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MHSOAC Counsel
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Proposed changes to draft PEI Regulations

Dear Counsel:

We reviewed the draft PEI regulations you are contemplating proposing and urge you to make changes to them. The purpose of regulations is to ensure the funds are spent as legislatively intended and not diverted to other purposes. We fear the draft regulations do the exact opposite: ignore what was legislatively mandated and ensure diversion of funds elsewhere. Media reports have documented extensive diversion of PEI funds to such things as hip hop car washes and other unproven uses. The regulations should prevent those types of diversions.

For example, the legislation specifically says counties "shall establish a program designed to prevent mental illness from becoming severe and disabling." In spite of this clear direction the draft regulations make the prevention program 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 designed "to prevent mental illnesses from becoming severe and disabling" ((5840(a)). In addition, 5840 (a), 5840 (b) and 5840 (c) all start by describing "The Program" not multiple programs.

We also suggest that much greater attention be given to Purpose and Intent Section 3, paragraph (e) of MHSA legislation which requires "ensur(ing) that all funds are expended in the most cost effective manner" Few of the regulations seem to appropriately limit expenditures to helping those contemplated by voters (people with serious mental illness), and many seem designed to encourage funds to be spent contrary to "the most cost effective manner". Likewise more attention should be paid to 5840(f) which requires the Oversight Commission and regulations "to reflect what is learned about the most effective prevention and intervention programs". The new proposed regs should be designed to curb the well documented abuses in the PEI program that were disclosed by the state auditor and our own report: MHSA: A 10 year $10 billion bait and switch.

Consistent with the findings of the state auditor, we are also disturbed that there is no requirement to measure outcomes of expenditures against the goals of the PEI provisions of MHSA, ie., to prevent mental illness from becoming severe and disabling and reduce the duration of untreated serious mental illness. While the findings and declarations and 5840(d) specifically mention the purposes of reducing homelessness, incarceration, arrest, rehospitalization, suicide and other meaningful outcomes, the draft regs ignore measuring those outcomes and substitute others.

The state auditor found that there are no procedures in place to ensure funds are spent on the targeted population (those with serious mental illness). The proposed regs should correct that.

We are disturbed to see that no provision has been made to ensure that expenditures comply with 5891 (a), the non supplantation provisions. We are disturbed that no draft regs were written to ensure the legislative direction in Section 1(b) of AB 100 "to establish a more effective means of ensuring that county performance complies with the Mental Health Services Act" is accomplished.

We are disturbed that clear language of 5840(d) has been ignored and the draft regulations actually encourage expenditures not allowed by the legislation. 5840(d) only allows the expenditure of funds for the listed outcomes if they 'result from untreated mental illness'. The draft regulations encourage counties to spend the funds reducing the outcomes listed in 5840 (d) (1-7) even when they don't 'result from untreated mental illness'. It was never the intent of MHSA to reduce all suicide, incarceration, school drop out, unemployment, prolonged suffering, homelessness, or

removal of children from home. The legislation is crystal clear that it is only intended to reduce those outcomes when they result from untreated mental illness. This has been a problem with PEI expenditures in the past. MHSA regs should reign in misspending, rather than encouraging more of it.

Overall, there seems to be a failure by the drafters to understand the difference between cause and effect. The legislation is intended to reduce negative outcomes that are caused by mental illness. The proposed regs seem to suggest the opposite: that it is the negative outcomes (ex. bad grades) that cause the mental illness and therefore parts of the regs seem to encourage counties to divert funds to worthy social services under the false construct that they cause mental illness or this is allowable by the legislation. It is the responsibility of MHSOAC to fix this.

Attached are our suggested amendments to the proposed regulations. Deletions are crossed out. (~~crossed out~~). Insertions are underlined (underlined). Footnotes explain the legislative basis for our proposed changes.

Feel free to contact us if you have any questions, comments or concerns.

Thank you for your help.

Sincerely yours

DJ Jaffe
Executive Director

Attached:
Draft Changes to newly Proposed regs
Problems with previously proposed regs

PROPOSED CHANGES TO OCTOBER 2013 DRAFT PEI REGS

Section 1. Prevention and Early Intervention (PEI)

(a) ~~(a)~~ "Prevention and Early Intervention Program" means the component of the Three ‐ Year Program and Expenditure Plan intended to prevent mental illnesses from becoming severe and disabling.

Unless otherwise noted, prevention funds may not be spent on 'preventing mental illness' or preventing serious mental illness'[1]

Unless otherwise noted, PEI funds may only be spent on people with serious mental illness or people with mental illness (if those later expenditures are to prevent the mental illness from becoming severe and disabling). [2]

Unless otherwise noted, PEI funds may not be spent to reduce suicide, incarceration, school failure or dropout, unemployment, prolonged suffering, or homelessness, among individuals who have not already been diagnosed with mental illness[3]

(b) The county shall only use PEI funds to implement Prevention and Early Intervention programs consistent with these regulations

(c) **The county shall include in its Prevention and Early Intervention Program**

(1) At least one Early Intervention Program

(~~A~~a) "Early Intervention Program" means treatment and other interventions that have demonstrated their effectiveness[4] and address and promote symptom amelioration[5], recovery and related functional outcomes for a mental ~~health~~ illness [6]~~disorder~~ early in its emergence

[1] 5840(a) defines the program as preventing mental illness from becoming severe and disabling, not preventing mental illness. This is intentional. 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..

[2] 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.

[3] 5840(d) clearly limits expenditures to reducing these outcomes in people with 'untreated mental illness'. We 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.

[4] Section 2 (e), Findings and Declarations allows funding of only '*effective* treatment and support'. Section 2 (f) Findings and Declarations calls for expanding programs that have 'demonstrated their *effectiveness*.' 5840(c) limits spending to those "similar to those provided under other programs *effective* in preventing mental illness from becoming severe." 5840(c) also limits spending to those that "have been *successful*". Media reports and our own investigation found numerous PEI programs that were being funded that had not 'demonstrated their effectiveness' (ex. Hip Hop Carwash). Therefore regs should highlight the need for programs to be effective

[5] Not everyone recovers. There is nothing in the legislation that allows the funding to be limited to those who recover. Ameliorating symptoms is an important component of "preventing mental illness from becoming severe and disabling'.

[6] The legislation is very clear that it is not intended to help those with a "mental health disorder". Using 'mental health' instead of 'severe mental illness' will encourage the diversion of funds to a population voters did not intend to serve. Proposition 63 Findings and Declarations Section 2 (a) 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." However, the legislation goes on to establish that it is not intended to help this large population. "**In any year, between 5% and 7% of adults have a serious mental illness as do a***

(~~B~~b) ~~Early intervention services shall not exceed eighteen months, unless the individual receiving the service is identified as experiencing first onset of a serious mental illness/emotional disturbance with psychotic features, as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, criteria for Schizophrenia Spectrum and Other Psychotic Disorders, in which case an intervention shall not exceed four years~~[7]

(~~C~~c) Early intervention services can include services to parents, caretakers, and other family members of the person with early onset of a mental illness, as long as such services are designed to prevent the individual with mental illness from having the mental illness become severe and disabling or reduce the duration during which that mental illness goes untreated[8]~~applicable~~

(2) Outreach to Gatekeepers

(A) "Outreach" is ~~a respectful process of building relationships, which meets people where they are with the goal of~~[9] engaging people who are most likely to be[10] in a position to identify, support, and refer individuals who need mental ~~health~~ illness services

(B) "Gatekeepers" means doctors, nurses, psychiatric social workers, police, sheriffs, correction officials, EMS, mobile crisis teams, psychologists, homeless services, shelter workers[11] families, ~~employers~~[12], primary care health care providers, school personnel, community service providers ~~and leaders,~~ and others most likely to come into contact with people likely to be mentally ill and are[13] in a position to identify early signs of potentially severe and disability mental illness, and support, and refer individuals who need mental health services

(C) Outreach to Gatekeepers Programs must have demonstrated their effectiveness.[14] This includes

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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." Rather than being for the mental illnesses that affect every family, MHSA is for this smaller group. 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."*** Therefore MHSA services must be limited to those with serious mental illness.

[7] There is nothing in the legislation that requires funding that works to prevent mental illness from becoming severe and disabling, be withdrawn ever, much less in 18 months or four years. Many services that prevent mental illness from becoming severe and disabling are needed over the consumer's lifespan. For example, peer support, case management, medication management and other services may be needed long-term to prevent mental illness from becoming severe and disabling.

[8] This additional language is needed to ensure that funds are not diverted to other purposes and are used for the primary goal of the legislation: to help those with severe mental illnesses.

[9] The language is superfluous and confuses outreach to gatekeepers with outreach to those who have a mental illness.

[10] Not everyone is equally likely to come into contact with a person with mental illness. In order for the services to be efficient and effective as required by the legislation, certain groups should be given priority. For example, serious mental illness is most likely to first occur in late teens and early twenties and therefore that suggests targeting High School, Trade School, Military Institutions and college personnel as opposed to kindergarten, pre-school and grade school. Ex. Those most likely to develop mental illness are first degree relatives of people with mental illness. That suggests targeting those who work with persons with mental illness so they can determine if relatives might be prone to illness. These facts suggest outreach should not be to the general public as that would not be as efficient a use of funds.

[11] Some of these are described in 5840(b)(1). The others are individuals who are most likely to come into contact with people with mental illness who need services to reduce the duration of it or prevent it from becoming severe and disablilng.

[12] Employers or 'leades' as a group are no more or less likely than the general public to come into contact with people who need outreach. Expending funds on populations like employers that are *less likely than others* (say H.S. teachers) to come into contact with people with mental illness is not an efficient use of funds.

[13] Again, the funds should be spent most efficiently, not the least efficiently. This means reaching gatekeepers who are more likely than the general population to come into contact with those who need help.

[14] See previous discussion of numerous references to the requirement that programs be evidenced-based, effective, successful, etc. Programs that are not, may only be funded with INN funds, not PEI.

encouraging and supporting individuals with mental illness[15] to identify their own signs ~~of potential mental illness and to seek treatment~~

(D) Outreach includes educating and learning from gatekeepers regarding ways to recognize and respond effectively to early signs of potentially severe and disabling mental illness

(E) Outreach to Gatekeepers can be a stand-alone program, a component of a Prevention or an Early Intervention program, or a combination

(d) The county ~~may~~ shall[16] include in its Prevention and Early Intervention Program

(1) One or more Prevention Programs

(A) "Prevention Program" means activities and interventions that have demonstrated their effectiveness at ~~to~~ preventing people with mental illnesses from having those illnesses become severe and disabling[17] or reduce the duration of untreated serious mental illness[18] ~~bring about mental health and related functional outcomes for individuals and members of~~[19]. Prevention Programs should target groups or populations ~~whose~~ who have a mental illness[20] or risk of developing a serious mental illness is significantly higher than average (as defined in (i) below) and, as applicable, their parents, caregivers, and other family members if services to these other populations are narrowly targeted at helping the person with mental illness.[21]

(i) Kinds of risk factors for serious mental illness ~~include, but are not limited to,~~are primarily, not exclusively, biological including genetic and neurological~~, behavioral, social/economic, and environmental~~[22],

(ii) Examples of risk factors for serious mental illness include~~, but are not limited to,~~ having a first degree relative with mental illness or serious mental illness, having a first degree relative who has previously attempted or completed suicide, has previously attempted suicide[23], ~~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,~~

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[15] Again: The PEI is limited to serving people 'with' mental illness, not those 'without'. Since there is not yet a way to predict who will develop serious mental illness, activities that claim to identify people before onset are not evidence based, effective, or efficient.

[16] There is nothing in the legislation that gives MHSOAC the ability to supercd the clear legislative language (ex. In 5840(a)) that counties 'shall' have prevention and early intervention programs. Much of the problems with these proposed regs come from the tortured attempt to separate prevention programs from early intervention programs.

[17] Per 5840(a). See also previous discussion on need to be effective and evidence-based to reduce very specific outcomes in a very narrowly targeted population (5-9% of total population per Findings and Declarations Section (2)(a)

[18] Per 5840 (c)

[19] The language is quite clear that PEI (and all MHSA programs) are for people with serious mental illness, not mere 'mental health' issues. See Purpose and Intent and Findings and Declarations.

[20] 5840 (a) establishes that the program is only for people who have a mental illness and need services to prevent it from becoming severe and disabling. Given the history of this requirement being ignored, it is important that regs specifically note it.

[21] Services may be provided to families and others to enable them to provide services and support for the person with serious mental illness. There is nothing in MHSA that suggests these other parties are entitled to services not related to helping someone with mental illness.

[22] We would be glad to provide the research showing that the risk factors for developing serious mental illness are largely genetic and biological. There is no behavior known to 'cause' serious mental illness. Being poor, coming from a broken home, getting bad grades etc. are not known to 'cause' serious mental illness. There are people with schizophrenia, bipolar, major depression who come from wealthy homes, poor homes, homes with two parents and no parents.

[23] We would be glad to provide MHSA the research showing that these are the primary risk factors associated with developing serious mental illness.

~~experiences of racism and social inequality, prolonged isolation,~~[24] ~~-~~or having a previous mental illness

(renumber) The county may include in it's Prevention and Early Intervention Program a (2) Stigma and/or Discrimination Reduction Campaigns [25]

(A) "Stigma ~~and Discrimination~~ Reduction Campaign" means direct efforts to people either diagnosed with a mental illness or seeking mental health services [26]to ~~-~~reduce negative feelings, attitudes, beliefs, perceptions, stereotypes a~~nd/or discrimination~~ [27] related to having a mental illness or to either being diagnosed with a mental illness or seeking mental health services ~~and to increase acceptance, dignity, inclusion, and fairness~~[28]

(B) Examples of Stigma ~~and Discrimination~~ Reduction Campaigns include, but are not limited to, campaigns in psychiatric hospitals, wellness centers, community mental health centers, jails, prisons, peer programs, shelters and other locations where people with serious mental illness are likely to be disproportionately represented.[29] It may also include other activities narrowly targeted at "those diagnosed with a mental illness or seeking mental health services" including social marketing campaigns, speakers' bureaus and other direct-contact approaches, ~~targeted~~ education and training, anti-stigma advocacy, web-based campaigns~~, ;efforts to combat multiple stigmas,~~[30] and efforts to encourage self-acceptance that are targeted to those diagnosed with a mental illness or seeking mental health services.[31]

Stigma campaigns may not be targeted to the general public.[32]

Stigma campaigns must be narrowly tailored to the 5-9% of Californians with serious mental illness, not the '1 in 4' with any mental health problem[33]

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[24] These issues may cause 'poor mental health', 'bad grades', unemployment, homelessness, etc. they do not cause mental illness or serious mental illness. The findings and declarations, purpose and intent, and specific language in all of MHSA make it clear that program is meant to 'define serious mental illness as a condition deserving priority attention'. The issues we have crossed out from the regs may cause poor mental health, but do not cause serious mental illness and are therefore not risk factors. "Adverse childhood experiences" are almost universal, and does not a cause serious mental illness. "Ongoing stress" is almost universal. "Poverty" is not a cause of mental illness. "Family Conflict" is almost universal and does not *cause* serious mental illness. "Racism" is not a cause of mental illness. "Social Inequality" is not a cause of mental illness. The inclusion of these in the list encourages a diversion of funds, rather than the proper expenditure of funds. We encourage the drafters to review Findings and Declarations Section 2(a) and draft regs that ensure focus is on the 5-9% defined in the legislation and prevent diversion elsewhere.

[25] Allowable Discrimination activities are defined in 5840(b)(4) separately from anti-stigma activities and therefore should have their own regulations.

[26] 5840(b)(3) limits stigma program targeting to those 'diagnosed with a mental illness or seeking mental health services". There has been extensive past abuse of this category of spending as counties have spent stigma funds on programs not designed to reach those with mental illness, in need of services, or seeking services. MHSOAC has an obligation to reign in this misspending.

[27] Stigma activities are defined 5840 (b)(3) while discrimination activities are described in 5840((b4). Stigma activities must be targeted to people with serious mental illness. Thererefore it makes sense to have separate regs for these two separate programs.

[28] These were not enumerated in the legislation.

[29] 5840(b)(3)) limits anti-stigma spending to those "diagnosed with a mental illness or seeking mental health services". Therefore, the examples given should be places where people with mental illness or seeking services are disproportionately represented. This also helps the funds are spent efficiently and effectively as required by other sections of the legislation. Failure to include this language will lead to the continued misspending of stigma funds to reach the general public rather than those defined in the legislation.

[30] MHSA stigma campaigns must clearly be limited to mental illness not other so-called stigmas.

[31] Per 5840(b)(3).

[32] Per 5840(b)(3).

[33] Findings and declaration (a) clearly states that it is the intent of the legislation to focus on the 5-9% with serious mental illness. In the past PEI stigma funds have been used to address the "1 in 4" with a mental health issue. This is

(C) Discrimination Reduction Campaign means reduction in discrimination against people with serious mental illness.[34] Examples of Discrimination Reduction Campaigns include those targeted to police, sheriffs, psychiatrists, psychologists, hospital workers, psychiatric social workers, providers, those who work with the homeless, probation and parole officers, mental health care workers and peers[35]. Special attention should be given to reducing stigma against those with psychotic features, as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, criteria for Schizophrenia Spectrum and Other Psychotic Disorders by other mental health clients and mental health programs.

The county may include in it's Prevention and Early Intervention Program a (3) Suicide Prevention Campaign

(A) Suicide Prevention Campaign means efforts specifically designed to prevent suicide that ~~do not focus on specific individuals at risk of or with serious mental illness~~ result from untreated mental illness Suicide Campaigns should not attempt to reduce all suicide. Suicide campaigns should not focus on populations not at increased risk of suicide due to mental illness.[36]

~~(B) Examples of direct efforts to combat mental health–related suicide that do not focus on specific individuals include, but are not limited to, public and targeted information campaigns, suicide prevention networks, capacity building programs, culturally specific approaches, screening programs, and training and education~~[37]

~~(C) Programs that aim to reduce suicidality for specific individuals at risk of or with early onset of a potentially serious mental illness can be either Prevention or Early Intervention Programs~~

(Renumber) Unless otherwise prohibited, prevention and early intervention funds may be used for AB1421 programs and individuals enrolled in those programs in counties that have implemented it. For purposes of Section 5840, enrollment in AB 1421 programs shall not be considered discrimination.

(e) All programs listed in subdivisions (c) and (d) shall include all of the following strategies

(Reunumber)

Be evidence based. Be evidence based to reduce the duration of untreated serious mental illness or prevent mental illness from becoming severe and disabling. Evidence based means programs supported by scientific peer reviewed independent research, that are effective for people with serious mental illness; and are proven to reduce incarcerations, homelessnesss, suicide attempts, arrest, violence, and needless hospitalization.[38]

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contrary to legislation. Also see Section 3 (a), Purpose and Intent. "To define **serious mental illness** ….as a condition deserving priority attention."

[34] Per 5840(b)(4).

[35] In order to meet the previously discussed requirements that all MHSA funded efforts be efficient and effective, discrimination reduction campaigns should also be targeted at those with a higher than average likelihood of interacting with the 5-9% of the population with serious mental illness. Otherwise most of the efforts will be wasted.

[36] 5840(d)(1) specifically limits suicide campaigns to lowering suicides that "result from untreated mental illness, not lowering all suicides." To suggest campaigns should focus on those not at risk is the exact opposite of what the legislation is attempting to accomplish and would (and has) led to a diversion of funds and waste of funds.

[37] There is no evidence that mass media suicide reduction campaigns work. There is some evidence they may increase suicide. Targeting suicide campaigns to the entire population is not an efficient or effective way to reduce suicide due to untreated mental illness, which are they only suicide activities allowed in MHSA. We would be glad to share the evidence with you on this.

[38] See Section 2(c), findings and declarations. MHSA is designed to 'define serious mental illness as a condition deserving priority attention'. So programs must be evidence based to help those with serious mental illness. Further, in 5840(d) and findings and declarations, very specific outcomes are listed (ex. reduced homelessness). Therefore for program to be evidence based they must (a) serve the target population; and (b) impact the listed outcomes.

(1) Be designed and implemented to create Access and Linkage to Treatment

(A) "Access and Linkage to Treatment" means connecting children with severe mental illness, as defined in Section 5600.3, and adults and seniors with severe mental illness, as defined in Section 5600.3, as early in the onset of these conditions as practicable, to medically necessary care and treatment, including but not limited to mobile crisis intervention services, mental illness clinics, hospitalization, respite care, and care provided by county or state mental health programs. Include processes and procedures to engage individuals with anosognosia and other individuals with serious mental illness who need but refuse treatment.

(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~~ with serious mental illness[39] from an underserved population as defined in Title 9 California Code of Regulations Section 3200.300 ~~who needs mental health services because of risk or presence of a mental illness~~[40] receives appropriate services as early in the onset as practicable after diagnosis[41], through program proven effective at reducing the duration of untreated serious mental illness and/or prevents mental illness from becoming severe and disabling[42]. ~~features~~ Features may also include connection to inpatient care when needed, ~~such as~~ accessibility, cultural and language appropriateness, transportation, family focus, hours available, and cost of services

(B) PEI programs shall provide services to people with serious mental illness[43] in the most effective and efficient culturally appropriate settings including ~~convenient, accessible, acceptable, culturally appropriate settings such as primary healthcare, schools, family resource centers, community-based organizations, places of worship, and public settings unless a~~ mental health settings that ~~enhances~~ provide access to quality services and outcomes for underserved populations

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

(A) "Strategies that are Non-Stigmatizing" refers to promoting, designing, and implementing programs in ways that reduce and circumvent stigma and discrimination, including self- stigma, and make services accessible, welcoming, and positive both for individuals who have a achieved a high level of recovery and those who have not[44]. For purposes of this section, AB-1421 programs, 5150 admissions, inpatient hospitalization are not stigmatizing[45]

[39] All MHSA and PEI programs must be limited to people with serious mental illness. Being a member of an underserved population does not make the individual eligible for MHSA services unless serious mental illness is also present

[40] MHSA is for serious mental illness, not mental health. It requires the presence of mental illness. There are not yet any known risk factors that can be eliminated that would lead to the prevention of mental illness.

[41] There is no way to predict who will and won't develop serious mental illnesses. While there may be prodromal indications, the research is not developed enough to say they are predictive.

[42] See 5840(a) and 5840 (c).

[43] All MHSA and PEI programs must be limited to people with serious mental illness.

[44] Many people with SMI, do not recover. 90% do not work. Messages that communicate that everyone recovers or can become a productive member of society are stigmatizing to those who as a result of their illness remain highly symptomiatc.

[45] MHSA is intended to help the most seriously ill. Some of these may on occasion need hospitalization, guardianship or assisted interventions. It would be a misuse of MHSA funds to encourage stigma or discrimination against these

(B) Examples include, but are not limited to, positive messages and approaches with a focus on symptom amelioration recovery, wellness, and resilience; communicating the appropriate use of hospitalization; medications, therapy, the use of culturally appropriate language and concepts; efforts to acknowledge and combat multiple and confounding stigmas to the extent they impact on serious mental illness, such as those related to race, sexual preference, etc; co-location of mental health services with other life resources; promoting positive attitudes and understanding of recovery among mental health providers; understanding not everyone recovers, inclusion and welcoming of family members; highly symptomatic consumers, and employment of peers in a range of roles if supported by independent evidence[46].

Special attention should be given to reducing stigma and discrimination against people with psychotic features, as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, criteria for Schizophrenia Spectrum and Other Psychotic Disorders by mental health programs. [47]For purposes of this section communicating the relationship between untreated serious mental illness and violence, use of AB-1421 programs, guardianships, and inpatient hospitalization are non stigmatizing.

(f) The County shall measure and report outcomes for all programs listed in subdivisions (c) and (d) and for strategies listed in subdivision (e) (1) and (2)

(g) All programs listed in subdivisions (c) and (d) and all strategies listed in (e) shall use effective methods likely to bring about intended outcomes, based on ~~one of t~~he following standards~~, or a combination of the standards~~

(1) Evidence-based practice: interventions for which there is scientific evidence consistently showing improved mental health outcomes for ~~the intended population~~people with serious mental illness[48], including, but not limited to, evidence from randomized clinical trials. Evidence based programs must improve one or more of the outcomes intended to be improved by the legislation, specifically reduction in homelessness, arrest, incarceration, sucide and hospitalization among people with mental illness.[49]

~~(2) Community and or practice-based evidence: Interventions for which there is clinical, client/family, and community consensus that the practice achieves culturally relevant mental health outcomes for the intended population, especially for underserved communities~~[50]

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individuals or work to make the services they need less likely to be provided. This is especially true since these types of services were specifically authorized by the legislature

[46] We refer drafters to " Consumer-providers of care for adult clients of statutorybmental health services" by the Cochrane Collaborative, considered one of the highest quality authorities on research. That research, as well as that by others, examines the evidence base for peer support and strongly suggests that MHSOAC and counties are using MHSA funds for peer activities not supported by evidence. Available at http://www.ncbi.nlm.nih.gov/pubmed/23543537

[47] These are defined in the 5840(b)2. Stigma activities, like all others must be designed to help people with serious mental illness. Unfortunately, much of what passes for anti-stigma activities is stigmatizing to those with serious mental illness. It suggests that they can recover, when they don't. Ex. According to Bazelon, 90% of SMi do not work. In spite of this, anti-stigma campaigns often claim everyone can become productive members of society, thereby stigmatizing those who can't.

[48] Programs that help people without serious mental illness, ex a 'mental health issue' are not evidence based to help those MHSA and PEI are intended to serve.

[49] See findings and declarations and Purpose and Intent and 5040(a) previously discussed for a list of outcomes MHSA and PEI in particular is intended to improve. Programs that do not improve these outcomes or improve softer measures are not evidence based to accomplish the objectives of the legislation

[50] The legislation is quite specific that only interventions that are evidence based are allowed. The fact that there is a 'consensus' around some interventions does not make it evidence based. Evidence based is a function of peer review, not a popularity contest. Historically PEI funds have routinely been diverted to these programs, favored by

(h) A PEI program is consider changed f the county changes the intended outcomes or substantially changes the activities or interventions provided to bring about the intended outcomes

(RENUMBER)
Prevention and Early Intervention funds may not be used for public relations; to stigmatize or cause a reduction in services to those with serious mental illness in inpatient units, guardianship, 5150 or AB-1421 programs; communicate falsehoods about serious mental illness; lobbying; or influencing legislation. Funds must serve individuals with serious mental illness, except that funds may be used to prevent those with mental illness from having it become severe and disabling. No funds may be used to prevent serious mental illness without a waiver from MHSOAC as there is currently no evidence that serious mental illness can be prevented.

Section 2. Program Evaluation
(a) For each PEI program listed in subdivisions (c) and(d) of Section 1 and for strategies (1) and (2) listed in subdivision (e) of Section 1 the County shall define evaluation methods and measure program outcomes at least annually, report results as specified in Section 5, and use data from evaluations for quality improvement

(1) For Prevention and Early Intervention programs that serve specific clients, including families
(A) The County shall measure the reduction of prolonged suffering that may result from untreated mental illness referenced in Section 5840(d)(5) and report on diagnosis.

(i) Reduction in prolonged suffering is measured by a reduced ~~risk or~~ severity of mental illness as indicated by reduced ~~risk factors or~~ [51]symptoms and direct measures of recovery, improved mental health status~~, or increased protective factors~~. ~~Examples~~ Primary required measures include reductions in violence, arrest, incarceration, suicide attempts, suicide, homelessness, and needless hospitalization.[52] Others are optional and secondary. ~~mental and emotional well being, positive relationships and social connectedness, hopefulness, self-efficacy, perceived peace and harmony, a sense of meaning and life-satisfaction, pro-social behaviors, and choices and actions that promote wellness~~[53]

(B) The county may select, define, and measure indicators, ~~each of which is logically related to the reduction of any of the other MHSA negative outcomes~~ referenced in Section 5840(d) and Findings and Declarations, Section 2 paragraphs (c) and (d) ~~that may result from~~ among people with untreated mental illness
(i) Reduction in suicide, incarcerations, school failure or drop out, unemployment, homelessness, or removal of children from their homes as a consequence of untreated mental illness, if applicable to a particular program, is assessed for individuals ~~at risk of or~~ with a serious mental illness using appropriate indicators that the county selects. Examples include, but are not limited to, school success (attendance, grades, or graduation), lack of involvement in the criminal justice system, reduced suicid~~eal ideation~~ or attempts (increased help-seeking), having a place

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stakeholders (have consensus) but which lack evidence. We would be glad to provide evidence of programs funded by PEI because there was 'consensus' but not an evidence base. This is one of the problems MHSOAC should be reigning in, versus encouraging.
[51] The risk factors associated with serious mental illness are biological and genetic and we do not know how to reduce.
[52] These are defined as the important measures in Section 2, findings and declarations, paragraphs (c) and (d) and 5840(d)
[53] These are not described anywhere in the legislation. The regulations should see that the intent of the legislation (reduced homelessness, suicide, incarceration, hospitalization) are achieved and not substitute the legislative intent with other measures.

to live, children remaining in their homes (decrease in family risk factors, positive parent-child relationships and communication), or employment (participation in training or job readiness programs) among people with mental illness

(C) The county must report statistical information on the diagnosis of individuals served and the processes used to ensure that MHSA PEI funds are restricted to people diagnosed with mental illness and serious mental illness. The county must report steps to monitor and ensure programs are serving only eligible populations.[54] The county must report on steps taken to monitor and ensure MHSA funds are not supplanting other funds and are being used to expand existing systems of care.

(2) For Outreach to Gatekeepers programs referenced in subdivision (c) (2) of Section 1,the County shall measure
(A) The number and kind of gatekeepers engaged, with a breakdown by setting
i. Examples of settings include, but are not limited to, jails, police departments, sheriff departments, hospitals, mental health centers, homeless services, inpatient units, libraries, public transit facilities[55], family resource centers, senior centers, schools, cultural organizations, churches, ~~recreation centers~~[56], residences, shelters, and clinics

(3) For Stigma ~~and Discrimination~~ Reduction Campaigns referenced in subdivision (d)(2) of Section1, the County shall measure
(A) Changes in attitudes and knowledge related to mental illness among people with mental illness or are seeking services for mental illness: for example, more accurate information about mental illness, symptom amelioration, prognosis ~~and~~ recovery, increased awareness of the effectiveness of ~~prevention and~~ medication and other treatments for mental illness, increased comfort and openness to interacting with other people with mental illness
(i) County shall use a validated method to assess changes in attitude, knowledge, and/or behavior. Example of instruments: the CAMI – Social Restrictiveness Scale and the Brief Implicit Association Test

(B) Changes in attitudes and knowledge related to seeking mental health services
(i) County shall use a validated method to assess changes in attitude, knowledge, and/or behavior. Example of instruments: Self-Stigma of Seeking Psychological Help Scale, Perception of Stigmatization by Others for Seeking Help Scale, and the Attitudes toward Seeking Professional Psychological Help Scale

(4) For Suicide Prevention Campaign referenced in subdivision (d) (3) of Section 1, the County shall ensure that the campaigns were targeted at people with mental illness or seeking mental illness treatment and not the general public[57]. Counties shall measure
(A) suicide rates and attempted suicide rates.[58] ~~Changes in knowledge about suicide, for example~~

[54] The auditor found there was no assurance that funds were reaching intended recipients. MHSOAC regulations should ensure that funds are reaching those defined in PEI section which is individiuals with serious mental illness and individuals with mental illness who need services to prevent the illness from becoming severe and disabling.
[55] In order for programs to meet MHSA requirements to be effective and efficient they must target gatekeepers most likely to come into contact with people with serious mental illness
[56] Recreation centers are not more likely than other settings to see people with serious mental illness. An argument can be made that people with serious mental illness are less likely than the general population to use recreaction centers.
[57] 5840(b)(3) limits stigma activities to those "diagnosed with a mental illness or seeking mental health treatment"
[58] 5840(d)(1) limits suicide reduction activity to reducing suicide among those with untreated mental illness. The best measure is a reduction of suicide or suicide attempts. The other measures proposed are needlessly divorced from and ineffective ways to measure reduced suicide and suicide attempts. The other measures are likely to lead to a diversion of funds as counties try to improve those measures, even as suicide and suicide attempts rise.

~~about warning signs, most useful response to someone who is suicidal, available resources and most effective ways to encourage people to utilize them, cultural variations in attitudes about suicide and culturally-specific prevention strategies~~

(B) Changes in behavior: for example, decreased suicidal attempts, increased identification of individuals at risk of suicide, increased successful referrals ~~an~~m d support, increased positive self-care and help-seeking by individuals who are feeling suicidal.

For Discrimination Reduction campaigns referenced in 5840(b)(4) counties may measure understanding of serious mental illness, the difference between serious mental illness and improving mental health and an understanding of the types of services needed to improve outcomes for people with serious mental illness including adequate inpatient facilities, mobile crisis intervention teams, CIT teams, Mental Health Courts, respite centers, medications, and other services that help people with serious mental illness.

(5) For PEI strategy to provide Access and Linkage to Treatment referenced in subdivision (e)(1) of Section 1, the County shall measure

(A) Number of referrals to treatment by diagnosis, kind of treatment to which person was linked (level of care), and reduced duration of untreated mental illness defined as interval from medical records or when not available[59] self- reported (or parent/family member-reported) onset of symptoms until initiation of treatment

(6) For PEI strategy to Increase Timely Access to Services for Underserved Populations referenced in subdivision (e)(2) of Section 1, the County shall measure

(A) Diagnoses

~~(A)~~(B) Number of referrals of ~~members of underserved groups~~persons with mental illness or serious mental illness to various kinds of care (prevention, early intervention, and treatment) by diagnosis, reduced duration of untreated mental illness defined as interval from medical records, professional records or if not available[60] self-reported (or parent/family member-reported) onset of risk indicators or symptoms until initiation of services, including treatment. For treatment, indicate kind of treatment to which person was linked (level of care)

(b) ~~(b)~~ Evaluation designs shall be culturally appropriate and shall include the perspective of (a) diverse people with ~~lived experience of~~ mental illness, ~~including~~ (b) their family members; (c) those who care for those who experience the "negative outcomes" listed in 5840(d) which would include police, sheriffs, EMS, shelter workers, mobile crisis services, courts, psychiatric hospitals, emergency rooms and corrections.

~~—~~For example, an assessment of increased integration of systems should reflect the extent to which individuals, ~~and families~~ families, criminal justice, homeless programs, EMS, and courts perceive an integrated service experience. ~~and i~~Intended outcomes should be meaningful and relevant to participant~~s~~. Evauluations should corroborate self reported findings.[61]

[59] Self reports are notoriously unreliable. This is especially true for those with anosognosia. Self reports should only be used when documentation is unavailable.

[60] Self-reported information is notoriously unreliable. Ex. Many patients with anosognosia do not know they are ill. They would not self-report illness or follow through on orders. Self reports should only be used when professional reports by treatment providers or medical records are unavailable. If those records are unavailable, counties should determine why.

[61] How the system looks to those in the mental health system is often radically different to how it looks to courts, corrections, police, sheriffs, EMS, shelters, etc. Those in the mental health system see those who have not been offloaded to prisons, jails and shelters. Since the legislation is designed to reduce incarceration, homelessness, arrest,

(c) ~~(c)~~ A County ~~may~~ shall also, as relevant and applicable, define and measure the impact of PEI programs on the mental health and related systems, including, but not limited to jails, prisons, criminal justice, sheriffs departments, police departments, EMS, corrections, psychiatric hospitals and units, mobile crisis units, homeless shelters,[62] education, physical healthcare, juvenile justice, social services, and community supports specific to age, racial, ethnic, and cultural groups. ~~Examples~~ Primary examples of system outcomes include, but are not limited to, reduced homelessness, arrest, incarceration, hospitalization and homelessness[63]. Secondary outcomes include increased provision of mental illness services to people with serious mental illness by ethnic and cultural community organizations, hours of operation, integration of services including co‐location, involvement of ~~clients~~ persons with mental illness and families in key decisions, identification and response to co‐occurring substance‐use disorders, staff knowledge and application of recovery and symptom amelioration principles, collaboration with diverse community partners, or funds leveraged

County plans must document the diagnoses of the persons being served, proof that programs are evidenced based to help the target population: those who have serious mental illness (vs. a 'mental health disorder); documentation that the program cause progress by actually reducing homelessness, suicide, incarceration, hospitalization, arrest or other issues defined in the legislation's purpose and intent or findings and declarations. Plans must document steps taken to ensure that ineligible individuals are not recipients of MHSA funding and that MHSA funds are used to expand existing systems of care and are not supplanting other funds.

(a) As part of the Three‐Year Program and Expenditure Plan or annual update, the county shall include in the Prevention and Early Intervention Program Plan the following information:

(1) A description of how the county ensured that staff and stakeholders involved in the Community Program Planning process required by Title 9 CCR section 3300, were informed about and understood the purpose and requirements of the MHSA Prevention and Early Intervention component and the process for evaluating stakeholder input and rejecting input that diverts funds from helping to improve important outcomes in people with serious mental illness.
(2) A description of the county's plan to involve community stakeholders, including police, sheriffs, hospital administrators, courts, corrections, and EMS meaningfully in all phases of Prevention and Early Intervention program, including program planning and implementation, monitoring, quality improvement, evaluation, and budget allocations

3 Steps taken to ensure that stakeholder recommendations that are (i) outside the purpose and intent of the legislation (II) not evidenced based to improve the most important outcomes, or (III) in people without serious mental illness were not incorporated in plans.

(renumber) The process used to reject stakeholder suggestions that are inconsistent with the MHSA.

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and suicide, it is important that those who are called when those outcome occur be involved in the evaluation to provide their perspective.

[62] Again: the purpose of MHSA is to reduce these outcomes, therefore evaluation of success or failure can only be achieved by involving those who are called to address the legislatively defined outcomes.

[63] MHSOAC must ensure that counties measure the *outcomes* of MHSA investment in terms of reduced hospitalization, suicide, arrest, incarceration, and homelessness as primary measures. Other secondary, softer *process* measures may be monitored, but in no way should *process* measures substitute for *progress* measures.

(3) A brief description, with specific examples of how each Prevention and Early Intervention funded program will reflect and be consistent with all relevant (potentially applicable) MHSA General Standards set forth in Title 9 CCR section 3320 and the requirement to limit services and programs to those with mental illness or serious mental illness.

(4) For each new Early Intervention program, the county shall include a description of the program including but not limited to:

(A) Identify the target population for the intended mental health outcomes
i. Specify demographics including, but not limited to, age, race/ethnicity, gender, primary mental illness diagnosis[64]; and if
relevant, primary language spoken, military status, and LGBTQ identification
ii. Specify the mental illness for which there is early onset and the mental illness whos duration is being reduced.
iii. Affirmation that each person has a mental illness, the primary diagnosis and s~~S~~pecify how each participant's early onset of a potentially serious mental illness will be verified
(B) Specify any MHSA negative outcomes referenced in Section 5840(d) that the program is expected to affect in persons with mental illness.
i. List the indicators that the county will use to measure reduction of prolonged suffering as referenced in Section 2(a)(1)(A)
ii. If the county decides to measure the reduction of any other specified MHSA negative outcome as referenced in Section 2(a)(1)(B), list the indicators that the county will use to measure the intended reductions in persons with mental illness or serious mental illness.
iii. 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) Specify the type of problem(s) and need(s) for which the intervention will be directed and the activities and interventions to be included in the program that are intended to ~~bring about mental health and related functional~~ prevent mental illness from becoming severe and disabling or reduce the duration of untreated serious mental illness. ~~outcomes for individuals with early onset of potentially serious mental illness~~
(D) Provide strong evidence that the approach is likely to reduce specified MHSA negative outcome referenced in Section 5840(d) for the intended population, including reduction of prolonged suffering as defined in Section 2 (a)(1)(A) and (B), using ~~one of~~ the ~~two~~ following standards ~~(or a combination)~~ using criteria specified in subdivision (g) of Section 1:
i. If evidence-based, provide a brief description of or reference to the peer-reviewed independent 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 ii. ~~If practice-based, describe the evidence that the approach is likely to bring about MHSA outcomes for the intended population~~ [65]

(5) For each new Prevention program, the county shall include a description of the program including but not limited to: (A) Identify the target population for intended mental health outcomes by diagnosis

[64] Serving people with serious mental illness is at the core of MHSA. Any evaluation that does not ensure those receiving services are part of the targeted population, are by definition, useless.
[65] See previous discussion on evidence based programs. Programs are evidence based if proven in scientifically rigorous studies to improve major outcomes in people with serious mental illness."Consensus" does not trump the need for evidence.

(i) Specify 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
(ii) Specify how each participant's ~~risk of a potentially~~ serious mental illness will be defined and verified
(B) Specify any MHSA negative outcomes referenced in Section 5840(d), in addition to reduction of prolonged suffering, that the program is expected to affect
i. List the indicators that the county will use to measure reduction of prolonged suffering as referenced in Section 2(a)(1)(A)
ii. If the county decides to measure the reduction of any other specified MHSA negative outcome as referenced in Section 2(a)(1)(B), list the indicators that the county will use to measure the intended reductions
iii. 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) Specify the type of problem(s) and need(s) for which the intervention will be directed and the activities and interventions to be included in the program that are intended to bring about mental health and related functional outcomes for individuals with ~~higher than average risk of potentially~~ serious mental illness
(D) Provide peer reviewed evidence that the approach is likely to bring about specified MHSA negative outcomes referenced in Section 5840(d) for the intended population, including reduction of prolonged suffering as defined in Section 2 (a)(1)(A) and (B), using ~~one of~~ the ~~two~~ following standards (~~or a combination)~~ using criteria specified in subdivision (g) of Section 1
i. If evidence-based, provide a brief description of or reference to the relevant peer review, independent, 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
~~ii. If practice-based, describe the evidence that the approach is likely to bring about MHSA outcomes for the intended population~~
~~(6) For each new Outreach to Gatekeepers program, the county shall include a description of the program including but not limited to:~~

(A) Identify the kinds of gatekeepers the program intends to reach,

i. Describe briefly the gatekeeper's setting and why they have a greater than average ~~opportunity to identify diverse~~ exposure to individuals with mental illness who are likely to develop ~~early signs and symptoms of potentially~~ serious mental illness
(B) Specify the methods to be used to engage gatekeepers and for gatekeepers 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, including timeframes for measurement
(C) Provide evidence that the proposed method is likely to bring about intended outcomes using one of the two following standards (or a combination) using criteria specified in Section 1(g)
i. If evidence-based, provide a brief description of or reference to the relevant evidence applicable to intended outcome, explain how the practice's effectiveness has been ~~demonstrated~~ proven and explain how the county will ensure fidelity to the evidence-based practice in implementing the program
~~ii. If practice-based, describe the evidence that the approach is likely to bring about MHSA outcomes~~
(D) Indicate if the county intends to measure other outcomes than those required in Section 2 (a)(2)(A) (B), and (C) and, if so, what and how

For each new Stigma ~~and Discrimination Reduction~~ Campaign, the county shall include a description of the program including but not limited:

(A) Identify whom the campaign intends to influence and the evidence that the group is at higher than average risk of having a serious mental illness.[66]

(B) Specify the methods and activities to be used to ~~change~~ improve attitudes, knowledge, and/or behavior regarding mental illness and increasing the likelihood of seeking mental health services for mental illness, consistent with requirements in Section 2 (a)(3)(A) and (B), including timeframes for measurement

(C) Provide evidence that the proposed method is cost-effective and likely to bring about the selected outcomes using ~~one of the two following~~evidence based standards ~~(or a combination) using criteria specified in Section 1(g)~~

If evidence-based, provide a brief description of or reference to the relevant evidence applicable to achieving the intended outcome in people with serious mental illness, 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 practice-based, describe the evidence that the approach is likely to bring about MHSA outcomes~~

(8) For each new Suicide Prevention Campaign, the county shall include a description of the program including but not limited:

(A) Identify whom the campaign intends to influence and why the group is at increased risk of suicide caused by mental illness.

(B) Specify the methods and activities to be used to change attitudes and behavior to prevent suicide in individuals with mental illness.

(C) Indicate how the county will measure ~~changes in attitude, knowledge, and/or behavior related to suicide risk~~reduced suicide and suicide attempts due to mental illness, consistent with requirements in Section 2(a)(4)(A) and (B), including timeframes for measurement

(D) Provide evidence that the proposed method is likely to bring about selected outcomes using ~~one of the two following standards (or a combination) using~~ criteria specified in Section 1(g)

i. If evidence-based, provide a brief description of or reference to the relevant evidence applicable to the intended outcome, 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

~~ii. If practice-based, describe the evidence that the approach is likely to bring about MHSA outcomes~~

(9) For all new programs referenced in subdivisions (4) through (8) above, explain how the program will be implemented to create Access and Linkage to treatment for individuals with serious mental illness as referenced in Section 1(e)

(A) 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 and

(B) 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

(C) Explain how the program will follow up with the referral to support engagement in treatment and the steps taken to ensure the referral is completed

(D) Indicate if the county intends to measure outcomes other than ~~those required in Section 2~~

[66] PEI provisions allow specify that stigma reduction campaigns must reduce stigma in people diagnosed with mental illness or seeking services. They are not intended for those without mental illness or who are not seeking service. County plans should document an understanding of this.

~~(a)(5)(A)~~reduced homelessness, suicide, incarceration, arrest, and hospitalization among people with serious mental illness.

(10)For all new programs referenced in subdivisions (4) through (8) above, indicate how the program will use strategies to Increase Access to Services for Underserved Populations with serious mental illness or a mental illness that is likely to become severe and disabling, as required in Section 1(e)

(A) For each new program, the county shall indicate the intended setting and why this setting enhances access for specific, designated underserved ~~populations~~population with mental illness that is likely to become severe and disabling or has serious mental illness. If the county intends to locate the program in a non mental health setting, explain why this choice enhances access to quality services and outcomes for specific underserved populations and what steps are taken to ensure the funds are only used for those with serious mental illness or mental illness that is likely to become severe and disabling.

~~(B) Indicate if the county intends to measure other outcomes than those required in Section 2 (a) (6) (A) and, if so, what and how, including timeframes for measurement~~

(11)For all new programs referenced in subdivisions (4) through (8) above, indicate how the program will use Strategies that are Non-stigmatizing, including a description of the specific strategies to be employed and the reasons the County believes they will be successful and meet intended outcomes in persons with serious mental illness.

(12)For all programs for the following fiscal year, the county shall include the following information

(A) Estimated number of children, adults, and seniors to be served in each Prevention and each Early Intervention program that serve specific individuals, by diagnosis.

(B) The county may also include estimates of the number of individuals with serious mental illness or mental illness that will likely become severe and disabling who will be reached by Outreach to Gatekeeper, Suicide Prevention Campaigns, and Stigma and Discrimination Reduction Campaigns

(13)Fiscal projections: The county shall include projections for each Prevention and Early Intervention program by fiscal year and the following sources of funding

(A) Estimated total mental health expenditures, MHSA Prevention and Early Intervention funding, Medi-Cal FFP, 1991 Realignment, Behavioral Subaccount, and other funding

(B) The county shall identify each PEI-funded program as Prevention, Early Intervention, Gatekeeper Outreach, Stigma and Discrimination Reduction Campaign, or Suicide Prevention Campaign and 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

i. The county shall estimate the amount of funding for PEI Administration ii. The county shall estimate the amount of funding for PEI Assigned Funds. PEI

Assigned Funds represent funds voluntarily assigned by the County to CalMHSA or any other organization in which counties are acting jointly Total estimated PEI Assigned Funds is automatically calculated

(b) Changed PEI program: If a county determines a need to change the intended outcomes or to make a substantial change to the activities or interventions provided to bring about the intended outcomes of any of the PEI programs described in the county's most recent Three-Year Program and Expenditure Plan or annual update, 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 original Three-Year Program and Expenditure Plan or annual update
(2) A description of the change
(3) Explanation for the change including, if any, evaluation data supporting the change and stakeholder involvement in the decision

Section 4. Prevention and Early Intervention Program Report

(a) The county shall report the following program 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 that serves specific clients, including families, list the numbers served and the number with serious mental illness by diagnosis. For those without serious mental illness, indicate the serious mental illness that is being prevented.

(A) Unduplicated numbers of individuals served in each Prevention and each Early Intervention program If a program serves both individuals at risk of ~~(Prevention)~~ and individuals with early onset of (Early Intervention) potentially serious mental illness, the county shall report numbers served separately for each category Programs that serve families shall report information for each individual family member served and the diagnosis of the family member that made the family eligible for MHSA funded support.

(2) For each Outreach to Gatekeepers program, number of gatekeepers as defined in Section1(c) successfully engaged broken out by kind of settings

(3) Access and Linkage to Treatment Strategy: (A) Number of individuals with serious mental illness successfully referred to treatment, and kind of treatment to which person was linked (level of care)

(B) Interval between onset of mental illness (as reported by client or parent) and entry into treatment

(4) Increase Timely Access to Services for Underserved Populations Strategy: (A) Identify the specific underserved populations for whom outreach was conducted by diagnosis

(B) Number of successful referrals to PEI services or to treatment that resulted from this outreach

(C) Break down of access to services across the mental health continuum (prevention, early intervention, treatment including level of care, recovery support) for underserved populations compared to county demographics or other appropriate comparison

(D) Interval between onset of risk indicators or mental illness (as reported by client or parent, in most instances) and entry into treatment

(E) Interval between referral and client engagement in services, including treatment

(5) For the information reported under subdivisions (1) through (4) above, disaggregate numbers served, number of gatekeepers engaged, and number of referrals for treatment and other services by: (A) Age group by the following ages: 0-15 (children/youth); 16-25 (transition age youth); 26-59
(adult); and ages 60+ (older adults)

(B) Race/ethnicity and diagnosis by the following categories:
(i) American Indian or Alaska Native
(ii) Asian Indian
(iii) Asian, other
(iv) Black or African American
(v) Cambodian
(vi) Chinese
(vii) Filipino
(viii) Gumanian

(ix) Hispanic/Latino (x) Multi-racial
(xi) Hmong
(xii) Japanese
(xiii) Korean
(xiv) Laotian
(xv) Mien
(xvi) Native Hawaiian
(xvii) Pacific Islander
(xviii) Samoan
(xix) Vietnamese
(xiv) Unknown/not reported
(xv) White or Caucasian

(C) Primary language spoken broken down by threshold languages (C) Sexual orientation ,if known,
(D) Disability, if any
, (E) Veteran status,
(F) Gender
(G) Any other data the County considers relevant

(6) For Stigma ~~and~~ or Discrimination Reduction Campaigns and Suicide Prevention Campaigns, counties shall report number of suicides and sucide attempts. Counties may report available numbers of individuals with serious mental illness 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.
(7) For all programs and strategies, counties may report implementation challenges, successful and unsuccessful approaches, lessons learned, and relevant examples.

Section 5. Evaluation Report
(a) The County shall submit the Evaluation Report to the MHSOAC every three years as part of the Three-Year Program and Expenditure Plan. The Evaluation Report answers questions about the impacts of PEI programs on individuals with r~~isk or early onset of~~ mental illness oor serious mental illness and on the mental health and related jail, homeless, corrections, criminal justice and hospital systems.

(b) The Evaluation Report shall describe the evaluation methodology, including methods used to select outcomes and indicators, collect data, and analyze results, including timelines.

(c) The Evaluation Report shall provide results and interpretation of results for all required evaluations set forth in Section 2

(d) The county may also include in the Evaluation Report any other evaluation data on selected outcomes and indicators, including evaluation results of the impact of PEI programs on mental health and related systems.

(e) The county may report any other available evaluation results in Annual Updates.

Section 6. Prevention and Early Intervention Annual Revenue and Expenditure Report
(a) The county shall report as part of the MHSA Annual Revenue and Expenditure Report the following:

(1) The total funding source dollar amounts expended during the reporting period on each PEI program broken by the following funding source: MHSA PEI funds, Medi-Cal FFP, 1991 Realignment, Behavioral Health Subaccount, and other funds

(A)The county shall identify PEI programs as either those focused on Prevention, Early Intervention, Gatekeeper Outreach, Stigma and Discrimination Reduction Campaign, or Suicide Prevention Campaign. If a program includes more than one element, the county shall estimate the percentage of funds dedicated to each element

(2) The amount of funding expended for PEI Administration broken by the following funding source: MHSA PEI funds, Medi-Cal FFP, 1991 Realignment, Behavioral Health Subaccount, and other funds.

(3) The amount of funding for PEI Assigned Funds.

(A) PEI Assigned Funds represent funds voluntarily assigned by the County to CalMHSA or any other organization in which counties are acting jointly.

Problems with previously considered regulations and guidance

CA DMH and MHSOAC have issued numerous guidance, emergency regulations, proposed regulations, promulgated regulations, pseudo-regulations and lapsed regulations guiding how PEI and other MHSA funds are to be spent. Most of these had the effect of diverting funds from people with mental illness to those without. Even when the regulations were never promulgated counties were being required to rely on them. Many counties still rely on them. For example, Monterrey County had its PEI plan rejected by MHSOAC because they were serving people with mental illness as required by the legislation, rather than focusing resources on people without mental illness as DMH/MHSOAC suggested. In Orange County's 2013 Plan they refer to MHSOAC guidance that requires them to spend 51% of PEI funds on children under age 25. There is no such requirement in the legislation.

The Department of Health Care Services and MHSOAC should immediately communicate forcefully and clearly that previous guidance directing funds to people without mental illness is null and void and simultaneously communicate that the funds must be spent on people with mental illness. Following are some of the regulations that counties are still relying on, how the regulation diverts funds, and the type of clarifying statement that should be issued to correct the erroneous guidance.

Proposed and enacted CCR Title 9 Regulations that diverted funds from seriously mentally ill	**How the regulation diverts funds**	**Corrections that should be communicated to counties**
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.	Prevention and Early Intervention funds should be used to help people with mental illness. Previous guidance suggesting the funds were exempt from helping people with mental illness were incorrect. PEI funds should be used in people with serious mental illness on programs that reduce the duration; and on people with mental illness to prevent it from becoming severe and disabling.
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 (5813(f) only says "Funds shall not be used to pay for persons incarcerated in state prison or parolees from state prisons." This regulation goes further than that precludes support for those incarcerated in federal prisons and paroled from federal prisons.	Funds may be used to pay for people incarcerated in federal prisons, or county jails. Funds may be used for parolees from local jails and federal prisons. Previous guidance suggesting funds could not be used for those incarcerated or paroled from federal prisons was incorrect.

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

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 regulation 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.	Prevention and Early Intervention funds should be used to prevent mental illness from becoming severe and disabling. This often requires ongoing treatment. There is no requirement to stop funding treatment when treatment is needed to prevent mental illness from becoming severe or disabling or to reduce the duration of untreated mental illness. Previous guidance limiting PEI funds to those experiencing first onset was incorrect and is not operative.

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.	Previous guidance erroneously listed priority populations and did not make clear that they must ALSO meet the criteria for having a mental illness for which treatment is needed to prevent it from becoming severe and disabling; or have a serious mental illness which needs treatment to reduce it's duration. The following groups are NOT priority populations unless they ALSO have a mental illness that needs treatment to prevent it from becoming severe and disabling or have a serious mental illness: Being the member of a racial or ethnic population; lesbian, gay, or transgender individual, being a child or transition age youth, being affected by unemployment, homelessness, substance abused, violence, absence of care giving adult; being in an out-of-home-placement; being at risk of school failure, being at risk of or involved in juvenile justice system.
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 regulation 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.	Prevention and Early Intervention funds may not be used to prevent serious mental illness, since we do not know how to prevent serious mental illness. Previous guidance that suggested using funds to prevent serious mental illness was incorrect. Prevention and Early Intervention may be used anytime they are needed to prevent a mental illness from becoming severe and disabling or to reduce the duration of untreated serious mental illness. Previous guidance limiting PEI expenditures to intervention early in the emergence of a mental health problem was incorrect.
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:	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	Prevention and Early Intervention funds may not be used for individuals prior to a diagnosis. Prevention and Early Intervention funds are specifically limited to serving those with a mental illness, not those without .

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.	'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.[ii]	Those most at risk of mental illness are those with first degree relatives who have mental illness. Those most at risk of suicide are those who have previously attempted suicide or are the first degree relatives of people who have attempted or completed suicide. Therefore, any selective prevention activities should be aimed at these groups. Previous guidance suggesting Selective Prevention Activities be targeted at other groups was inaccurate. Prevention and Early Intervention funds may not be used on Universal Prevention Activities. There is a requirement that PEI funds be used effectively and efficiently and targeting groups that are not at risk does not accomplish that. Previous guidance allowing the use of PEI funds for the general public were incorrect. PEI legislation limits the use of 'stigma' funds to those diagnosed with mental illness. Therefore, stigma activities should fall within the selective prevention activities umbrella and target those with mental illness or likely to develop it.
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	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 regulation prohibits that expenditure contrary to the	Prevention and Early Intervention funds may be used for as long as needed to prevent mental illness from becoming severe and disabling or reducing the duration of untreated serious mental illness. Previous guidance suggesting services had to be withdrawn after one year were incorrect.

access to quality services and outcomes for unserved/underserved populations.	legislation. 3920(g) pushes for services to be outside where mentally ill people are: i.e. mental health settings.	
PEI Programs serve Californians of all ages. Counties (except small counties) are required to spend 51% of PEI funds on individuals between ages 0 and 25[iii]	While half of all mental illnesses may begin before age 14, MHSA was intended to define 'serious mental illness' (not all mental illness) as a priority. Serious mental illness most often begins in late teens and early twenties and rarely begins earlier.	The bulk of Prevention and Early Intervention Funds should be spent on children and adults older than 16, since serious mental illness starts in late teens or early twenties and can often be present throughout the rest of an individuals life. Previous guidance requiring 51% of funds to be spent on individuals between 0 and 25 was inaccurate.

[i] 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.

[ii] 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

[iii] See guidance at http://www.mhsoac.ca.gov/MHSOAC_Publications/docs/FactSheet_PEI_121912.pdf

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REACTION TO SUGGESTIONS NOT INCORPORATED BY DRAFTERS OF PEI REGS
October 29, 2013

MHSAOC posted suggestions they are not incorporating in their draft regs. Many are problematic and seem contrary to the legislative intent and likely to result in misuse of funds.

Following are changes we would ask the drafters to reconsider
http://www.mhsoac.ca.gov/Meetings/docs/Meetings/2013/OAC_102413_Handout_Tab2_SuggestionsNOTIncorporatedPEI.pdf.

PROPOSED CHANGE THAT WAS REJECTED BY MHSOAC	REASON MHSOAC GAVE FOR REJECTING CHANGE THEY SHOULD HAVE ACCEPTED	WHY MHSOAC IS PREVENTING FUNDS FROM BEING USED AS LEGISLATIVELY DIRECTED BY NOT IMPLEMENTING THE PROPOSED CHANGE
3. Include Laura's Law in early intervention services.	This is not within PEI section of statute. The new statutory language passed by SB 585 which allowed MHSA funds to be used for services under Laura's Law was added to the section of the MHSA dealing with CSS and not PEI.	There is no proscription in MHSA before SB 585 that prevented MHSA Funds, including PEI Funds from being used for Laura's Law. On this, we are in agreement with Disability Rights California which wrote, "There is no language in MHSA that prohibits the use of **any funds** for Laura's Law. (Disability Rights California "Memo to Interested Persons", 5/3/2005). There was no proscription inserted in SB 585 that prevents MHSA funds, including PEI from being used for Laura's Law. We encourage the drafters to read "Proposition 63 proceeds may be used to fund services to individuals eligible for Laura's Law" by Mental Illness Policy Org at http://mentalillnesspolicy.org/states/california/ok2usemhsa4ll.pdf. Also read "Mental Health Services Act and funding AB 1421 implementation" by Treatment Advocacy Center at http://mentalillnesspolicy.org/states/california/tac-mhsa-ok-4-ll.pdf Read an analysis by West Coast MIPO office at http://mentalillnesspolicy.org/states/california/maryannbernardmhsa4ll.pdf Following is a small excerpt from one of those documents that clearly documents that MHSA PEI Funds should be used for AB 1421 Programs ***Counties may use Prevention and Early Intervention (PEI) proceeds to provide treatment to individuals in Laura's Law*** (O)ther than perhaps the Adult System of Care services provisions, the Prevention and Early Intervention (PEI) sections of Proposition 63 are most closely aligned with and properly used for Laura's Law.[1] PEI funding is intended to go to programs that "emphasize strategies to reduce the…negative outcomes that may result from untreated mental illness".[2] That is a good description of Laura's Law. Individuals who need Laura's Law are a subset of those PEI funds are intended to help. "The [PEI] program *shall* include the following components …Access and linkage to medically necessary care provided by county mental health programs … for adults and seniors with severe mental illness, as defined in Section 5600.3.[3] Laura's Law provides "access and linkage to medically necessary care provided by county

		mental health programs" for individuals who are a subset of that group, specifically, "suffering from a mental illness as defined in paragraphs (2) and (3) of subdivision (b) of Section 5600.3"[4] Further, PEI funding is intended to "prevent mental illnesses from becoming severe and disabling".[5] Laura's Law prevents mental illness from becoming severe and disabling.[6] PEI funding is intended to help the underserved.[7] Individuals eligible for Laura's Law are an underserved population.[8] PEI funds are intended to fund outreach[9]. Laura's Law provides outreach.[10] PEI Programs are intended to reduce stigma.[11] Providing services to people under court orders reduces stigma.[12] PEI funding is intended to reduce suicide.[13] Laura's Law reduces suicide.[14] PEI funding is intended to reduce incarcerations.[15] Laura's Law reduces incarceration. [16] PEI funding is intended to reduce school failure or dropout.[17] Laura's Law may reduce school failure or dropout.[18] PEI funding is intended to reduce unemployment.[19] Laura's Law reduces unemployment.[20] PEI funding is intended to reduce prolonged suffering.[21] Laura's Law reduces prolonged suffering.[22] PEI funding is intended to reduce homelessness.[23] Laura's Law reduces homelessness. [24] PEI funding is intended to prevent removal of children from their homes."[25] Laura's Law likely prevents removal of children from their homes.[26] MHSA PEI 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 and assisting people in quickly regaining productive lives".[27] Laura's Law meets this criteria of being "effective in preventing mental illnesses from becoming severe" and is "successful in reducing the duration of untreated severe mental illnesses and assisting people in quickly regaining productive lives".[28] # # # Finally, we point out that Title 9, California Code of Regulations, section 3400 states "No person shall be denied access based solely on his/her voluntary or involuntary legal status." The refusal to admit patients in AB1421 programs to PEI funded services would be a denial based solely on his or her voluntary or involuntary legal status. PEI funds may be and should be used for programs to assist those who are subject to a Laura's Law court order.
No time limit for early interventions services if the county does not have a prevention program.	A time limit is necessary to differentiate between early intervention and CSS programs.	There is no necessity to differentiate between prevention programs and early intervention programs. The legislation says counties shall have 'a' program. There is nothing in the legislation that requires services needed to prevent mental illness from becoming severe and disabling to be withdrawn. Requiring the services to be withdrawn flies in the face of the intent of the legislation. Question for drafters: Must peer-support services and access to Hmong Gardens be withdrawn when a time-limit is met? We know of no program that does that or direction from MHSOAC suggesting it. We would ask that this be made clear.
Risk factors for mental illness should be primarily focused on biological or genetic.	Draft regulations document a range of risk factors, including biological and genetic, validated by	A stated purpose (e) of the legislation is "To ensure that all funds are expended in the most cost effective manner and services are provided in accordance with recommended best practices subject to local and state oversight to ensure accountability to taxpayers and to the public" The other factors included are not known to cause serious mental illness and

	research.	therefore do not represent a cost effective expenditure. The failure to use evidence based practices was a criticism of the auditor that MHSOAC should not ignore. If MHSOAC disagrees with our conclusion that genetic and biological factors are the primary cause of serious mental illness and therefore the ones that for efficiency and effectiveness should be focused on, we respectfully ask that they produce research that the other risk factors cause the types of illnesses MHSA is intended to ameliorate.
Focus stigma and discrimination efforts on individuals with psychotic features.	Kept the broader definition to be consistent with the MHSA.	The problem the drafters are facing are caused by the (1) bifurcation of stigma and discrimination campaigns into two components; and (2) a failure to stick to the clear language of the legislation. The language allows "Reduction in stigma associated with either being diagnosed with a mental illness or seeking mental health services." The legislation defines those illnesses in 5600. Regulations must ensure that stigma efforts are not targeted to those without mental illness or are not seeking services. This change should be accepted or replaced by one that accomplishes the same purpose: ensure expenditures on stigma are consistent with the regulations.
2. Delete practice-based evidence option.	Eliminating the option of practice-based evidence precludes many programs for communities of color, with whom practices have not been tested using formal clinical trials.	We frankly found this explanation for ignoring the legislation offensive. There are many practices that have not been tested on communities of color or communities without color. The fact that a program has not been tested nor proven does not make it eligible for PEI funding. This flies in the face of a stated purpose (e) of the legislation "To ensure that all funds are expended in the most *cost effective manner* and services are provided in accordance with recommended *best practices* subject to local and state oversight to ensure accountability to taxpayers and to the public" The drafters of the regulations noted this when rejecting a different change proposed by CMHDA when the drafters responded "Requiring "effective" methods of services is consistent with the MHSA." Requiring services be effective is as true for populations of color as it is for those who are not. An argument could be made that practices for which there is not evidence, only alleged 'consensus' could be funded with INN funds. No valid argument can be made they should be funded with PEI funds. If the drafters insist on this tortured explanation to allow, foster and encourage spending on non-evidence based programs, because they have special applicationto communities of color then they should limit those expenditure to the communities there is alleged to be consensus they work in. However, we believe that is illegal discrimination, and it is wrong to substitute proven treatments for communities of color with unproven ones (ex. more Hmong Gardens). As we previously noted, there is nothing in the legislation that allows 'consensus' to substitute for 'evidence'. The issue of not using validated techniques and not evaluating them was a core part of the auditors findings and we are disappointed to see the commission rejected this.

REACTION TO SUGGESTIONS INCORPROATED IN DRAFT PEI REGS

http://www.mhsoac.ca.gov/Meetings/docs/Meetings/2013/OAC_102413_Handout_Tab2_SuggestionsIncPEIRegs.pdf
MHSAOC posted suggestions they are incorporating in their draft regs. Many are problematic and seem designed to encourage misuse of funds. Following are changes we would ask the drafters to reject rather than accept

PROPOSED CHANGE THAT WAS ACCEPTED BY MHSOAC	**REASON MHSOAC GAVE FOR ACCEPTING THE CHANGE THEY SHOULD HAVE REJECTED**	**WHY MHSOAC IS PREVENTING FUNDS FROM BEING USED AS LEGISLATIVELY DIRECTED BY ACCEPTING THE PROPOSED CHANGE**
3. Add to list of Gatekeepers the following: community	None	We have no problem with adding leaders of faith bath organizations and individuals who support those who are homeless to the list of gatekeepers as they are disproportionately likely to interact with those

leaders, leaders of faith-based organizations, cultural brokers, people who support individuals who are homeless.		with mental illness. However MHSA is intended to support evidence based practices and support services that are effective. MHSOAC is charged with being stewards of the public purse. There is no evidence that 'community leaders' or 'cultural brokers' are any more or less likely than members of the general public to interact with persons with serious mental illness. Gatekeeper programs must be targeted at those disproportionately likely to interact with persons with mental illness in order to be considered effective and efficient.
4.Add concept that persons with signs and symptoms can be their own gatekeepers.	None	The clear purpose of the gatekeeper provisions are to help those likely to interact with persons with mental illness to identify and help those with mental illness. This will result in diversion of funds from those who are in position to identify multiple individuals who need help, to those who will spend the money on identifying themselves. This provision seems like a way to divert funds from gatekeepers.
2. Clarify that the regulation applies to counties and not the PEI Statewide Stigma and Discrimination Reduction Project.	None	We have no problem with counties pooling funds into statewide entities to achieve the objectives of MHSA. But those entities, like the counties, must comply with the regulations that ensure the funds are spent properly. MHSOAC responsibility is to see all funds are spent effectively and efficiently. By allowing counties to transfer funds to a statewide project and then absolve the statewide entity from having to comply with the legislation, facilitates misspending not proper spending. MHSOAC should not be setting up processes that allow counties to circumvent legislation. This is particularly true, for Stigma and Discrimination Reduction Projects. In spite of the clear legislative language that Stigma Campaigns focus on those with mental illness or seeking services the JPA created campaigns that don't. And diverted money to elsewhere. They also created campaigns that focus on the 1 in 4 with a mental health issue rather than the 5-9% defined in the legislation. In light of past abuse and waste in JPAs, it is critical that counties not be allowed to use it as a forum to facilitate spending outside the goals of the legislation.
4. Add "efforts to combat multiple stigmas to the list of examples of stigma and discrimination reduction programs.	None	The only stigma mentioned in the legislation is the stigma that comes from having a mental illness or seeking services. By accepting this, MHSOAC is facilitating the diversion of funds from legislatively allowable programs to those that are not.
1. Add an optional program category for county's suicide efforts that do not focus on or have intended outcomes for specific individuals.	None	The legislation is clear that it is supposed to reduce suicide caused by untreated serious mental illness. By accepting this, MHSOAC is facilitating the diversion of funds from legislatively allowable programs to those that are not. That is also why the measurement for this program must be a reduction in suicide or suicide attempts and not other measures.
3. Add "combat multiple social stigmas."	None	The only stigma mentioned in the legislation is the stigma that comes from having a mental illness or seeking services. By accepting this, MHSOAC is facilitating the diversion of funds from legislatively allowable programs to those that are not.
For Suicide Prevention Programs, add changes in knowledge about the relationship to untreated mental illness and suicide to the examples of change in knowledge that counties can measure.	None	The purpose of suicide campaigns is to reduce suicides. The metric that ensures evidence based practices are used and funds are spend efficiently is a reduction in suicide or suicide attempts. Any other metric is likely to lead to a diversion of funds and programs that don't reduce suicide being deemed 'successful' based on a false metric.
Delete requirement that county specify	None	Due to the past history of abuse within MHSA programs whereby funds were diverted to worthy social service programs that were not related to

how each participant's early onset of a potentially serious mental illness will be verified.		serious mental llness, it is important counties have a valid procedure to ensure funds are only spent on eligible individuals. Again, this was a point made by the State Auditor. There was no way to validate expenditures as being effective because, among other reasons, there was no way to know who was being served.

[1] Currently, PEI money is being used for purposes arguably contrary to the Mental Health Services Act, which designated PEI funds to "prevent mental illness from becoming severe and disabling" (5840(a)). This diversion is partially due to regulatory failures that could and should be fixed. DJ Jaffe "Myriad problems with Mental Health Services Act funding", Capitol Weekly, January 30, 2012. Legislative Fix Needed To Stop Waste of Millions Earmarked For Severe Mental Illness," http://www.californiaprogressreport.com/site/print/9704 (December 29, 2011), D.J. Jaffe, Mary Ann Bernard, "In California's system of care for the mentally ill, leadership is lacking" Capitol Weekly, August 25, 2011.

[2] Section 5840.

[3] Section 5840(b)(2).

[4] Section 5346.2.

[5] Section 5840(a).

[6] Providing services to individuals who are under court orders "prevent(s) mental illness from becoming severe and disabling". "The effect of sustained outpatient commitment, according to the Duke study, was particularly strong for people with schizophrenia and other psychotic disorders. When patients with these disorders were on outpatient commitment for an extended period of 180 days or more, and also received intensive mental health services, they had 72 percent fewer readmissions to the hospital and 28 fewer hospital days than the nonoutpatient commitment group". (Laura's Law Section 1(b)(6) findings). Statistics on reduced hospitalization, reduced incarceration, reduced homelessness, and higher "Milestones of Recovery Scores" achieved by implementing Laura's Law in Nevada and Los Angeles counties are in Appendix A.

[7] Prevention and Early Intervention programs "shall emphasize improving timely access to services for underserved populations." (Section 5840(a)).

[8] Individuals eligible for Laura's Law are underserved. "Thirty-seven and two-tenths percent, or 19,118, had no record of outpatient service use in the previous 12 months." (Laura's Law Section 1(b)(1)(D)).

[9] Section 5840(b)(1).

[10] The Proposition 63 Protection and Early Interventions program shall include the following components: O*utreach to families*, employers, primary care health care providers, and others to recognize the early signs of potentially severe and disabling mental illnesses. (Section 5840 (b)(1)). Laura's Law provides that outreach. County plans should include "Plans for services, including *outreach to families whose severely mentally ill adult is living with them*…Recipients of outreach services may include families, the public, primary care physicians, and others who are likely to come into contact with individuals who may be suffering from *an untreated severe mental illness* who would be likely to become homeless if the illness continued to be untreated for a substantial period of time." (Section 5348(a)(2)(B)).

[11] Prevention and Early Intervention "program(s) shall include the following components: Reduction in stigma associated with either being diagnosed with a mental illness or seeking mental health services. Reduction in discrimination against people with mental illness. (Section 5840(b)(3 and 4)).

[12] AOT reduces stigma. "Researchers also noted that people who underwent mandatory treatment reported higher social functioning and slightly less stigma" (February 2010 Columbia University. Phelan, Sinkewicz, Castille and Link. Effectiveness and Outcomes of Assisted Outpatient Treatment in New York State Psychiatric Services, Vol. 61. No 2).

Reducing violence by individuals with mental illness leads to a reduction in stigma. (Torrey, Stigma and Violence: Isn't it time to connect the dots? Schizophrenia Bulletin. June 7, 2011) "Why is stigma so strong despite better public understanding of mental illness? The answer appears to be fear of violence: people with mental illness, especially those with psychosis, are perceived to be more violent than in the past". (*Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Center for Mental Health Services, National Institute of Mental Health, 1999).

Laura's Law is designed to reduce violence. "In view of the person's treatment history and current behavior, the person is in need of assisted outpatient treatment 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, as defined in Section 5150." (Section 5346(a)(8)) AOT reduces violence (Appendix A).

[13] Section 5840(d)(1).

[14] As no study has been done on Laura's Law impact on suicide rates, research on suicide is from New York's Kendra's Law which has been more extensively studied and which Laura's Law was modeled on. Assisted Outpatient Treatment reduces suicide attempts 55 percent (N.Y. State Office of Mental Health "Kendra's Law: Final Report on the Status of Assisted Outpatient Treatment. March 2005).

[15] Section 5840(d)(2).

[16] In Nevada County, Laura's Law reduced the Number of Incarceration Days decreased 65.1 percent from 1824 days vs. 637 days post-treatment. In Los Angeles County Laura's Law reduced incarceration 78 percent from 388 days during the six months prior to enrollment in AOT to 85 days during the six months after.(Los Angeles County data: Marvin Southard, Director of County of Los Angeles, Department of Mental Health "Outpatient Treatment Program Outcomes Report April 1, 2010 – December 31, 2010" sent to Cliff Allenby, Acting Director California Department of Mental Health February 24, 2011. Nevada County data: Behavioral Health Director Michael Heggarty "The Nevada County Experience," Nov. 15, 2011. These also represent the source data for reducing the following negative consequences).

[17] Section 5840(d)(3).

[18] We are unaware of specific studies on this.

[19] Section 5840(d)(4).

[20] Nevada County found 'higher employment rates' (They did not quantify).

[21] Section 5840(d)(5).

[22] In Los Angeles Laura's Law reduced hospitalization from 345 days to 49 (86% reduction) percent comparing six months prior to AOT and during AOT. Only one person was hospitalized. Researchers then looked at the question of, "Does the beneficial effect of Laura's Law end after enrollment in Laura's Law ends?" They found Laura's Law reduced hospitalization 77 percent even after discharge from Laura's Law. Since discharge from Laura's Law participants had 81 days of hospitalization, or a reduction of 77 percent in days of hospitalization. In Nevada County, under Laura's Law, the number of Psychiatric Hospital Days decreased 46.7 percent from 1404 days vs. 748 days post-treatment.

[23] Section 5840(d)(6).

[24] In Nevada County, Number of Homeless Days decreased 61.9 percent from 4224 days vs. 1898 days post-treatment.

[25] Section 5840(d)(7).

[26] By providing care for parents before they become gravely disabled or dangerous it avoids inpatient commitment and incarceration both of which could lead to removal of children from the home.

[27] Section 5840(c).

[28] See Appendix A.