. Several of Monterey County's PEI programs currently target mental health consumers; however, to be consistent with the PEI Guidelines, please clarify that these programs include persons **without a mental health diagnosis.**" Letter available at http://mhsoac.ca.gov/Counties/PEI/docs/PEIplans/PEI_Monterey.pdf (Accessed 6/22/13)

Background:
20% of MHSA Funds-- $2 billion to date--were earmarked for Prevention and Early Intervention (PEI) Programs.[10] PEI programs are required to operate within the overall intent of Prop 63 which is to give "s*erious mental illness*…priority attention." PEI programs were created to "prevent mental illness from becoming **severe and disabling**", "to reduce the duration of **untreated mental illness,** or reduce certain negative outcomes that "result from **untreated mental illness**". Limited other usage is allowed but they must be connected to 'serious' or 'severe' mental illness.

The Prevention and Early Intervention program was not created to "prevent mental illness" because we do not know how. As Senator Darrel Steinberg eloquently stated when campaigning for Prop 63:

> *"As I've said before, we can't prevent certain mental illnesses, such as schizophrenia and bipolar disorder, but we can prevent them from becoming severe and disabling."* –Darrel Steinberg. 4/13/2004[11]

PEI is designed to help those already with "mental illness" (20% of population)[12] from developing a "serious mental illness" (5-9%).[13] We do know how to do that. For example, if someone has schizophrenia or bipolar disorder, maintaining them in treatment, often medications, can prevent the disorder from becoming 'severe and disabling'. *See Appendix A for a more detailed explanation of allowable uses of PEI funds.*

Problems
- At least $1 billion (50% of the PEI funds) was diverted to people without mental illness[1].
- Approximately $1 billion is being diverted to programs that falsely claim they 'prevent mental illness".
- People with the most serious mental illnesses are being excluded from PEI programs.

Oversight Commission guidance encouraged counties to exclude people with mental illness from PEI funded programs. Counties readily agreed. The Oversight Commissions PEI Guidelines provided to counties state "Prevention Programs are expected to focus on individuals 'prior to' diagnosis"[14] In other words: people without mental illness. This was done in spite of the fact the legislation requires the funds to serve people with mental illness not those without. This direction accounts for the bulk of the $2 billion that was diverted.

The Oversight Commission and counties disguised worthy and unworthy social service programs as mental illness prevention programs in order to make them eligible for MHSA funding. The Oversight Commission issued and enforced a regulation that defined seven priority population groups as eligible for PEI funds.[15] Only one group was "Individuals experiencing onset of a serious mental illness". The other priority population groups are not required to be individuals experiencing onset of mental illness. They were being prioritized for services based sexual orientation, employment status of parents, presence of parents, whether or not someone in the family ever died, age, criminal history

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[10] WIC 5840
[11] Official Weblog of the Campaign for Mental Health, April 13, 2004. Created by Darrel Steinberg to get voters to pass MHSA. Available at http://digital.library.ucla.edu/websites/2004_996_010/darrell/2004/04/index.html Accessed 6/20/13
[12] Substance Abuse and Mental Health Services Agency (SAMHSA) available at http://www.samhsa.gov/newsroom/advisories/1211273220.aspx (Accessed June 14, 2013)
[13] NIMH and Mental Health Services Act Findings
[14] Minutes of September 22, 2011 MHSOAC Commissioners. Available at http://www.mhsoac.ca.gov/meetings/docs/PriorMeetingMinutes/2011/MinutesApproved_Sept2011.pdf Accessed 6/24/13.
[15] CCR Title 9 3905 lists 7 priority populations. However, nothing in the reg requires those priority populations to have a mental illness for which treatment is needed to prevent it from becoming severe and disabling.

and substance abuse—even in the absence of a mental illness. None of these so-called 'risk factors' cause schizophrenia, or bipolar or other serious mental illnesses. They are at best, social service concerns.

The Oversight Commission forced counties to prioritize those least likely to have a serious mental illness. The Oversight Commission required 51% of PEI funds go to children and youth between age 0 and 25.[16] Serious mental illnesses like schizophrenia rarely manifest themselves before late teens and early twenties. There is no way to predict who will get it until they symptoms manifest. To the extent the funds are being used in prior to late teens, they are not reaching those most likely to develop serious mental illness.[17]

The Oversight Commission freed PEI programs from the requirement to measure outcomes.[18]

The Oversight Commission freed counties from using the funds as they said they would use them.[19]

The Oversight Commission freed counties from having to use evidence based practices.[20]

Diverting Funds via Regulations:

Officials issued regulations redefining the purpose PEI Funds so they could be spent on people without mental illness. [21] Some examples:

- 3200.251 redefined the purpose of PEI programs from what voters intended ("preventing mental illness from becoming severe and disabling") to "prevent serious mental illness" (we don't know how); "promoting mental health" (making people happier) and "building the resilience of individuals".
- 3400 (b) illegally separated PEI programs from having the statutory tie to serious mental illness. The first part of the regulation states "Programs and/or services provided with MHSA funds shall: (1) Offer mental health services and/or supports to individuals/clients **with** serious mental illness and/or serious emotional disturbance, and when appropriate their families. But it goes on to state "**The Prevention and Early Intervention component is exempt from this requirement.**" There is nothing in voter intent or legislative language that suggest PEI funds were 'exempt' from helping people *with* serious mental illness. This exempted $2 billion in taxpayer Prevention and Early Intervention funds from serving people with mental illness.

The science of prevention and early intervention:
Any program that purports to prevent bipolar disorder or schizophrenia by intervening before it is diagnosed is making a false claim. Bad parents, bad grades, bad marriages, bad jobs, bad housing, bullying, and in most cases, loss of loved ones do not cause serious mental illness although they may exacerbate symptoms in those who already have it.

Serious mental illnesses are likely caused by a combination of genes, gene stressors, neuroanatomical differences and chemical imbalances. There is no test to predict who will develop serious mental illness before symptoms materialize making many so-called early intervention programs ineffective.

Schizophrenia usually manifests itself in late teens and early twenties. The illness occurs in 1% of the general population, 10% who have a parent or sibling with the disorder; and 40-65% of those who have an identical twin with the disorder. Problems in utero may trigger the disorder in those genetically predisposed. Diagnosis is made by eliminating other causes and analyzing the effect of the disorder on the individual.

Bipolar disorder often develops in a person's late teens or early adult years. Children with a parent or sibling who has bipolar disorder are four to six times more likely to develop the illness, compared with children who do not have a family history of bipolar disorder.

Improving employment, grades, marriage satisfaction, etc. does not reduce the incidence of serious mental illness and is not a targeted intervention. Targeted interventions would aim at the offspring of those with mental illness, not those without.

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[16] http://www.mhsoac.ca.gov/MHSOAC_Publications/docs/FactSheet_PEI_121912.pdf Accessed 6/24/13.

[17] Oversight Commissioners quote a figure that half of mental illness begins before age fourteen. But that is not 'serious mental illness'. MHSA was passed to "define serious mental illness" not all mental health, as a condition deserving priority attention. Serious mental illness usually first becomes manifest in late teens early twenties. Other issues like bad grades, lack of self-esteem, anti-social behavior do present themselves earlier but are outside the scope of MHSA.

[18] The commissioners were told by their own evaluator that there is "no requirement (for counties) to measure outcomes" This allowed a massive diversion to programs that were politically popular regardless of their utility. Minutes of September 22, 2011 MHSOAC Commissioners. Available at http://www.mhsoac.ca.gov/meetings/docs/PriorMeetingMinutes/2011/MinutesApproved_Sept2011.pdf

[19] During the period of this review, the legislation required counties to submit PEI plans to the Oversight Commission for review. Minutes show that MHSOAC review of counties was "based on what counties said they were going to do, rather than actual on the ground assessment". http://www.mhsoac.ca.gov/meetings/docs/PriorMeetingMinutes/2011/MinutesApproved_Sept2011.pdf

[20] Voters included a specific *legislative finding that "*By expanding programs that have demonstrated their effectiveness, California can save lives and money." At a MHSOAC board meeting, MHSOAC Vice-chair Van Horn admitted "there are not a lot of evidence-based practices (being used) in the PEI arena." He then went on to lower the standards a program has to meet: "PEI Guidelines have requirements that counties must use *some* level of evidence to support the programs that they are proposing. It doesn't have to be evidence-based practice; it could be a range of evidence."

[21] Some of these were promulgated, some not, some lapsed. As will be seen in next section, the direction to not use PEI funds for persons with mental illness was continually and forcefully communicated to counties and was defacto policy regardless of which regulations were in effect.

- 3200.305 encouraged counties to spend on so-called "Universal Prevention Activities." That "*target the whole population or a subset of the population that does not have a higher risk for developing the symptoms of mental illness."* [22] It takes the most tortured reading of Prop 63 to conclude that voters intended to fund PR campaigns, television shows, newspaper advertising, etc. for people without mental illness.

(See Appendix C for more Regulations that were proposed at various times).

Commissioners kept ineffective programs funded.

~~2.~~ 1. At an MHSOAC board meeting, "Commissioner Vega pointed out that results from some PEI programs, particularly those involving youth, cannot be known until years later." This claim is frequently used to justify continuing unproven programs. The reason programs for youth don't work to "prevent mental illness from becoming severe and disabling' is (1) they are not targeting those most likely to develop serious mental illness (first degree relatives of people with serious mental illness; (2) they are not targeting people with mental illness; and (3) there is not yet a known way to prevent serious mental illness.
2. At an MHSOAC board meeting a Los Angeles FSP Program Manager admitted the L.A. job training program had only increased employment days 4.2 percent and that was mainly due to government creating jobs versus any private sector jobs being created.[23] The program continues to receive funding.

Commissioners intended to (may have) approved expenditures they knew were not allowable by law. Oversight Commission minutes show that the commissioners funded substance abuse programs specifically not included for funding in the final language of the legislation. "MHSOAC Vice-Chair Van Horn commented that …the reason co-occurring disorders (substance abuse) were not mentioned in the MHSA was because during the Proposition 63 focus groups they were informed that using that language would lead to the defeat of the proposition." He then went on to state, "**It is clear that co-occurring disorders need to be dealt with at the same level.**"[24] In spite of not including this in the legislation, Commissioner Van Horn clearly expressed his intent to fund it.[25]

Oversight Commissioner and counties fail to address waste and diversion of funds. The Associated Press, San Francisco Chronicle[26], as well as our own op-eds[27] and letters to the Oversight Commission have attempted to bring the problems in PEI programs to their attention so they could be remedied. The Oversight Commission has ignored the reports, defended the status quo, and in at least one instance threatened a newspaper that was thinking of reporting on the problems with having their advertising pulled.[28]

County behavioral healthcare directors encourage, lead, and fail to overrule a flawed stakeholder process that diverts funds

Proposition 63 established stakeholder process to advise counties on spending. While county behavioral health commissioner are supposed to consider this input, they allowed participants to prioritize non-evidenced programs; programs that don't serve people with serious mental illness; and caused programs that help the most seriously ill to go without funding. In many if not most counties, the Behavioral Health Directors actually lead the meetings. (See chapter on "Failed Stakeholder Process").

See following section for examples.

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[22] http://www.preventionearlyintervention.org/go/PromotingWellnessPrevention/UniversalPrevention.aspx

[23] "Commissioner Poat, Mr. Delgado, and Mr. Refowitz agreed that employment is a challenging need to meet in the whole recovery process. The hiring freeze in Orange County and the overall downturn in the economy have made it harder to find employment for FSP graduates."

[24] Minutes of MHSOAC Board Meeting September 22, 2011. Available at http://www.mhsoac.ca.gov/meetings/docs/PriorMeetingMinutes/2011/MinutesApproved_Sept2011.pdf Accessed 6/24/12

[25] From a policy perspective, we agree with Commissioner Van Horn that funding co-occurring substance abuse in people who have serious mental illness or mental illness that needs treatment to prevent it from becoming severe and disabling, makes sense. But the point for this report, is that it is not allowable, he knew it, yet was still trying to achieve it.

[26] http://www.sfgate.com/opinion/article/Prop-63-Mental-Health-Services-Act-not-as-3688777.php

[27] http://mentalillnesspolicy.org/states/california/capitalweeklyopeds.html

[28] This is the only fact we are making in this report that we will not provide additional documentation for. That is because we want to protect the identity of the reporter. After s/he questioned an MHSA official, MHSA PR operation reached out to the publisher and threatened to pull advertising. The reporter was, according to him/her chastised, and the story killed.

Examples of statewide misspending within PEI (and/or Innovation Funds)

Case Study: According to a reporter at the Orange County Register reported suicide in California is up and the MHSA suicide prevention program is not working:

"Jenny Qian, a manager in county behavioral services, says thanks to an injection of money from Proposition 63, Orange County has beefed up its suicide programs in the past two years and continues to roll out more programs. Qian tells me by calling what she describes as a local hotline number, 1-877-727-4747, people will find all the local help they need."

"I called that number and asked for help for someone needing a counselor in the Mission Viejo area. I was informed the person who needs help should call. I pressed and was told they can't help with local counselors because the service is nationwide." http://www.ocregister.com/articles/suicide-504805-county-gun.html

Statewide Prevention and Early Intervention Initiatives ($129 million)[29]

MHSA PEI funds are generally given to counties to spend. However, there are two sources of statewide funds.

~~5.~~1. CalMHSA. CalMHSA is a Joint Power Authority created by counties to pool their MHSA funds to execute programs that are more efficiently executed by a statewide entity, rather than by individual counties. These expenditures must still comply with MHSA requirement to serve people with serious mental illness, "prevent mental illness from becoming severe and disabling" or "reduce the duration of untreated serious mental illness. They were still subject to approval by the Oversight Commission. CalMHSA bought 34 Ipads for County Behavioral Health Directors.[30]

~~6.~~2. Oversight Commission- The Oversight Commission has extensive funds of their own. These are generally used for reports, studies, and research, that create good press for the commission, jobs for those who get the contracts, but have very little to do with providing care to people with serious mental illness. While these come out of administrative funds (rather than PEI) we will discuss them here.

It is often difficult to determine which MHSA funded projects described below were funded from which buckets of money, but the fact that MHSA funds are being used is indisputable.

1. Suicide Prevention wastes up to $32 million[31]

Background: Suicide is mentioned twice in MHSA. The "Findings and Declarations" declared, "Untreated mental illness is the leading cause of disability and suicide and imposes high costs on state and local government." and "The (PEI) program shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness: (1) Suicide."[32] MHSA is only to reduce suicide that results from untreated mental illness. California previously created a "Strategic Plan on Suicide Prevention" (a/k/a "Schwarzenegger Plan[33]) that included data and strategies to prevent suicide and noted mental illness was a leading cause of suicide.[34]

Problems: CalMHSA ignored the research included in the Schwarzenegger Plan and funded non evidenced based suicide programs instead. For example, the Schwarzenegger Plan found kids 10-15 are the lowest suicide risk but CalMHSA focused PEI suicide money on children. Adults, the group with the highest death rates—responsible for 50% of all suicides are not prioritized.

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[29] A description of some of the statewide programs with dollar amounts is at http://www.mhsoac.ca.gov/Meetings/docs/Meetings/2011/Jul/OAC_072811_Tab3_CalMHSA_StatusReport.pdf. Some are annual expenditures. Others may be multi-year.

[30] See last page, last paragraph at http://calmhsa.org/wp-content/uploads/2012/06/CalMHSA-Budget-Package-2012-2013-FINAL.pdf

[31] $129 million was spent on CalMHSA on PEI of which 25% was allocated to suicide ($32 million). Page three at http://calmhsa.org/wp-content/uploads/2012/01/CalMHSA-Implementation-Work-Plan-FINAL-11-18-10-POSTED.pdf $3 million of this suicide prevention funding went to NAMI, whose former President Ralph Nelson was on MHSAOC Board. $3 million of this went to MHA of SF, whose former Executive Director, Eduardo Vega was on MHSAOC board.

[32] WIC 5840(d)(1)

[33] http://www.mhsoac.ca.gov/docs/Suicide-Prevention-Policy-Plan.pdf

[34] "(N)early half of suicide cases involve at least one documented mental health diagnosis. It is estimated that as many as 90 percent of individuals who died by suicide had a diagnosable mental illness or substance abuse disorder. Certain psychiatric diagnoses increase the risk of suicide substantially. Among individuals diagnosed with a major mood disorder (a spectrum that includes major depression and bipolar disorder), up to 20 percent die by suicide. The risk tends to be highest among those who have frequent and severe recurrences of symptoms."

Prop 63 funding is funding ineffective, unproven, mistargeted TV, radio, billboard, print campaign to reduce suicide.[35] There is no evidence that media campaigns reduce suicide and some evidence they increase it[36]. It is also inefficient because they reach the general public versus high risk populations like those with serious mental illness, those who have previously attempted suicide, or the first degree relatives of those who have attempted suicide.[37]

CalMHSA also uses MHSA funds for anti-suicide websites like http://www.yourvoicecounts.org Your Voice Counts lets Californian's vote on what is effective at suicide prevention. It substitutes polling for science in deciding where MHSA Suicide prevention money should go.

2. Stigma and Discrimination Reduction wastes up to $48 million[38]

MHSA eloquently differentiated 'extremely common' mental illnesses from serious mental illnesses and stated the intent of the legislation to help the later and not the former.[39] In spite of this, stigma funds are being spent on those with common illnesses and not those with serious mental illnesses.

- A glossy four-color magazine insert was produced, printed, and distributed statewide in newspapers that is headlined, "Mental Illness Affects Everyone." That was clearly not designed to inform about the much smaller group with 'serious' mental illness[40].

- A TV commercial in five languages was produced[41]:

  Title "One in Four"
  Anncr: Every year, 1 in 4 Californians experience mental illness.
  Mental illness does not discriminate.
  It can happen to anyone of any ethnicity, income or gender.
  It is a medical condition that affects thinking, feeling, mood, ability to relate to others, daily functioning.

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[35] The CalMHSA suicide prevention efforts have a $32 million budget, but we don't know what percentage is being spent on this particular effort. http://www.prweb.com/releases/prweb2012/12/prweb10229719.htm

[36] The theory behind these campaigns is that they educate people to see warning signs so they can intervene to prevent the suicide. But research shows it doesn't work mainly because suicide is exceedingly uncommon. Per the press release announcing the CalMHSA Suicide Prevention Media Campaign, of the 37.5 million Californians, 3,823 (.01%) took their own lives, and 16,425 (.04%) were hospitalized for self-inflicted injuries. To be effective, all experts agree that suicide prevention efforts should be highly targeted to those populations with higher rates of suicide or attempts. Populations with high rates of suicide include those who have previously attempted suicide and first degree relatives of those who have attempted suicide. It is simply a waste to fund TV campaigns when trying to reach less than 4,000 or 17,000 people.

We researched the professional literature and could not find any scientific evidence media campaigns reduce suicide. There are reputable sources that suggest (without proof) that these campaigns should be used, but in almost all cases they say the campaigns should be targeted at high-risk individuals.

The Suicide Prevention Resource Center does not list any public relations campaigns in their list of "Evidence Based Programs" They do list education and training, but these are targeted to 'gatekeepers', like nurses, doctors, and social workers so they can recognize symptoms. See http://www.sprc.org/bpr/section-i-evidence-based-programs#sec1listings

The Schwarzenegger Plan does suggests public education efforts (without citing any source or rationale) but immediately goes on to suggest that targeting gatekeepers is the most important strategy http://mhsoac.ca.gov/docs/Suicide-Prevention-Policy-Plan.pdf

There are many studies showing efforts targeted to the public are not supported by research. See *Suicide Prevention Strategies: A systematic review Journal of the American Medical Association available at http://jama.jamanetwork.com/article.aspx?articleid=201761* and *Why are we not getting any closer to preventing suicide? DIEGO DE LEO, FRANZCP BJ Psych available at http://bjp.rcpsych.org/content/181/5/372.short The later sates "*The conflict between political convenience and scientific adequacy in suicide prevention is usually resolved in favor of the former. Thus, strategies targeting the general population instead of high-risk groups (psychiatric patients recently discharged from hospital, suicide attempters, etc.) may be chosen"

We also contacted Dr. Alan Berman Executive Director of the American Association of Suicidology, to triple check our findings. He confirmed that there is no evidence PR campaigns reduce suicide and confirmed the research that they may in fact do harm (have 'untoward' effect).

[37] Spending $32 million to reach 3,832 (est.) individuals results in a per capita expenditure of $8,370 per suicide prevented.

[38] 37.5% of $129 million per California Mental Health Services Authority Statewide Prevention and Early Intervention Implementation Work Plan page iii at http://calmhsa.org/wp-content/uploads/2012/01/CalMHSA-Implementation-Work-Plan-FINAL-11-18-10-POSTED.pdf

[39] After noting that mental illnesses are "extremely common" MHSA findings and declarations went on to state that these people with everyday common mental illnesses are not serious mental ill that MHSA was intended to help, "In any year, between 5 percent and 7 percent of adults have a serious mental illness as do a similar percentage of children— between 5 percent and 9 percent. " MHSA funds are intended to 'define *serious mental illness* as a condition deserving priority attention".

[40] Available at http://issuu.com/news_review/docs/2013-01-03_mentalillness

[41] Available on right side at http://www.mhsoac.ca.gov/Prop63_Website/Prop63_NewWebsite.aspx

There are many causes including life history particularly stress, trauma, abuse.
If you or someone you know is hurting, get help. Contact your county mental health or behavioral health department. (MHSOAC Logo)

This PSA does not even mention *"serious"* mental illness. The PSA misstates the science[42] and proposes a solution that will not likely work for many of the most of the seriously ill.[43]

- Five "Mental Health Minutes" (sponsorships) were produced.[44] Only one mentions serious mental illness.

- **$11 million in stigma funding was given to a Sacramento public relations firm (**Runyon Saltzman & Einhorn).[45] Among other tasks, they ran a Facebook group "Good News About Proposition 63". It did not provide any information to help people with mental illness, only puff pieces on how great Prop 63 is. When people started posting info about waste and fraud within Prop 63, rather than look at the site as useful tool to collect such information, they took the page down. The PR firm also writes op-eds extolling the virtues of MHSA[46] and generates positive news stories.[47] These efforts have made it very difficult for the truth about Prop 63 to get out to the public. Voters did not pass prop 63 because they felt a dearth of PR firms.

- **$2.9 million in stigma funding is going to Disabilities Rights California (DRC)[48] and is being used to oppose Laura's Law**[49] a program that has been proven to help people who are so seriously ill they do not recognize their need for treatment[50].

- **Approximately $12 million in stigma funds were given directly to organizations headed by members of the Oversight Commission.** See Insider Dealing chapter for information on approximately $3 million each in stigma funds given to NAMI, MHSA, and DRC all of which are headed by members of the Oversight Commission.

- **Stigma funds were used to tell newspaper reporters and editors how to write their stories.[51]**

- **Stigma funds were used to produce a documentary film for TV.**[52] When the Sacramento Bee questioned the use of MHSA funds to produce public television shows, the MHSA PR firm stated "it was tremendously successful," pointing to an increase in traffic at a website, ReachOut.com, and viewers of the PBS show". But creating visitors to a website or viewers for a television show was not the purpose of MHSA. Some PSAs in Sacramento now feature the Senate Leader Pro Tem.

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[42] "Serious" mental illness is not caused by "stress, trauma, abuse" like the PSA says. Serious mental illness like schizophrenia is likely due to multiple interrelated genes somehow interacting with external influences like viruses. It may be a disorder incurred in-utero. Bipolar disorder, the other serious mental illness Prop 63 proceeds were intended to help is even more genetically related than schizophrenia. The "one in four" mental illnesses may not "affect...daily functioning" as the PSA says. It is the "serious" mental illnesses (that affect 5-9% of people) that are likely to "affect...daily functioning". Put another way, the author of this report has depression and takes Prozac. It doesn't affect his daily life at all. He's a "1 in 4" not a 5-9%. MHSA was not intended to serve me. The language of the legislation, and materials used to sell it to the public, clearly state Prop 63 is intended to serve the **seriously** ill.

[43] Up to 50% of those who have *schizophrenia or bipolar* and are not currently receiving treatment may be so ill they don't recognize they have it. It's called anosognosia. Lack of awareness of illness (a brain so sick it doesn't know it is not working) is the Number One reason people with serious mental illness won't accept treatment. So admonishments to "Get Help" will not work.

[44] Available on left side at http://www.mhsoac.ca.gov/Prop63_Website/Prop63_NewWebsite.aspx

[45] http://www.californiahealthline.org/articles/2011/10/18/agency-doles-out-11-2m-for-mental-health-campaign.aspx

[46] http://www.mhsoac.ca.gov/ArchivedOpinionEditorials.aspx

[47] http://www.mhsoac.ca.gov/ArchivedInTheNews.aspx

[48] Oversight Commissioner Eduardo Vega is on the DRC board.
http://www.mhsoac.ca.gov/Meetings/docs/Meetings/2011/Jul/OAC_072811_Tab3_CalMHSA_StatusReport.pdf

[49] http://lauras-law.org/states/california/llresultsin2counties.html

[50] According to Carla Jacobs of California Treatment Advocacy Coalition, DRC sued Los Angeles to prevent implementation of Laura's Law. For some 2005-2012 DRC anti-Laura's Law activity see http://lauras-law.org/states/california/p&aopposition.pdf

[51] At least one editor of one large California Daily was approached by MHSA funded stigma program which wanted her to use their "style guide" to change how she was writing about mental illness, i.e., downplay violence.

[52] The documentary was called, "A new state of mind: Ending the Stigma of Mental Illness. The Sacramento Bee ran a story on it "Public Eye: State Funding of Mental Health Documentary Questioned" See http://www.sacbee.com/2013/06/02/5464315/state-funding-of-mental-health.html. In response to the criticism, the PR firm responded that the documentary was successful because more people visited the website.

Examples of county social service programs masquerading as mental illness programs[53]

Many of the county programs below that came to our attention are admirable, worthy and even important social service programs. But they are not mental illness programs. They are therefore ineligible for MHSA funding. Diverting MHSA funds to these programs is not what voters intended, and leaves those with serious mental illness living untreated at home or homeless, living under lice infected clothing and eating out of dumpsters, while funds intended to help go elsewhere.

- **Butte County** uses MHSA funds for
  - A "Therapeutic Wilderness Experience".[54]
  - Hmong Gardens.[55] This is a good example of a failed stakeholder process. Butte did a study of the need for housing for people of Hmong ancestry.[56] Eight people participated. We do not know if any had serious mental illness or if any housing was ever built. But this focus group found that two important services for this housing that is not limited to people with mental illness are "gardens" and a "community room". The researchers aggregated the two to conclude that if they built housing, 58% wanted "community room and garden" and therefore a garden was a service that prevents mental illness from becoming severe and disabling.
  - African American Cultural Center.[57]
  - PR brochures that positioned the county behavioral health director as an effective steward of MHSA funds. They include no financial data on how the money is spent.[58]

- **Contra Costa** County is using MHSA funding
  - To teach parenting skills to parents($360,000)[59]
  - for a hip-hop carwash, family activity nights and a homework club.[60]
  - to help the elderly with or without mental illness.[61]
  - "New Leaf Collaborative.[62] This works to improve grades.
  - Native American Health Center[63].
  - Lesbian, Gay and Transgender programs. Being lesbian gay or transgender are no longer considered mental illness. There is no evidence that being lesbian gay or transgender makes someone more likely to develop a

[53] These are only the ones we have become aware of, and do not represent a complete list. We did not evaluate every county MHSA plan, only programs that came to our attention.

[54] We are not aware of any information that shows a Therapeutic Wilderness Experience will prevent mental illness from becoming severe and disabling http://www.mhsoac.ca.gov/Innovation/docs/InnovationPlans/Butte_INN_Approval_Summary.pdf

[55] http://www.fresnobee.com/2012/07/30/2929985/fresno-hmong-garden-praised.html#storylink=cpy

[56] http://www.buttecounty.net/Behavioral%20Health/Mental%20Health%20Services%20Act%20-%20Old/~/media/County%20Files/Behavioral%20Health/Public%20Internet/MHSA/Housing/HmongFocusGroupDataResults.ashx

[57]http://www.buttecounty.net/Behavioral%20Health/~/media/County%20Files/Behavioral%20Health/Public%20Internet/MHSA/Public%20Announcements/12-13%20Annual%20Update%20Narrative%20DRAFT%201.ashx
and
http://www.buttecounty.net/Behavioral%20Health/~/media/County%20Files/Behavioral%20Health/Public%20Internet/MHSA/Public%20Announcements/BH1213MHSAPlanUpdateplan.ashx

[58]
http://www.buttecounty.net/Behavioral%20Health/~/media/County%20Files/Behavioral%20Health/Public%20Internet/MHSA/Public%20Announcements/MHSA%20Benefits%20to%20Butte%20County.ashx

[59]
http://64.166.146.155/agenda_publish.cfm?mt=ALL&get_month=10&get_year=2012&dsp=agm&seq=12398&rev=0&ag=238&ln=23705&nseq=12400&nrev=0&pseq=&prev=#ReturnTo23705

[60] The "purpose" of the hip-hop car was to help at-risk children learn life skills that will make them productive citizens, by promoting educational and vocational opportunities any by providing training, support and other tools they need to overcome challenging circumstances." That may be worthy, but is outside the purpose and intent of MHSA which is to help people with serious mental illness. http://66.39.42.45/services/mental_health/prop63/pdf/pei_agencies_descriptions.pdf and http://www.contracostatimes.com/top-stories/ci_18356480

[61] http://www.mhsoac.ca.gov/MHSOAC_Publications/docs/PressReleases/2011/PEITrendsReport_05-11-11.pdf

[62] To "prove" it works the county notes, "Fifty-two students were enrolled in New Leaf last year. Of these, 71% of students improved their attendance; 78% earned the necessary academic credits at or above grade level; and 77% achieved at least 4 out of 6 individual goals." That is likely true. But improving school attendance, helping people get through high school are not the purpose of MHSA. http://library.constantcontact.com/download/get/file/1109615552347-349/CalMHSA_Contra_Costa_FINAL.pdf

[63] This is a social service program designed "to reverse the impact of discrimination, strengthen families and build community." But the purpose of MHSA is to help people with mental illness.
http://library.constantcontact.com/download/get/file/1109615552347-349/CalMHSA_Contra_Costa_FINAL.pdf

serious mental illness like schizophrenia and bipolar.[64]

- **Fresno County** used MHSA funds for
  - What stakeholders wanted, even when inconsistent with the legislation and it prevents programs for seriously mentally ill from being funded.[65]
  - To expand outpatient services for children who are not seriously emotionally disturbed ($750,000).
  - Community Garden ($40,000)[66]

- **Imperial County** used MHSA funds
  - For people experiencing trauma, child or domestic abuse, chronic neglect, enduring deprivation and poverty, homelessness, violence (personal or witnessed), racism and discrimination, intergenerational or historical trauma, the experience of refugees fleeing war and violence, loss of loved ones, and natural and human disasters.[67]

- **King County** spends MHSA funds
  - on children in "stressed families".[68]
  - on youth reading below grade level.[69]
  - RESTATE. This is an $800,000 program operated jointly with Tulare County and alternatively describe as a stigma and discrimination reduction program or a suicide prevention program.[70] It is basically an arts project that lets kids create a PSA. It is based on "Mental Health First Aid, a non-evidence based highly criticized approach.[71]

- **Los Angeles** (Also see "The Failed Stakeholder Process: LA County as Case Study"[72]) Los Angeles is using MHSA funds for
  - Triple P Parenting Skills"[73] is being funded on Los Angeles, Shasta, and other counties. It is designed to reduce child abuse. In addition to not being a mental illness program, extensive research has been published

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[64] It would, perhaps, arguably, be appropriate to have specialized (rather than mainstreamed) mental illness services for members of the LGBTG community, but there is no indication the services being provided by the county are for those with mental illness.

[65] (Behavioral Health Director) "Thornton said he would like more of the Mental Health Services Act money to treat people with severe mental illness. With county budgets tight, he said, the priorities should be "crisis first, treatment and then early intervention, prevention. Evans said the county plan isn't perfect, but it is a compromise between what the community wants and what the staff sees as gaps in the system "It's all a compromise," she said. The quote appeared in the January 6, 2013 Fresno Bee formerly available at http://www.fresnobee.com/2013/01/06/3124110/fresno-county-mental-health-projects.html (accessed 1/7/13)

[66] "The county would add a seventh community garden to six already in operation at a cost of about $40,000." The quote is believed to be from the January 6, 2013 Fresno Bee formerly available at http://www.fresnobee.com/2013/01/06/3124110/fresno-county-mental-health-projects.html (accessed 1/7/13) What is especially disturbing is that funding gardens in lieu of services for people with mental illness, had already come under public scrutiny at this time. However the commissioner was not worried about being audited. "Taylor said she wouldn't be concerned if the state audited the gardens. But that is unlikely to happen, because the state selected three counties to review, and Sacramento County was chosen in the Central Valley, she said.

[67] "Trauma" is common. Everyone loses a loved one. Funds may not be spent to 'reduce trauma' however, they may be spent to treat PTSD if that occurs.
http://www.mhsoac.ca.gov/MHSOAC_Publications/docs/PressReleases/2011/PEITrendsReport_05-11-11.pdf

[68] http://www.co.kern.ca.us/artman2/kcmh/uploads/1/1MHSA_Update_Cover_12-13post3.pdf

[69] This was funded with Innovative funds. Innovative Services funds must have a nexus to the overall intent of MHSA to help people with serious mental illness. Few who are reading below grade level will develop a "serious mental illness". Improving reading does not "prevent mental illness from becoming severe and disabling." It is a classic example of a worthy social service program masquerading as a mental illness program in order to access funds not intended for them.
http://mhsoac.ca.gov/Counties/Innovation/docs/InnovationPlans/INN_Kings_020911.pdf

[70] http://www.sptf.org/english/index.cfm/programs/restate/ and http://www.hanfordsentinel.com/news/local/programs-target-teen-suicide-mental-health/article_bd82bf6e-63f4-11e2-9d10-001a4bcf887a.html

[71] We have seen no evidence it helps persons with serious mental illness, although no doubt the kids enjoy creating the PSAs and the arts departments of the participating schools appreciate the additional funding. The website alludes to the fact that this is part of the Mental Health First Aid USA, a commercially available program distributed by various non-profits. Mental Health First Aid is non-evidence based. Thirty six of the 55 peer reviewed articles on Mental Health First Aid were authored or co-authored by the vendors of the approach. A 2005 study of Mental Health First Aid found "There has not yet been an evaluation of the effects on those who are the recipients of the first aid" and acknowledged, "Perhaps the most important unanswered question is the benefits of being a recipient of MHFA" Mental Health First Aid does not appear on SAMHSA's National Registry of Evidence Based Practices.

[72] In other budget documents, LA County claims to have spent $80 million on housing for seriously mentally ill. We would be interested in, but did not have time to determine, if any of the promised housing was built or- to ascertain the diagnosis of those provided housing. See http://www.hacla.org/en/cms/7931/

[73] http://www.redding.com/news/2012/nov/08/shasta-county-child-abuse-rate-climbs-twice-state/

showing Triple P is ineffective.[74]
  - "emotional recovery" centers, "stigma" campaigns, tuition reimbursement programs, market research, employment offices[75]
  - Student 'well-being' massage chairs, Zumba classes, a meditation room and a biofeedback lab ($230,000)[76]
  - Populations that may or may not have mental illness such as Children/youth at risk for school failure and children/youth at risk of or experiencing juvenile justice involvement"[77]
  - Free Your Mind Radio Show [78]
  - Unsuccessful employment training programs[79]

Case Study: Laura's Law a Good Program Being Funded with PEI Funds in Los Angeles. While this appendix lists inappropriate spending, we do note that Los Angeles has a tiny pseudo-Laura's Law program being very appropriately funded with MHSA funds. LA should expand this program by cutting the misspending identified above. Using their version of Laura's Law, Los Angeles reduced incarceration of people with the most serious mental illnesses 78%; reduced hospitalization 86%; and reduced hospitalization 77% even after discharge

- **Marin County** is using MHSA funds for
  - Teen Screen.[80] Teen screen has proven to be ineffective at reducing teen suicide.[81]
  - Triple P Parenting.[82] See discussion under Los Angeles County for lack of evidence program is effective.

- **Merced County** is using MHSA funds for
  - To host a Halloween event at Yosemite Lake, a Multicultural Celebration, Thanksgiving Lunch, Winter Celebration, Cinco de Mayo Celebration, Black History Month, the Hmong Harvest Celebration and... Mental Health Month Picnic at the Lake."[83]
  - Caring Kids.[84] It teaches skills to parents of children 0 – 5 years old. Funding the program with mental health dollars is almost offensive because it suggests parents cause mental illness and that by teaching parents skills they will not cause the mental illness.[85]

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[74] Thirty two of the thirty three studies purporting to show it works were by the same people who created the program. A meta study "found no convincing evidence that Triple P interventions work across the whole population or that any benefits are long-term. The "evidence' for it turned out to lack validity. See "Triple P-Positive Parenting programs: the folly of basing social policy on underpowered flawed studies" published in BMC. Available via NIMH at http://www.ncbi.nlm.nih.gov/pubmed/23324495. Also see "How evidence-based is an 'evidence-based parenting program'? A PRISMA systematic review and meta-analysis of Triple P." available via NIMH at http://www.ncbi.nlm.nih.gov/pubmed/23121760. See meta-study at http://www.biomedcentral.com/content/pdf/1741-7015-10-130.pdf

[75] These arguably benefit the least "severely" ill but inarguably don't benefit the most "severely" ill http://ceo.lacounty.gov/ccp/mhsa_pei.htm#GI! And http://lacdmh.lacounty.gov/News/Publications/Enews/Documents/APR1411ENEWS.html

[76] http://blogs.laweekly.com/informer/2012/07/california_tax_for_mentally_ill_massage_chairs_zumba_socal.php and http://www.namicalifornia.org/uploads/eng/mhsa full report.pdf

[77] http://www.freeyourmindprojects.com/static-pages/about-us/#.UDTo044Zy70

[78] It allows recipients of MHSA funding to go on radio to say how important their work is. In the promo materials, they readily admit this is for the 'one in four' who have mental health issues, rather than the 5-9% with serious mental illness identified as being a priority population in MHSA legislation (who would be hard to reach by radio shows).

[79] At an MHSOAC board meeting a Los Angeles FSP Program Manager admitted the L.A. job training program had only increased employment days 4.2 percent and that was mainly due to government creating jobs versus any private sector jobs being created. See http://lacdmh.lacounty.gov/News/Publications/Enews/Documents/APR1411ENEWS.html and http://www.mhsoac.ca.gov/meetings/docs/PriorMeetingMinutes/2011/MinutesApproved_Sept2011.pdf

[80] http://www.co.marin.ca.us/depts/HH/main/mh/mhsa/MHSA%20PEI%20fund%20shift%20to%20Prudent%20Reserve%20June%202012.pdf

[81] "On 15 November, TeenScreen, a program to detect depression in young people, announced on its website: "The National Center will be winding down its program at the end of this year. The center did not give a reason for the closure of its multimillion dollar project, nor did anyone from TeenScreen respond to inquiries by the BMJ. Critics of the program said that the test had not been proven to reduce suicides and that an analysis by its inventor, David Shaffer, showed that the computer based screening test had a positive predictive value of only 16%. Direct and indirect ties between the drug industry and TeenScreen fueled the concerns of critics that the program would inevitably cause more children, including preschoolers, to be treated with antidepressant drugs." http://www.bmj.com/content/345/bmj.e8100

[82] http://www.co.marin.ca.us/depts/HH/main/mh/mhsa/MHSA%20PEI%20fund%20shift%20to%20Prudent%20Reserve%20June%202012.pdf

[83] http://www.co.merced.ca.us/pdfs/mentalhealth/mhsa/mhsa_annual_update_2012_2013.pdf

[84] http://blogs.webmd.com/childrens-health/2012/08/study-links

[85] The program claims to have made the following positive impacts, not having to do with preventing serious mental illness. "Parents, Child Care Providers, and Teachers have learned new ways to manage children's behavior. Our support groups have helped parents learn new parenting skills. Parents have learned about how children grow. Parents have learned better ways to discipline their children. Parents have learned to share experiences and feelings with other parents. Parents have learned about information on community

- **Nevada County** uses MHSA funds for

> **Case Study: Laura's Law: A good program in Nevada County** By using MHSA funds to allow individuals under court orders access to existing programs Nevada County served the most seriously mentally ill and decreased number of Psychiatric Hospital Days 46.7%; number of Incarceration Days 65.1%, number of Homeless Days 61.9%; number of Emergency Interventions 44.1%. Laura's Law implementation saved $1.81-$.2.52 for ever dollar spent and "receiving services under Laura's Law caused a reduction in *actual* hospital costs of $213,300 and a reduction in *actual* incarceration costs of $75,600 (http://lauras-law.org/states/california/llresultsin2counties.html)

- **Orange County** is using MHSA funds
  - Wellness Centers specifically for those "who have achieved a high level of recovery," Groups to improve "personalized socialization," relationship building, and exploring educational opportunities.[86]
  - Teen Screen, an ineffective teen suicide program. See Marin County for a discussion of Teen Screen.
  - High end annual report with no data on where the money went.[87]

- **Placer County** received numerous critical comments about their use of MHSA funds for social services masquerading as mental illness programs. They did not address them.[88] MHSA uses MHSA funds for
  - "Youth Council: What is Success Video Project[89].
  - "Ready for Success: Incredible Years", and "Parent Project."[90] These programs allegedly strengthen parenting competencies but are not related to mental illness. It is now well established that having bad parents does not cause serious mental illnesses like schizophrenia and bipolar disorder.
  - "Positive Indian Parenting"[91]
  - "Native Youth Development Program"
  - To "prevent mental illness".[92] No one knows how to do that.
  - Native Culture Camps
  - "Life Skills Training", a substance abuse prevention program[93]. Substance abuse programs (except for those with mental illness) were specifically excluded from the MHSA Legislation.[94]
  - "Teaching Pro Social Skills" teaches kids about teasing, embarrassment, and expressing feelings.[95]
  - Adventure Risk Challenge (ARC) a literacy program.[96]

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resources and services. Parents have learned to take better care of themselves. Parents have learned better ways to handle stress. Child Care Providers have learned new ways to promote attachment and bonding."

[86] http://ochealthinfo.com/docs/newsletters/recoveryconnection/2008-2010-RecoveryConnection.pdf

[87] http://ochealthinfo.com/docs/behavioral/mhsa/Resources/Reports/MHSA_5_Year_Booklet_WEB.pdf

[88] Ex. Dr. Frank Lozano asked for "hard data" for number of individuals seen/program and the results of their time spent under the guidance of Placer Mental Health". He also noted several programs were social services programs. Gayle Smullen of NAMI Placer County reported on the lack of programs for people with serious mental illness, and the preponderance of social service programs for non mentally ill being funded with Placer County MHSA funds. He did not receive an adequate response. Sharen Neal of Placer County NAMI noted that Placer county focused its PEI resources on children, when serious mental illness does not manifest itself until teens and twenties. Focusing on children left those most likely to develop mental illness least likely to be served. The response of Placer County authorities was inadequate, avoided the issue, and frequently blamed the Oversight Commission for the problems by saying they were due to their direction. See last pages of comments at http://www.campaignforcommunitywellness.org/wp-content/uploads/2012/12/MHSA12-13AnnualUpdateFINALtoBOS.pdf

[89] Page 11 at http://www.campaignforcommunitywellness.org/wp-content/uploads/2012/12/MHSA12-13AnnualUpdateFINALtoBOS.pdf

[90] Page 7 at http://www.campaignforcommunitywellness.org/wp-content/uploads/2012/12/MHSA12-13AnnualUpdateFINALtoBOS.pdf . Note that a large percentage of parents dropped out of the program.

[91] Page 8 at http://www.campaignforcommunitywellness.org/wp-content/uploads/2012/12/MHSA12-13AnnualUpdateFINALtoBOS.pdf

[92] http://www.sierrasun.com/article/20120625/COMMUNITY/120629945/1066&ParentProfile=1051

[93] http://www.campaignforcommunitywellness.org/wp-content/uploads/2012/12/MHSA12-13AnnualUpdateFINALtoBOS.pdf

[94] September 22, 2012 MHSOAC Board Minutes, MHSOAC "Commissioner Horn commented that …the reason co-occurring disorders were not mentioned in the MHSA was because during the Proposition 63 focus groups they were informed that using that language would lead to the defeat of the proposition" He then went on to express the importance of doing it anyway. This program is the result of that thought process. Minutes of MHSOAC Board Meeting September 22, 2011. Available at http://www.mhsoac.ca.gov/meetings/docs/PriorMeetingMinutes/2011/MinutesApproved_Sept2011.pdf Accessed 6/24/12

[95] Page 10 at http://www.campaignforcommunitywellness.org/wp-content/uploads/2012/12/MHSA12-13AnnualUpdateFINALtoBOS.pdf

[96] http://www.namicalifornia.org/uploads/eng/mhsa%20full%20report.pdf

- "What is Success" Video Project "to send the message to Middle and High School students that everyone has the ability to choose what success means to them and that it is never too late to start working towards your own goals."[97]

- **Riverside County** is using MHSA funds for
  - Parenting Program for Latina mothers ($2,958,317).[98]

- **Sacramento** is using MHSA Innovation Funds to
  - Provide "culturally sensitive help to all generations" (United lu-Mien)[99]. Not a mental illness program.[100]
  - Reduce Bullying[101]
  - Reduce Violence[102]
  - Increase Social Connectedness[103]
  - Help 12-26 year olds "to gain positive, proactive, successful life skills"[104]
  - "To improve the well being of caregivers" (Del Oro Caregiver Resource Center[105]). The caregivers being helped are caregivers for persons with dementia, not mental illness
  - Reduce stigma and promote mental health in population not identified by MHSA[106]
  - Capital Adoptive Families[107]. This organization supports adoptive parents and does not have the tight nexus to helping people with serious mental illness.
  - "Strengthening Families Project". Within this program are "Quality Child Care Collaborative", "HEARTS for Kids", "Bullying Prevention Education and Training", "Early Violence Intervention Begins With Education" and "Independent Living Program 2.0". When presented at the May Mental Health Board meeting a participant correctly noted these were social services programs and ineligible for MHSA funding. They were told, "when the public hearing were held on these programs, the community wanted them"[108]

- **San Bernandino County** is using MHSA Funds to
  - Reduce teen prostitution $895,000.[109]
  - Acupuncture and acupressure, teach art classes, equine therapy, tai-chi and zumba to the general public; and an LGBT prom.[110]
  - Interagency Youth Resiliency Team.[111] It "employs former foster and probation youth to serve as mentors to "system involved" youth ages 13 - 21.[112]

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[97] http://www.campaignforcommunitywellness.org/wp-content/uploads/2012/12/MHSA12-13AnnualUpdateFINALtoBOS.pdf

[98] While a worthy program, there is no evidence that serious mental illness is caused by parents (other than possibly genetically). Attaching the word 'mood' or "mental" to a program does not turn a program that helps people with mental illness. http://blogs.laweekly.com/informer/2012/07/california_tax_for_mentally_ill_massage_chairs_zumba_socal.php

[99] http://www.sacbee.com/2012/11/30/5021702/grants-aid-four-sacramento-county.html

[100] We could not find the term "mentally" or "mental" used once. This suggests to us the funds will not be used for mentally ill.

[101] Page 23 at http://www.dhhs.saccounty.net/BHS/Documents/Reports--Workplans/MHSA-Reports-and-Workplans/RT-2013-14-MHSA-Annual-Update--Sacramento-County.pdf

[102] Page 27 at http://www.dhhs.saccounty.net/BHS/Documents/Reports--Workplans/MHSA-Reports-and-Workplans/RT-2013-14-MHSA-Annual-Update--Sacramento-County.pdf

[103] Page 24 at http://www.dhhs.saccounty.net/BHS/Documents/Reports--Workplans/MHSA-Reports-and-Workplans/RT-2013-14-MHSA-Annual-Update--Sacramento-County.pdf

[104] Page 27 at http://www.dhhs.saccounty.net/BHS/Documents/Reports--Workplans/MHSA-Reports-and-Workplans/RT-2013-14-MHSA-Annual-Update--Sacramento-County.pdf

[105] http://www.sacbee.com/2012/11/30/5021702/grants-aid-four-sacramento-county.html

[106] Page 28 has a 'mental health promotion' project that features a web site http://www.stopstigmasacramento.org Note that the site addresses the 1 in four with mental health issues. But MHSA has specific language saying it is not for one in four (25%) of population, it is only for the 9% with the most serious mental illnesses. It also includes info designed to minimize and confuse the public about the incidence of violence. http://www.dhhs.saccounty.net/BHS/Documents/Reports--Workplans/MHSA-Reports-and-Workplans/RT-2013-14-MHSA-Annual-Update--Sacramento-County.pdf

[107] http://www.sacbee.com/2012/11/30/5021702/grants-aid-four-sacramento-county.html

[108] Reported to us by an attendee who requested anonymity.

[109] http://www.sbcounty.gov/dbh/Announcments/2010/Innovation%20Plan%20Final%202-8-10.pdf

[110] http://blogs.laweekly.com/informer/2012/07/california_tax_for_mentally_ill_massage_chairs_zumba_socal.php

[111] http://www.marketwatch.com/story/foster-youth-prepares-for-adulthood-with-help-from-new-mentor-program-from-emq-familiesfirst-2012-11-18

[112] That is a worthy social service program, but it is not a program that reduces the duration of untreated mental illness or prevents mental illness from becoming severe and disabling. The PR announcement for it does not mention mental illness or mental health (except to state MHSA funds are being used for it) A PowerPoint explaining who IYRT serves is at http://emqff.org/about/docs/FY12_agency-wide_report_pp_final.pdf . Page 8, shows that only 2% of the population they serve have psychotic disorders (serious mental illness)

- **San Diego** is using MHSA funds[113]
    - To reduce gang violence
    - Triple P Parenting Program, a program proven unsuccessful at reducing child abuse
    - "Reaching Out", a program for those with Alzheimer's

- **San Francisco** is using MHSA funds
    - for yoga, line dancing and drumming.[114]
    - 90 minute movie about mental health (not mental illness).[115] It was shown at a community center and funded by MHA/SF, a large recipient of MHSA funds. MHA/SF Exec. Dir. Is on the Oversight Commission. While videos and movies are fun to make it is hard to see how making these movies should trump delivering services to people with mental illness.

- **San Luis Obispo County** uses MHSA funds for
    - employment programs [116]
    - To help "Tens of thousands" rather than people with serious mental illness.[117]

- **Shasta County** is using MHSA funds for
    - A Gatekeeper program to improve services for the elderly.[118]
    - Triple P Parenting program. See "Los Angeles" County above for information showing Triple P has no scientific basis and is unproven. Shasta is a good example of how the stakeholder process was used to gain funding for this program in spite of its lack of efficacy.[119]
    - Reducing "Adverse Childhood Experiences"[120]

- **Stanislaus County** is using MHSA funds for
    - "Arts for Freedom"[121] an art show for people who want to display their art.
    - Stanislaus considered a good program, but we don't know if they ever followed through on it. "*Stanislaus Count officials are talking with local hospitals about forming crisis teams to stabilize patients who are considering suicide or having psychotic symptoms. The units with staff able to prescribe medication would choose people with the best chances of being stabilized, so they can return home and not be admitted to Doctors Behavioral Health Center on Claus Road.*[122]

- **Tehema County is using MHSA funds for**
    - Teen Screen, an ineffective program designed to reduce teen suicide[123]
    - Drumming Circles[124]

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[113] http://sandiego.camhsa.org/files/PEI-Prg-Serv-Summ-Current.pdf

[114] http://www.sfdph.org/dph/comupg/oservices/mentalHlth/MHSA/FY11_12AnnualPlanUpdate_03012011.pdf

[115] http://www.mentalhealthsf.org/programs/solve/

[116] They are not for people who have mental illness, but are for "Transitional Age Youths" (TAYs) The County justifies the expenditures by claiming the groups are underserved in the County; they are likely to have experienced numerous traumatic events and be vulnerable to developing mental illness, substance abuse, *domestic violence, homelessness, criminal activity, and unemployment*. Trauma (losing a loved one, seeing something untoward) happens to many people and rarely ever results in a mental illness. http://www.mhsoac.ca.gov/MHSOAC_Publications/docs/PressReleases/2011/PEITrendsReport_05-11-11.pdf

[117] The director of Behavioral Health in SLO claims MHSA is helping tens of thousands in her county. http://www.sanluisobispo.com/2011/07/12/1680175/viewpoint-our-mentally-ill-deserve.html

[118] http://www.redding.com/news/2012/nov/07/senior-living-gatekeeper-program-keeps-eye-out/

[119] Shasta County claims that Triple P got on the list of funded programs because "During MHSA's stakeholder input process, community members ranked children and youth in stressed families as the #1 population to work with in preventing mental illness". It is true that reducing stress in families of people with mental illness can improve the course of outcome. However, there is no science that says stress causes mental illness, or reducing stress in families of people without mental illness lowers the incidence of mental illness. This is a worthy social service program masquerading as a mental health program to access MHSA funds. http://media.redding.com/media/static/Annual_Report_7th_FINAL.pdf. See description of Triple P under LA County.

[120] http://www.mhsoac.ca.gov/Counties/PEI/docs/PEIplans/ShastaPEIPlan.pdf and http://media.redding.com/media/static/Annual_Report_7th_FINAL.pdf

[121] http://www.stanislausmhsa.com/pdf/public/INN%20Project%20Brief%20Descriptions%20Posted_8.25.11.pdf and http://www.modbee.com/2012/04/25/2173965/county-promotes-mental-health.html

[122] http://www.modbee.com/2012/11/11/2451993/stanislaus-county-mental-health.html We don't know if this was ever implemented or if merely exists in press release form.

[123] http://www.mhsoac.ca.gov/Counties/PEI/docs/PEIplans/PEI_Tehama_Final_2-1-10.pdf. See Marin County for Teen Screen discussion.

[124] http://www.namicalifornia.org/uploads/eng/mhsa%20full%20report.pdf

- **Tulare County** used MHSA funds for
    - farming webinar for dairy farmers who, due to the current economic state, are experiencing a downturn in milk prices.[125]
    - RESTATE. This is an $800,000 program operated jointly with King County and alternatively describe as a stigma and discrimination reduction program or a suicide prevention program. See discussion under King County on this being an ineffective non-evidenced based program that seems to move MHSA funds from helping persons with mental illness to funding school art departments.

[125] http://www.mhsoac.ca.gov/MHSOAC_Publications/docs/PressReleases/2011/PEITrendsReport_05-11-11.pdf (Page 14)

Full Service Partnerships: $2.5 billion unaccounted for

Background: MHSA was intended to expand successful existing programs.[126] Full Service Partnerships (FSP) were not an existing program and do not appear in California law or MHSA legislation. After Proposition 63 passed, the California Department of Mental Health created a broad definition of them:

> *"the collaborative relationship between the County and the client, and when appropriate the client's family, through which the County plans for and provides the full spectrum of community services so that the client can achieve the identified goals."*[127]

FSPs are colloquially described as "doing whatever it takes", albeit only for voluntary patients. As a result of direction to spend money on FSPs,[128] $2.5 billion went to FSPs instead of existing programs that had already proven their effectiveness.[129] FSPs are serving some people with serious mental illness and doing a good job. FSPs are only voluntary, and therefore exclude many of the most seriously ill, like those who are psychotic. No information is collected or reported on the diagnosis of those being served. It is unclear how many of the individuals in FSPs have serious mental illnesses like schizophrenia or bipolar disorder or if FSPs are better than the existing programs that failed to receive funding as a result of the prioritization of FSPs.

Problems

1. Zero oversight to ensure people enrolled in FSPs have schizophrenia, bipolar disorder or other serious mental illness.

The Oversight Commission collects extensive information on age, ethnicity, sexual orientation of FSP enrollees, but not diagnosis.[130] Thus, there is no way to know whether the $2.5 billion FSP initiative is serving people with serious mental illness as required by the legislation.

Partially in response to growing public concerns, MHSOAC did contract with UCLA, a large recipient of MHSA funds for a report on FSPs.[131]

- Before releasing the report, at the request of the commission and others, the UCLA authors amended the supposedly independent report to "focus on positive outcomes".[132]
- The report intentionally and knowingly overstated cost savings from incarceration by allocating fixed costs (which do not change due to number of people served) to each patient and calculating it as savings.[133]
- In order to "prove" FSPs save money, the UCLA authors added 'physical health' savings--a welcome, secondary, but not primary goal of MHSA, and a goal that can be readily achieved by serving people with physical illnesses rather than serious mental illnesses.
- The report recommended more studies be conducted the result of which would send more money to programs associated with the commissioners.
- The UCLA report did not include any information of diagnosis of participants.
- The UCLA report did not reveal the multiple regulations that make many of the most seriously mentally ill ineligible

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[126] "The legislature found "By expanding programs that have demonstrated their effectiveness, California can save lives and money" (Findings and Declarations (f)). The Purpose and Intent of the law was "To expand the kinds of successful, innovative service programs for children, adults and seniors begun in California"

[127] Emergency regulation in Cal. Admin. Code tit. 9, § 3200.130

[128] Because FSPs were an unproven new program it might have been appropriate to spend Innovative Funds on them. 5% of MHSA funds are set aside for Innovative New Programs. Instead, massive general funding was mandated to be used. See direction at http://www.dmh.ca.gov/DMHDocs/docs/letters05/05-05CSS.pdf

[129] MHSOAC allocated 51% of all CSS funds which are 50% of all MHSA funds to them, making FSPs the largest MHSA expenditure. If MHSA raised $10 billion since inception, $2.5 billion were spent on FSPs.

[130] Diagnosis information would be available via MediCal or anonymized questionnaires.

[131] "Full Service Partnerships: California's Commitment to Support Children and Transition-Age Youth with Serious Emotional Disturbance and Adults and Older Adults with Serious Mental Illness" prepared by UCLA Center for Healthier Children, Youth and Families (10/31/12). Available at http://mhsoac.ca.gov/Meetings/docs/Meetings/2012/Nov/OAC_111512_Tab4_MHSA_CostOffset_Report_FSP.pdf

[132] See page 4 of UCLA Report.

[133] See discussion by Commissioner Brown (who represents law enforcement on the commission) starting on page 16 of November 2012 Oversight Commission Board meeting minutes. Among other comments, Commissioner Brown noted the use of fixed versus variable costs and correctly stated, "(T)hat that is not an accurate measure of cost savings and may taint the rest of the report in terms of what savings are achieved. This report will be open to criticism regarding the types of cost savings indicated. Additionally, there is a disparity where Los Angeles used a figure of over $1,000 a day when every other county used a figure substantially lower." "Available at http://mhsoac.ca.gov/Meetings/docs/Meetings/2013/OAC_012413_Tab1_Minutes111512.pdf

for FSP services or that FSPs were only serving those well enough to volunteer.

Oversight Commissioners used the UCLA report to declare their stewardship of FSP programs a success.

2. FSPs exclude many of the most seriously ill. They only serve those well enough to recognize they are ill.

Regulations were issued that required MHSA funded programs to be designed for voluntary patients only.[134] This made the most seriously ill ineligible for FSPs. Up to 40% of those with bipolar disorder and 50% of those with schizophrenia are so ill, they don't know they are ill (anosognosia).[135] For example, a homeless person yelling they are the Messiah, or screaming the FBI planted a transmitter in their head would not likely be well enough to volunteer for services. These individuals are excluded from FSPs. Doing 'whatever it takes', should extend to helping people who lack awareness of their illness.[136] See Appendix D flow charts show the steps programs are skipping when determining if someone qualifies for MHSA-funded support.[137]

4. To fund FSPs, programs that that help people with serious mental illness who are homeless were left unfunded.

Proponents of Full Service Partnerships claim FSPs *are* referred to in MHSA because the Finding and Declarations reference AB 34 programs.[138] The population served by AB 34 Existing Systems of Care programs are "**severely mentally ill** adults who are **homeless, recently released from a county jail or state prison**, or otherwise at risk of homelessness or incarceration."[139] There is no indication FSPs are serving the same population as AB-34 programs. In fact, since 2007, "the proportion of prison inmates with mental illnesses has grown from 19 percent in 2007 to 26 percent now".[140]

AB 34 programs reduced the number of consumers hospitalized, 42.3%; number of hospital admissions, 28.4%; number of hospital days, 55.8%; number of consumers incarcerated, 58.3%; number of incarcerations, 45.9%; number of incarceration days, 72.1%; number of consumers who were homeless, 73%; and many other barometers of success.[141] They deserve equal or better funding than FSPs.

4. The FSP model may help higher functioning get housing but is least successful at helping people with schizophrenia and bipolar disorder get housing—the two most serious mental illnesses.[142]

Conclusion:
$2.5 billion is spent on FSPs without any oversight of whether they are serving eligible individuals. FSPs exclude many of the most seriously ill.

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[134] CCR Title 9 Regulation 3400(b)
(b) Programs and/or services provided with MHSA funds shall…(2) be designed for voluntary participation" While the regulation went on to state, "No person shall be denied access based solely on his/her voluntary or involuntary status" the use of MHSA funds to prevent implementation of Laura's Law has obviated that option.

[135] See anosognosia at http://mentalillnesspolicy.org/medical/anosognosia-studies.html

[136] One way around this conundrum would be for counties to implement Laura's Law.

[137] Flow charts: Impact of the Full Service Partnership Programs on Independent Living. Nicholas C. Petris Center on Health Care Markets and Consumer Welfare School of Public Health University of California, Berkeley May 2010

[138] Findings and Declarations (b): A recent innovative approach, begun under Assembly Bill 34 in 1999, was recognized in 2003 as a model program by the President's Commission on Mental Health[138]. This program combines prevention services with a full range of integrated services to treat the whole person, with the goal of self sufficiency for those who may have otherwise faced homelessness or dependence on the state for years to come.

[139] Legislative analysis at http://www.leginfo.ca.gov/pub/99-00/bill/asm/ab_0001-0050/ab_34_cfa_19990816_185010_sen_comm.html

[140] Associated Press. California Mental Health Dollars Bypass Mentally Ill , July 28, 2012 as published in Sacramento Bee.

[141] http://www.homebaseccc.org/PDFs/CATenYearPlan/CAHighlightOutreach.pdf

[142] Schizophrenia and bipolar disorder are two of the most serious mental illnesses. The housing initiatives funded by MHSA help people with those disorders the least. *"The Impact of the Full Service Partnership Programs on Independent Living* found *"not having schizophrenia or bipolar disorder*" led to increased likelihood of independent living." *Nicholas C. Petris Center on Health Care Markets and Consumer Welfare School of Public Health University of California, Berkeley . "The Impact of the Full Service Partnership Programs on Independent Living: A Markov Analysis of Residential Transitions" Petris Report # 2010-3. Available at http://www.dmh.ca.gov/Prop_63/MHSA/Publications/docs/3_Petris_Residential_Report_Final.pdf*

Insider Dealing: $23 million diverted to organizations associated with Oversight Commission

Summary

Over $23 million in Mental Health Services Act (MHSA) funds are going to organizations currently or formerly run by those responsible for oversight of the expenditures. This may be a violation of California's conflict-of-interest laws and raises questions about whether MHSA funds are being spent appropriately. Some of the funds are being used to prevent people with serious mental illness from receiving treatment.

Background

Proposition 63 established the MHSA fund to provide services to individuals with "serious mental illness" and prevent those "with mental illness" from having it become "severe and disabling". Proposition 63 also established the Mental Health Services Oversight and Accountability Commission (Oversight Commission) to approve certain MHSA expenditures which are distributed by the Oversight Commission directly; or presented to them for approval as part of county mental health plans or via the California Mental Health Services Authority (CalMHSA), a Joint Power Authority that pools the resources of individual counties.

Methodology

We examined the 2011 "Prevention and Early Intervention" (PEI) component of MHSA which represents 20% of overall MHSA funds. We did not look for potential insider dealing in the other 80% or in prior years. To determine who received PEI funds we examined the 2011 CalMHSA Funding Report which includes PEI grants by dollar amounts[143] and a list of PEI programs funded by MHSA which does not include dollar amounts.[144] We then went to the websites of the organizations that received the funds to determine who sat on their boards of directors and in key staff positions. Finally, we compared the boards and staff of fund recipients with the names of those who serve the oversight commission.[145]

Findings

Rusty Selix - $5.92 million

Mr. Selix is on the MHSOAC Mental Health Funding and Policy Committee and Evaluation Committee[146]. During the period of the study, he was Executive Director of Mental Health America of California (MHAC).[147] MHSOAC commissioners approved one grant for $3 million and another for $2.92 million to MHA of San Francisco a chapter of MHAC. Other chapters of MHAC that had their grants approved by oversight commissioners include MHA Orange County (two grants); MHA LA (2 grants); MHA of SLO; and MHA Sutter-Yuba.

Mr. Selix is Executive Director of the California Council of Community Mental Health Agencies (CCCMHA).[148] CCCMHA members receive MHSA funds. (See Richard Van Horn, below.) Mr. Selix received $681,758 in compensation from CCCMHA (per CCCMHA 2010 990 IRS form).

Richard Van Horn - $11 million

During the period of our study, Mr. Van Horn was the MHSOAC Vice-Chair[149] and on the board of California Council of Community Mental Health Agencies (CCCMHA) a trade association representing providers of community mental "health" services.[150] Rusty Selix is Executive Director and received $681,758 in compensation. MHSOAC commissioners approved $2 million to go to CCCMHA member Didi Hirsch Psychiatric Services. They approved $9 million to be split between CCCMHA members Transitions Mental Health Association, Kings View Corporation and others. The MHSOAC commissioners approved grants for the following CCCMHA members: Anka Behavioral Health; Bonita House (2 grants); Buckelew Programs; Chamberlain's Mental Health Services; Edgewood Center for Children and Families; EMQ Families First (3 grants); Fred Finch Youth Center (2 grants); La Clinica de La Raza; Pacific Clinics (3 grants); Rubicon Programs; San Fernando Valley Community Mental Health Center; Seneca Center; Social Model Recovery Systems: and Tulare Youth Service Bureau.

Mr. Van Horn has also been President and Chief Executive Officer (CEO) of the Mental Health America of

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[143] http://www.mhsoac.ca.gov/Meetings/docs/Meetings/2011/Jul/OAC_072811_Tab3_CalMHSA_StatusReport.pdf Accessed 7/23/13

[144] http://www.namicalifornia.org/uploads/eng/mhsa full report.pdf Accessed 7/23/13

[145] While many of these grants were given out by counties and CalMHSA, all were required to be reviewed and approved by the Oversight Commissioners. In addition, counties and CalMHSA, are dependent on the commission to approve other grants they make which would give them an incentive to curry favor with the oversight commissioners.

[146] http://www.mhsoac.ca.gov/Committees/docs/Charters/2012/MHFPC_Charter_2012.pdf

[147] http://www.mhac.org/advocacy/key_leaders.cfm Accessed 7/23/13

[148] http://www.cccmha.org/aboutus.html Accessed 7/23/13

[149] http://www.mhsoac.ca.gov/About_MHSOAC/Commissioner_Bios.aspx Accessed 7/23/13.

[150] http://www.cccmha.org/ourMembers.html

Los Angeles[151] which received at least two grants. MHALA paid Mr. Van Horn $111,175 (per 2009 990 IRS form) Mr. Van Horn is a member of the board of the Mental Health Association of California (See grants listed under Selix).

Eduardo Vega - $2.9 million
During the period of this report, Mr. Vega was an MHSOAC Commissioner. He is on the board of directors of Disability Rights California[152] a special interest law firm active in preventing counties from using Laura's Law, to help persons with serious mental illness[153]. DRC received a $2.9 million grant approved by Mr. Vega and the other commissioners. Mr. Vega has served as the Executive Director of the Mental Health Association of San Francisco[154] that received two grants each in the $3 million range for a total of almost $6 million. Previously, he served as Associate Director of Project Return. Project Return received a MHSA grant.

Ralph Nelson Jr., M.D. - $3 million
Dr. Nelson is an MHSOAC Commissioner.[155] During the period of this report, he was president of the National Alliance on Mental Illness in California. NAMI CA received a $3 million grant of MHSA funds. Local chapters of NAMI that received MHSA funding include NAMI Sonoma and NAMI Orange County. Other NAMI chapters run programs benefiting from MHSA funds including NAMI Butte; NAMI Riverside (2 programs); NAMI San Diego (3 projects); NAMI San Mateo (2 projects); NAMI Santa Cruz; NAMI Sonoma; NAMI Stanislaus (4 projects): NAMI Ventura (2 programs;) and NAMI Amador (3 programs).

Delphine Brody and Sally Zinman - $1.5 million
During the period of this report, Delphine Brody and Sally Zinman were on numerous Oversight Commission committees.[156] Ms. Zinman founded and Ms. Brody was Director of Public Policy for the California Network of Mental Health Clients[157]. The Commissioners approved a grant of $1.5 million to CNMHC.

Mr. Selix,[158] Mr. Vega,[159] Mr. Nelson, Ms. Brody, Ms. Zinman and their organizations have all lobbied against treatment for people with the most serious mental illnesses who are so ill they are not aware they are ill. They have played a role in preventing counties from implementing Laura's Law which helps prevent people with serious mental illness from becoming violent.

[151] http://www.mhala.org/board-volunteers.htm Accessed 7/23/13
[152] http://www.disabilityrightsca.org/about/board_bios.htm Accessed 7/23/13.
[153] http://www.disabilityrightsca.org/OPR/PRAT2012/AB1421.pdf Accessed 7/23/13.
[154] http://www.mentalhealthsf.org/about-us/staff/ Accessed 7/23/13.
[155] http://www.mhsoac.ca.gov/About_MHSOAC/Commissioner_Bios.aspx. Accessed 7/23/13.
[156] http://www.mhsoac.ca.gov/Announcements/docs/AnnouncementsEvents/OAC_2011MHSOACCommitteeMembers.pdf Accessed 7/23/13
[157] http://www.mhsoac.ca.gov/Announcements/docs/AnnouncementsEvents/OAC_2011MHSOACCommitteeMembers.pdf Accessed 7/23/13
[158] http://www.pbs.org/newshour/bb/health/july-dec12/lauraslaw_12-26.html Accessed 7/12/13
[159] http://www.pbs.org/newshour/bb/health/july-dec12/lauraslaw_12-26.html Accessed 7/12/13

$9 million going to prevent counties from implementing Laura's Law

Background: Laura's Law allows courts to order--after extensive due process- very narrowly defined individuals who have serious mental illness and a past history of violence, dangerous behavior or needless hospitalizations to stay in treatment as a condition of staying in the community. It is only available "in order to prevent a relapse or deterioration that would be likely to result in grave disability or serious harm to himself or herself, or to others"[1] Laura's Law helps the most seriously ill patients. Many are so ill, they don't know they are ill and therefore refuse voluntary services.[2]

- After implementing Laura's Law with MHSA funds, Nevada County Psychiatric Hospital Days decreased 46.7 percent; number of Incarceration Days decreased 65.1 percent, number of Homeless Days decreased 61.9 percent; number of Emergency Interventions decreased 44.1 percent. Laura's Law saved $1.81-$.2.52 for ever dollar spent. "Receiving services under Laura's Law caused a reduction in *actual* hospital costs of $213,300 and *actual* incarceration costs of $75,600".[3]

- In Los Angeles using MHSA funds to implement Laura's Law reduced incarceration 78 percent; reduced hospitalization 86 percent and cut taxpayer costs 40 percent.[4] Similar results have been achieved in the other states that use it. Research shows 80% of those with serious mental illness who have actually received these types of services say they help them get well and stay well.[5] Laura's Law requires non-profit mental health organizations to accept the most seriously ill into their programs.

Problems:
Commissioners gave $9 million in MHSA funds to organizations –including their own- that are working to prevent counties from providing Laura's Law services to individuals with serious mental illness who could benefit from them.[6]

Disability Rights California – Eduardo Vega $3 million
During the period of our investigation, Disability Rights California received a $2.9 million in MHSA funds (via CalMHSA) ostensibly to "address stigma and discrimination by examining laws, policies, and practices". DRC threatens counties that are considering implementing Laura's Law[7], lobbies in favor of legislation to make Laura's Law difficult to use[8], and spreads disinformation on Laura's Law[9]. Eduardo Vega was an Oversight Commissioner and board member of Disability Rights California.

California Network of Mental Health Clients – Sally Zinman/Delphine Brody $1.5 million
During the period of our investigation, under the guise of "reducing stigma", $1,539,225 was given to California Network of Mental Health Clients, an organization that worked vigorously to prevent implementation of Laura's Law.[10] Two individuals associated with the Oversight Commission, Sally Zinman and Delphine Brody, were in CNMHC leadership positions.[11] In addition to using the funds to support their work in opposing Laura's Law, funds were diverted by other CNMHC employees to personal use.[12]

Mental Health America (MHA) Associations – $3 million (MHA/CA) and $2.9 million (MHA/SF)

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[1] Section 5346(a)(8). Extensive information on Laura's Law is available at http://lauras-law.org, a project of Mental Illness Policy Org.
[2] See Anosognosia at http://mentalillnesspolicy.org/medical/anosognosia-studies.html
[3] "The Nevada County Experienced", Michael Heggarty, http://lauras-law.org/states/california/nevada-aot-heggarty-8.pptx.pdf
[4] County of Los Angeles. "Outpatient Treatment Program Outcomes Report" April 1, 2010 – December 31, 2010. And Michael D. Antonovich, Los Angeles County Fifth District Supervisor, Los Angeles Daily News, December 12, 2011
[5] http://lauras-law.org/aot/consumers-like-aot.html
[6] Most of this money is distributed via CalMHSA, which pools county MHSA funds for statewide efforts. CalMHSA expenditures are approved by Oversight Commissioners. Read "MHSA can Fund Laura's Law" at http://lauras-law.org/states/california/ok2usemhsa4ll.pdf
[7] http://lauras-law.org/states/california/p&aopposition.pdf
[8] http://www.sfgate.com/opinion/openforum/article/Laura-s-Law-is-ineffective-3433801.php
[9] http://lauras-law.org/states/california/disability-advocates-sacbee.html
[10] See http://www.californiaclients.org/policy/policy_arguements.cfm Accessed 7/13/12
[11] Ms. Zinman founded and Ms. Brody was Director of Public Policy for the California Network of Mental Health Clients. In addition, Delphine Brody is on the MHSOAC Services Committee and Sally Zinman is on the Client and Family Leadership Committee. http://www.mhsoac.ca.gov/Announcements/docs/AnnouncementsEvents/OAC_2011MHSOACCommitteeMembers.pdf and http://www.californiaclients.org/
[12] http://www.sacbee.com/2012/11/11/4976722/3-million-in-state-contracts-yanked.html

Multiple grants went to MHA/CA and subsidiaries in San Francisco, LA and elsewhere. Rusty Selix (ED, MHA/CA) and Eduardo Vega (MHA/SF) regularly lobby against Laura's Law.[13]

[13] http://www.pbs.org/newshour/bb/health/july-dec12/lauraslaw_12-26.html

The Failed Stakeholder Process

Background
MHSA legislation codifies a stakeholder process to provide input to county MHSA plans[14]

Problems: In every county we looked into, we found the stakeholder process was fatally flawed and in most counties the process led by the county behavioral health director. The stakeholder groups were primarily composed of representatives and clients of social service and mental 'health' programs that do not serve people with serious mental illness and wanted funding for their own favored programs.

1. Professionals with experience treating and caring for the most seriously mentally ill were not part of the stakeholder process. i.e, police, sheriffs, corrections, district attorneys, inpatient doctors, inpatient nurses, doctors at homeless shelters, and others who treat the seriously ill individuals who are shunned by mental 'health' providers.
2. Stakeholders were allowed to prioritize programs that lacked evidence of efficacy or were known to be ineffective.
3. A billion dollar feeding frenzy erupted as programs tried to get MHSA funds for their own programs.
4. County behavioral health directors blindly accepted stakeholder input, even when inconsistent with the legislation.

Results:

~~2.~~1. Social Service programs that don't serve seriously mentally ill were prioritized for funding.
~~3.~~2. Programs received funding in spite of lack of evidence they work or known evidence they don't.
~~4.~~3. Programs that serve people with serious mental illness went unfunded.

Case Study: Fresno County allowed stakeholder input to trump helping people with serious mental illness:
The director of behavioral health services in Fresno County said "(H)e would like more of the Mental Health Services Act money to treat people with severe mental illness. With county budgets tight, he said, the priorities should be "crisis first, treatment and then early intervention, prevention. Evans said the county plan isn't perfect, but it is a compromise between what the community wants and what the staff sees as gaps in the system "It's all a compromise," she said. (Fresno Bee, January 6, 2013)

Case Study: Sacramento County allowed stakeholder input to trump helping people with serious mental illness.
At a Sacramento County Mental Health Board Meeting in May 2013 attendants were told about PEI "Strengthening Families Project". Within this program are Quality Child Care Collaborative, HEARTS for Kids, Bullying Prevention Education and Training, Early Violence Intervention Begins With Education and Independent Living Program 2.0. Someone noted these were social services programs and ineligible for MHSA funding. They were told, "when the public hearing were held on these programs, the community wanted them"

Case Study: Butte County allowed stakeholder input to trump helping people with serious mental illness.
Butte County's failed stakeholder process led to the funding Hmong Gardens. Butte did a study of the need for housing for people of Hmong ancestry. Eight people participated. We do not know if any had serious mental illness or if any housing was ever built. But this 'study' found that two important services for this housing that is not limited to people with mental illness are "gardens" and a "community room". The researchers aggregated the two to conclude that if they built housing, 58% wanted "community room and garden" and therefore a garden was a service that prevents mental illness from becoming severe and disabling and was included in the PEI Plan (See discussion of Butte under county misspending chapter).

[14] WIC 5848 (a) Each three-year program and expenditure plan and update shall be developed with local stakeholders including adults and seniors with severe mental illness, families of children, adults and seniors with severe mental illness, providers of services, law enforcement agencies, education, social services agencies, veterans, representatives from veterans organizations, providers of alcohol and drug services, health care organizations, and other important interests. Counties shall 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. A draft plan and update shall be prepared and circulated for review and comment for at least 30 days to representatives of stakeholder interests and any interested party who has requested a copy of the draft plans."

Los Angeles County as Case Study of Failed Stakeholder Process

LA County stakeholders were primarily those who provide social services to people without serious mental illness LA conducted an extensive, expensive stakeholder input process that included social service and 'mental health' groups who were vying for MHSA funding for their social service programs.[1] The stakeholder process included a

- A 100 member "Stakeholder Delegate Group" representing various special interests seeking funding.
- A 29 member Ad hoc "Plan to Plan Advisory Group" that included representatives of those seeking funding;
- A 28 member Ad hoc "Guidelines Advisory Group" largely comprised of those seeking funding;
- A 25 member ad hoc "PEI Plan Development Advisory Group", largely comprised of those seeking funding; and
- A 150 member "Service Area PEI Ad Hoc Steering Committee" many representing programs seeking funding.

LA County excluded stakeholders with the most expertise in serious mental illness.

- There was no input from persons with mental illness who are in inpatient units
- There was no input from mentally ill patients who live in jails or prisons. About 30% of LA County prisoners have serious mental illness. LA County Jail is the largest psychiatric facility in the state. There are 3 times as many Californians with mental illness in jails than hospitals.[2]
- We are unaware of any attempts to seek input persons with mental illness who live in shelters or are homeless.

We believe the failure to solicit and prioritize input from the most seriously ill and those who know most about the population the legislation states "deserve priority attention" led to a plan that made eligible individuals ineligible and diverted the funds to other.

LA County Behavioral Health Department misinterpreted the legislation and failed to reject stakeholder recommendations that were outside the law.

The Home Page[3] for the Los Angeles County Prevention and Early Intervention (PEI) Plan[4] states

> *The Los Angeles County Prevention and Early Intervention (PEI) Plan focuses on prevention and early intervention services, education, support, and outreach to help inform and identify individuals and their families who may be affected by* ***some level of mental health issue****" (*emphasis added).

That is incorrect. PEI funding is limited to those with mental "illness" or "serious mental illness" not "some level of mental health issue.[5] This misinformation is repeated in the 2009-2010 Plan.[6] This is not just nomenclature; there is a significant

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[1] To develop their Community Support Service (CSS) plan, LA County conducted a needs and strengths assessment with over 2000 people, conducted workgroup, and community engagement meetings involving over 11,000 participants, and conducted 17 meetings with an average participation of over 200 people; in addition to the public hearing on September 20, 2005 which drew over 400 people. While community input is to be commended, the result of that input can not be allowed to supersede the law. (See 9/25/05 letter and attachments from Marvin Southard, LA County MH Director to Board of Supervisors) which set the framework for all future CSS spending. Available at http://lacdmh.lacounty.gov/News/Board_Correspondence/Adopted_Board_Letters/Documents/Approval%20for%20Submission%20of%20the%20MHSA%20Community%20Services%20and%20Supports%20to%20Plan%20to%20the%20State%20Dept%20of%20MH_101105.pdf .

[2] The doctors, social workers, parole and correction officials who work there are much more informed as to what persons with serious mental illness need, but in spite of that, were not consulted and prioritized.

[3] http://dmh.lacounty.gov/wps/portal/dmh/!ut/p/b1/vZLdjoIwEIWfhQfYzJTys16ibUFjQaAu0huDycYoKJv9Y-Xpt9wZE_Fms52rzjmd801S0FASJNS3PUo82IA-V9-HffV5aM9VM9y1t-WIGCYit0MqApxzRlW8csha2cZQXulJSJnRneVsKhzTpDD-uoByOowwLrxzAnyEUIAeiUHp3ug3kCGO68MSMA4YR-3pFUoD6t_DmEQeKNigs82Pl7d5X_fZsU9_Pt6DTu14JxmnMYsXOX4RydYk78VK1W4Sq0wq3vVETsiLSHkg7IIlqfUozP_PMPdPwxag9027M5-vmMFJN8vLU51FHXkeqgss6xfMabNu/dl4/d5/L2dJQSEvUUt3QS80SmtFL1o2X0UwMDBHT0ZTMkczRkEwSUVEM1ROUDQxOTY0/

[4] Described starting on Page 6 of Prevention and Early Intervention Plan for Los Angeles County, 8/17/2009. Available at http://lacdmh.lacounty.gov/News/Board_Correspondence/Adopted_Board_Letters/Documents/Approval%20for%20Submission%20of%20the%20MHSA%20Community%20Services%20and%20Supports%20to%20Plan%20to%20the%20State%20Dept%20of%20MH_101105.pdf

[5] WIC 5840.

[6] "PEI focuses on evidence- based services, education, support, and outreach to help inform and identify those who may be affected by some level of mental health issue. Providing mental health education, outreach and early identification (prior to

difference between those "who may be affected by some level of mental health issue" (i.e., can be made happier), and those who have serious mental illnesses like schizophrenia and treatment resistant bipolar disorder. The funds are legislatively required to help the later, not the former.[7]

LA County Mental Health Department Plan relied on guidance from the California Department of Mental Health and MHSOAC that was contrary to statute, rather than relying on the statute itself[8]

LA County justifies the part of their plan that uses funds to 'encourage a state of well being' and target a population group 'not identified on the basis of risk', by quoting direction from the Oversight Commission:

> *Prevention in mental health involves reducing risk factors or stressors, building protective factors and skills, and increasing support.* ***Prevention promotes positive cognitive, social and emotional development and encourages a state of well-being*** *that allows the individual to function well in the face of changing and sometimes challenging circumstances.* ***Universal Prevention targets the general public or a whole population group that has not been identified on the basis of individual risks****.*

MHSA is to help people with serious mental illness, not improve 'well being' or 'target the general population'.

The LA County Plan justifies withdrawing services from people with serious mental illness by quoting direction from the Oversight Commission stating:

> *Early Intervention is directed toward individuals and families for whom a* ***short duration*** *(usually less than one year), relatively* ***low-intensity intervention*** *is appropriate to measurably improve a* ***mental health problem*** *or concern very early in its manifestation, thereby avoiding the need for more extensive mental health treatment or services, or to prevent a mental health problem from getting worse.*[9]

The LA plan, seems to suggest that PEI funds must be withdrawn once a person is identified. This direction from the former California Dept. of Mental Health and Oversight Commission is not true. To prevent "mental illness from becoming severe and disabling" often requires on-going treatment. By limiting PEI funding to short term, low intensity programs, they have essentially excluded those who face lifelong disability.

LA County Behavioral Health Department fails to report data by diagnosis or require a diagnosis so it can not know if it's programs are serving people "with mental illness" or "serious mental illness" as required by law.

In order to know if a program is targeting those with mental illness or preventing mental illness from becoming severe and disabling, officials would have to collect data on the
1 diagnosis of people being served,
2. diagnosis of the mental illness the program is 'preventing'
3. Diagnosis of the mental illness that they reduced duration of

This information is not collected or provided by the county.

Los Angeles' failed stakeholder process led to a failed spending plan.

The failed stakeholder process led to failed spending. For example, while serious mental illnesses are most likely to strike

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diagnosis) can mitigate costly negative long-term outcomes for mental health consumers and their families." http://file.lacounty.gov/dmh/cms1_159376.pdf

[7] This distinction is very clear from the first "Findings and Declarations". The legislation notes that "Mental illnesses are extremely common; they affect almost every family in California. They affect people from every background and occur at any age." But then the legislation goes on to talk about "'serious" mental illness: "In any year, between 5% and 7% of adults have a serious mental illness as do a similar percentage of children — between 5% and 9%. Therefore, more than two million children, adults and seniors in California are affected by a potentially disabling mental illness every year. People who become disabled by mental illness deserve the same guarantee of care already extended to those who face other kinds of disabilities.". The "Intent" of the legislation is then clearly defined: "To define serious mental illness among children, adults and seniors as a condition deserving priority attention, including prevention and early intervention services…" (emphasis added)

[8] On page two of the LA County PEI Plan they note that "On September 25, 2007 SDMH (State Dept. of Mental Health) released the Prevention and Early Intervention Guidelines" Many of these guidelines and regulations were contrary to the legislation and had the effect of (a) preventing those the funds were intended to serve from gaining access and (b) diverting those funds to organizations that used them to provide services to ineligible populations.

[9] Page five at http://file.lacounty.gov/dmh/cms1_179197.pdf

in late teens early twenties, LA allocated 60% of funds to Transition Age Youth.[10] Less than 3% of individuals in LA County PEI were the most seriously ill individuals with psychotic disorders.[11] Rather than focusing on the most seriously ill, LA focus is "clients at higher levels of recovery."[12] We could not find a single program that was designed specifically to help people with psychotic disorders or help the homeless who are at risk of becoming psychotic because they can't get medicine.

Incarceration of children went up.[13] This is surprising because one of the programs, "Incredible Youth" ($200K) is supposed to decrease incarceration.

$2,393,926 of funding for "at risk" families is likely wasted.[14] They are social service programs that purport to help people 'at risk' of mental illness. There are no known factors that put people at risk of "serious" mental illness (other than having a parent with it, which is a genetic issue). There are issues, like losing a family member or job that do put people at risk of being sad, being depressed, but not of the most serious mental illnesses like schizophrenia and bipolar disorder that MHSA was intended to prioritize.

$2,899,231 of Trauma Recovery spending are likely wasted[15]. Trauma is not a mental illness. Almost everyone experiences trauma of some degree of severity (losing a loved one, having an accident, witnessing something horrible). PTSD is a mental illness. Severe traumatic events (being held prisoner, war, etc.) might cause trauma disorder. But these services are likely going to people who experienced the rights of passage we all experience: knowing someone who died, failing a grade in school, breaking up with a boy/girlfriend, not paying rent, etc. For example, "Incredible Years" is a crime prevention initiative aimed at aggressive youth.

Many of the other programs Los Angeles is spending on are social service programs masquerading as mental illness programs: Reflective Parenting, Strengthening Families, Positive Parenting, Brief Strategic Family Therapy, Loving Intervention for Family Enrichment Program, Multidimensional Family Therapy Program and Promoting Alternative Thinking Strategies.

CONCLUSION

Flawed process led to massive mission creep. A stakeholder driven "gold rush" that excluded experts who work with the seriously mentally ill resulted in funding programs not directly related to the purpose of PEI or MHSA.

[10] http://file.lacounty.gov/dmh/cms1_179197.pdf
[11] Page 101 Table 4 County Plan at http://file.lacounty.gov/dmh/cms1_179197.pdf
[12] Page 30. Also see page 88 for stats on how well this group "who are at higher levels of recovery" are doing.
[13] Page 80. Authorities blamed a "coding error".
[14] Page 120 column six of LA County Plan available at http://file.lacounty.gov/dmh/cms1_179197.pdf
[15] Page 120 column seven of LA County Plan available at http://file.lacounty.gov/dmh/cms1_179197.pdf

Appendix A: Prevention and Early Intervention (PEI) Funds must serve seriously ill

Legislative Language

(a) The State Department of Mental Health shall establish a program designed to **prevent mental illnesses from becoming severe and disabling**. The program shall emphasize improving timely access to services for underserved populations.

(b) The program shall include the following components:

(1) Outreach to families, employers, primary care health care providers, and others to recognize the early signs of **potentially severe and disabling mental illnesses**.

(2) Access and linkage to medically necessary care provided by county mental health programs for children **with severe mental illness**, as defined in Section 5600.3, and for adults and seniors **with severe mental illness**, as defined in Section 5600.3, as early in the onset of these conditions as practicable.

(3) Reduction in stigma associated with either being diagnosed **with** a mental illness or seeking mental health services.

(4) Reduction in discrimination against people **with mental illness.**

Discussion: The purpose is "to prevent mental illness from becoming severe and disabling". It is not "to prevent mental illness" (which we don't know how to do) or "improve mental health". Outreach may only be to "recognize the early signs of potentially severe and disabling mental illnesses" not to recognize the signs of poor mental health, bad grades, potential unemployment. The outreach must be narrowly targeted. The responsibility to provide "access and linkage" is only to provide access and linkage "to medically necessary care" and even then, it is only for people who are already "with severe mental illness". It does not prioritize "access and linkage" to non-medical care, or to people without "severe mental illness". Stigma activities are limited to those that affect 'being diagnosed with mental illness" or seeking services. The bulk of misdirected PEI funds are being driven through the 'stigma' requirement. CalMHSA, MHSAOC, county behavioral directors justify massive spending that does not focus on 'serious mental illness' by saying it 'reduces stigma' or discrimination. Most of that spending is unjustified and little of it is being done 'cost-effectively'

(c) The program shall include mental health services similar to those provided under other programs effective in preventing mental illnesses from **becoming severe**, and shall also include components similar to programs that have been successful in reducing the duration of untreated **severe mental illnesses** and assisting people in quickly regaining productive lives.

Discussion: This does allow funds to be used for people with "mental illness" (20% of population) versus 5-9% who have "serious mental illness". However, the funds may only be expended to prevent that mental illness "from becoming severe". It also allows funding to reduce the duration of "untreated severe mental illness" (i.e., provide treatment). MHSAOC, county behavioral health directors, CalMHSA, MHA and others have read the last phrase "assisting people in quickly regaining productive lives" as freeing them from the responsibility to spend the money only on those with 'severe mental illness'

(d) 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.

*Discussion: This paragraph allows funding to reduce 1-7 **only insofar as they result from "untreated mental illness".** Both conditions must be met: 1. Untreated mental illness and 2. One of the seven outcomes. MHSAOC, CA DMH, county behavioral health directors, MHA, NAMI, and others have used this provision to provide services that reduce the seven bullet points to people **without** mental illness.*

(e) In consultation with mental health stakeholders, the department shall revise the program elements in Section 5840 applicable to all county mental health programs in future years to reflect what is learned about the **most effective** prevention and intervention programs for children, adults, and seniors.

Discussion: Many of the "most effective programs" for people with serious mental illness are not receiving funding. The best known would be Assisted Outpatient Treatment (Laura's Law). The Department of Justice and all research shows it reaches those with "serious mental illness" and reduces arrest, incarceration, homelessness, suicide, suffering and other outcomes.

Appendix B: 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[1]

Proposed and enacted CCR Title 9 Regulations that diverted funds from seriously mentally ill	How the regulation diverts funds
3400(b) Programs and/or services provided with MHSA funds shall: (1) Offer mental health services and/or supports to individuals/clients with serious mental illness and/or serious emotional disturbance, and when appropriate their families. (A) **The Prevention and Early Intervention component is exempt from this requirement.** … (d) The County is not obligated to use MHSA funding to fund court mandates.	This exempted Prevention and Early Intervention (PEI) programs from having a tie to serious mental illness. Nothing in MHSA precludes the use of MHSA funds for Laura's Law recipients, yet 3400(d) suggests they don't have to.
3610 (f) The County shall not provide MHSA funded services to individuals incarcerated in state/**federal** prisons or for parolees from state/federal prisons.	The legislation precludes support for those paroled from state prisons. This reg goes further and prevents funds from helping parolees from federal prisons.

The following regulations diverted PEI funds away from the intended purpose of the funds.[2]

Section 3930. (d) PEI funds **may not be used** for the following: (1) Individualized treatment, recovery, and support services for those who have been diagnosed with a serious mental illness or serious emotional disturbance, unless the client or individual has been identified by a provider as experiencing first onset of serious mental illness/emotional disturbance.	This reg specifically prevents funds from reaching those "who have been diagnosed with a serious mental illness". Yet the PEI legislation requires funds to be used to "prevent mental illness from becoming severe and disabling". The effect of this legislation is to prevent people with mental illness from receiving services.
Section 3905. (a) The following are Priority Populations for Prevention and Early Intervention programs: (1) Racial/ethnic populations and other unserved/underserved cultural populations, including lesbian/gay/bisexual/transgender populations. (2) Individuals experiencing onset of a serious mental illness or severe emotional disturbance, as defined in the Diagnostic and Statistical Manual of Mental Disorders. (3) Children and youth and transition age youth in stressed families such as families affected by unemployment, homelessness, substance abuse, violence, depression or other mental illness, absence of care-giving adults, or out-of-home placement. (4) Individuals exposed to traumatic events or prolonged traumatic conditions, including but not limited to grief, loss, and isolation. (5) Children and youth and transition age youth at risk of school failure. (6) Children and youth and transition age youth at risk of or experiencing involvement in the juvenile justice system. (7) Individuals experiencing co-occurring substance abuse issues.	This regulation severed funding from a requirement to help people with serious mental illness by creating new 'priority populations' who were not required to have a mental illness or be at risk (ex. the first degree relative of someone with mental Illness). It diverted funds to employment programs, substance abuse programs, grief programs, tutoring programs, crime prevention programs and substance abuse programs for people without mental illness. It prioritized the youngest while serious mental illness does not materialize until late teens and early twenties.
Section 3200.251. "Prevention and Early Intervention" means …(1) *prevent serious mental illness/emotional disturbance by promoting mental health, reducing mental health risk factors and/or building the resilience of individuals, and/or* *(2) intervene to address a mental health problem early in its emergence.*	The first part of this reg misstates the purpose of the legislation to "prevent serious mental illness" (No one knows how) "promoting mental health" (make people happier) and "reducing mental health risk factors" (versus serious mental illness) and "building the resilience of individuals". Paragraph (2) limits funds to 'mental health problems early in emergence versus people with serious mental illness whenever they need help. For example, one of the best ways to prevent mental illness from becoming severe and disabling is to ensure treatment. That may be needed early **or late** in the emergence of the illness.

[1] http://www.oal.ca.gov/CCR.htm click on CCR, click online on next page, click on List of CCR titles on next page, click on Title 9. CA Office of Admin Law says that is how to get them and they are official. Accessed 8/27/2012. Some of the regulations discussed here were promulgated, some merely given as direction, some promulgated and allowed to lapse. However, all are being relied on by counties when determining spending priorities.

[2] They are still on MHSAOC and CADMH websites and counties are still relying on them, although some seem to have expired, lapsed or never been promulgated.

Section 3920 (b) Prevention programs shall be designed to reduce risk factors or stressors and build protective factors and skills **prior to the diagnosis** of a mental illness and shall include one or both of the following: Section 3200.259. "Selective Prevention Activity" means a prevention activity within a PEI program that targets individuals or a subgroup whose risk of developing mental illness is significantly higher than average, such as older adults who have lost a spouse or young children whose mothers have postpartum depression. Section 3200.305. "Universal Prevention Activity" means a prevention activity within a PEI program that targets the general public, or a population group that has not been identified on the basis of individual risk, such as an activity that educates school-aged children and youth on mental illnesses.	3920(b) *requires* the expenditure of MHSA funds on people "prior" to diagnosis. There is no language that suggests PEI funds were meant for those without any mental illness at all. It also suggest that there are known 'protective factors' and 'skills' that can prevent serious mental illnesses like schizophrenia and bipolar. We are not aware of any. Using MHSA funds to lower risk factors in populations without mental illness is perhaps one of the most inefficient, less productive, most wasteful uses of MHSA funds. The primary risk factor of developing serious mental illness is being born to someone with serious mental illness. "Selective Prevention Activity" allows expenditure for people at *risk of developing any mental illness*, rather than limiting it to those with "serious mental illness" or to preventing mental illness from progressing to 'serious mental illness". We are not aware of research that schizophrenia or bipolar rates are increased by normal rights of passage like losing a spouse. (Although they can exacerbate symptoms in those already diagnosed). High risk should be those with one or two parents with serious mental illness. They are not mentioned in the reg. "Universal Prevention" diverts funds to the public who have "not been identified on the basis of individual risk". The program was meant to help people at risk, not those who have "not" been identified as being at risk. It basically diverts funds to PR firms.[3]
Section 3920. (c) Early Intervention programs shall target individuals exhibiting signs of a potential mental health problem, and/or their families, to address the individual's mental health problem early in its emergence. (1) Services shall not exceed one year, unless the individual receiving the service is identified as experiencing first onset of serious mental illness with psychotic features, as defined in the Diagnostic and Statistical Manual of Mental Disorders criteria for a psychotic disorder, in which case, an intervention shall not exceed five years. (g) PEI programs shall serve individuals and populations in non-traditional mental health settings such as primary healthcare clinics, schools, and family resource centers; unless a traditional mental health setting enhances access to quality services and outcomes for unserved/underserved populations.	3920(c) diverts funds away from "serious mental illness" or even "mental illness" to people exhibiting signs of a *potential* mental *health* problem." In fact, it diverts funds even further away to cover "their families". 3920(c)(1) requires stopping services for individuals experiencing onset of serious mental illness after one year if they are not psychotic and after five years if they are. The services needed to prevent mental illness from becoming severe and disabling may be long-term life long services. This reg prohibits that expenditure contrary to the legislation. 3920(g) pushes for services to be outside where mentally ill people are: i.e. mental health settings.
Section 3950. (a) The County shall participate in the Department's accountability, evaluation and improvement activities for the Prevention and Early Intervention (PEI) component as follows: (1) Submit the PEI Program Accountability and Evaluation Report as required in section 3570 and the Local Outcome Evaluation of a PEI Program Report as required in section 3515, unless exempt per section 3515, subdivision (g). (2) Participate in on-site reviews conducted by Department. (3) Complete surveys conducted by the Department.	3950 requires "evaluation" by MHAOC. That is a good thing. But minutes from the oversight committee show the Oversight Commission evaluates "based on what counties said they were going to do, rather than actual on-the-ground assessment."[4]

[3] Universal Prevention Activity is the most egregious blatant attempt to divert PEI funds to unintended uses. It diverts funds from helping individuals to creating brochures, radio programs, and other activities aimed at the public. People who are "not identified on the basis of individual risk". MHSAOC defines it on their web site as "o*ne of the categories of prevention funded by the California Mental Health Services Act (MHSA). Universal prevention programs target the whole population or a subset of the population that does not have a higher risk for developing the symptoms of mental illness"* There is nothing in Prop 63, that suggests the funds were meant other than for people with mental illness.
http://www.preventionearlyintervention.org/go/PromotingWellnessPrevention/UniversalPrevention.aspx

[4] Oversight Commission Minutes http://mhsoac.ca.gov/Meetings/docs/PriorMeetingMinutes/2011/MinutesApproved_Sept2011.pdf

Appendix C: How AB-100 that diverted $863 million from intended recipients and provisions in AB-1467 exempted $50 million annually from helping persons with serious mental illness.

The content that diverted funds in both these bills was proposed by the Senate Leader Pro Tem Darrell Steinberg[1].

AB 100[2]

California had preexisting responsibilities to serve people with serious mental illness, some of which were mandated by courts. For example, to special education students. When passing Proposition 63, voters included a provision stating the funds shall not be used to supplant other state funding[3]. In other words, the funds should be used to increase capacity not fund already funded initiatives. In 2011, legislators passed AB 100 with provisions inserted by Senator Steinberg. It modified the MHSA non-supplantation provision to allow the state to divert about $836 million of funds raised by MHSA to satisfy the other commitments the state had. This was done as a 'clarifying' amendment to allow passage with a 51% vote rather than a two-thirds vote required to overturn voter enacted legislation.

This amendment used MHSA funds to be used to lower the deficit, rather than expand services.

AB 1467[4]

When Proposition 63 was originally passed, voters allocated 5% of MHSA funds for Innovative Services

> "To expand the kinds of successful, innovative service programs for children, adults and seniors…(that) 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**." The programs would be approved by the Oversight Commission and were "(1) To increase access to underserved groups. (2) To increase the quality of services, including better outcomes. (3) To promote interagency collaboration. (4) To increase access to services."[5]

In July 2012, AB1467 added new language that greatly expanded the allowable uses of these funds. The legislation severed the tie of Innovative Funds from helping "**individuals most severely affected by or at risk of serious mental illness**" to doing almost anything for anyone. In part, new language stated

> "An innovative project may affect **virtually any aspect of mental health practices** or assess a new or changed application of a promising approach to solving persistent, seemingly intractable mental health challenges, including, but not limited to, any of the following:
> (1) Administrative, governance, and organizational practices, processes, or procedures. (2) Advocacy. (3) Education and training for service providers, including nontraditional mental health practitioners. (4) Outreach, capacity building, and community development. (5) System development. (6) Public education efforts. (7) Research. (8) Services and interventions, including prevention, early intervention, and treatment.

It freed funds for advertising, yoga, advocacy, community development, almost anything.

This amendment was passed with a simple majority, rather than the 2/3rds vote that should have been required. This was accomplished by defining it as a 'clarifying' amendment rather than what it really was: an amendment that changed a voter initiative.

This amendment diverted funds from people with serious mental illness.

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[1] They have 'AB' numbers because the Pro Tem's language was attached to bills already in process.
[2] http://www.leginfo.ca.gov/pub/11-12/bill/asm/ab_0051-0100/ab_100_cfa_20110315_103004_sen_floor.html
[3] There is a "non-supplantation" clause of Prop 63 that requires the maintenance of funding for previously existing programs so MHSA funds can result in incremental activity. "5891. The funding established pursuant to this act shall be utilized to expand mental health services. These funds shall not be used to supplant existing state or county funds utilized to provide mental health services. The state shall continue to provide financial support for mental health programs with not less than the same entitlements, amounts of allocations from the General Fund and formula distributions of dedicated funds as provided in the last fiscal year…"
[4] http://www.leginfo.ca.gov/pub/11-12/bill/asm/ab_1451-1500/ab_1467_cfa_20120613_164453_sen_comm.html
[5] WIC 5830