Draft Proposed Prevention and Early Intervention Regulations

(Note: Actual section numbers will be assigned later to fit within the current MHSA regulations.)

Draft Does Not Show Changes from October 24, 2013 Version

Section 1. Prevention and Early Intervention

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

(b) "Prevention and Early Intervention funds" means the Mental Health Services funds allocated for prevention and early intervention programs pursuant Section 5892(a)(3).

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

(d) The county shall include in its Prevention and Early Intervention:

(1) At least one Program to Intervene Early in the Onset of a Mental Illness.

(A) "Program to Intervene Early in the Onset of a Mental Illness" means services that provide treatment and other interventions to address and promote recovery and related functional outcomes for a mental illness early in its emergence, including the applicable negative outcomes listed in 5840(d) that result from untreated mental illness .

(B) Services delivered by programs to Intervene Early in the Onset of a Mental Illness shall not exceed eighteen months, unless the individual receiving the service is identified as experiencing first onset of a serious mental illness or emotional disturbance with psychotic features, as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, criteria for Schizophrenia Spectrum and Other Psychotic Disorders, in which case early intervention services shall not exceed four years.

(C) Services delivered by programs to Intervene Early in the Onset of a Mental Illness may include services to parents, caregivers, and other family members of the person with early onset of a mental illness, as applicable.

(D) Programs to Intervene Early in the Onset of a Mental Illness may include efforts to prevent relapse in an individual with early onset of a mental illness.

(2) Outreach for Increasing Recognition of Early Signs of Mental Illness:

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

(i) "Potential responders" include, but are not limited to, families, employers, primary health care providers, school personnel, community service providers, peer providers, cultural brokers, law enforcement personnel, emergency medical service providers, people who provide services to individuals who are homeless, leaders of faith-based organizations, and others in a position to identify early signs of potentially severe and disabling mental illness, provide support, and/or refer individuals who need treatment or other mental health services.

(ii) Increasing Recognition of Early Signs of Mental Illness may include reaching out to individuals with signs and symptoms of a mental illness, who can recognize their own symptoms.

(B) Outreach for Increasing Recognition of Early Signs of Mental Illness may be a stand-alone program, an element of a program to Reduce Risk Related to Mental Illness or an element of a program to Intervene Early in the Onset of a Mental Illness or a combination thereof.

(e) The county may include in its Prevention and Early Intervention Component:

(1) One or more Programs to Reduce Risk Related to Mental Illness.

(A) "Program to Reduce Risk Related to Mental Illness" means a set of related activities to bring about mental health and related functional outcomes including reduction of the applicable negative outcomes listed in 5840(d) as a result of untreated mental illness for individuals and members of groups or populations whose risk of developing a serious mental illness is significantly higher than average and, as applicable, their parents, caregivers, and other family members. The goal of this program is to reduce risk factors for developing a potentially serious mental illness and to build protective factors.

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

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

(B) Program to Reduce Risk Related to Mental Illness may include relapse prevention for individuals in recovery from a serious mental illness.

(C) Program to Reduce Risk Related to Mental Illness may include universal prevention efforts, defined as targeting a population that has not been identified on the basis of risk, only if there is evidence to suggest that the universal prevention effort is likely to bring about mental health and related functional outcomes for individuals and members of groups or populations whose risk of developing a serious mental illness is significantly higher than average.

(2) One or more Stigma and Discrimination Reduction Programs

(A) "Stigma and Discrimination Reduction Program" means a county's direct activities to reduce negative feelings, attitudes, beliefs, perceptions, stereotypes and/or discrimination related to being diagnosed with a mental illness, having a mental illness, or to seeking mental health services and to increase acceptance, dignity, inclusion, and equity for individuals with mental illness, and members of their families.

(B) Examples of Stigma and Discrimination Reduction Programs include, but are not limited to, 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 that have an impact on mental illness, and efforts to encourage self-acceptance for individuals with a mental illness.

(3) One or more Suicide Prevention Programs

(A) Suicide Prevention Program means organized activities that a county undertakes to prevent suicide as a consequence of mental illness. This category of programs does not focus on or have intended outcomes for specific individuals at risk of or with serious mental illness.

(i) Suicide prevention activities that aim to reduce suicidality for specific individuals at risk of or with early onset of a potentially serious mental illness can be a focus of a program to Reduce Risk Related to Mental Illness as defined in subdivision (e)(1) or a focus of a Program to Intervene Early in the Onset of a Mental Illness as defined in subdivision (d)(1).

(B) Organized activities to combat suicide related to mental illness that do not focus on or have intended outcomes for specific individuals include, but are not limited to, public and targeted information campaigns, suicide prevention networks, capacity building programs, culturally specific approaches, screening programs, suicide prevention hotlines or web-based suicide prevention resources, and training and education.

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

(1) Be designed and implemented to help 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 care provided by county mental health programs.

(i) Access and Linkage to Treatment can be a stand-alone program, an element of a program to Reduce Risk Related to Mental Illness or an element of a program to Intervene Early in the Onset of a Mental Illness, or a combination thereof.

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

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

(B) Programs shall provide services in 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 setting enhances access to quality services and outcomes for underserved populations.

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

(A) "Strategies that are Non-Stigmatizing and Non-Discriminatory" mean promoting, designing, and implementing programs in ways that reduce and circumvent stigma, including self-stigma, and discrimination related to being diagnosed with a mental illness, having a mental illness or seeking mental health services, and make services accessible, welcoming, and positive.

(B) Non-stigmatizing and Non-Discriminatory approaches include, but are not limited to, using positive messages and approaches with a focus on recovery, wellness, and resilience including but not limited to use of culturally appropriate language and concepts; efforts to acknowledge and combat multiple social stigmas that affect attitudes about mental illness and/or about seeking mental health services, including but not limited to race and sexual preference; co-locating mental health services with other life resources; promoting positive attitudes and understanding of recovery among mental health providers; inclusion and welcoming of family members; and employment of peers in a range of roles.

(g) The County shall measure and report outcomes for all programs listed in subdivisions (d) and (e) and for strategies listed in subdivision (f) (1) and (2) as required by Section 2 and Section 4.

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

(1) Evidence-based practice standard: Evidence-based practice means activities for which there is scientific evidence consistently showing improved mental health outcomes for the intended population, including, but not limited to, scientific peer-reviewed research using randomized clinical trials.

(2) Promising practice standard: Promising practice means programs and policies that have research demonstrating effectiveness, including strong quantitative and qualitative data showing positive outcomes, but the research does not meet the standards used to establish evidence-based practices and does not have enough research or replication to support generalizable positive public health outcomes.

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

(i) Changed program: If a county determines a need to make a substantial change to a program or strategy or target population of the program or strategy described in the county's most recent Three-Year Program and Expenditure Plan or annual update that was adopted by the local county

board of supervisors as referenced in 5847, the county shall comply with the requirements described in Section 3(c) regarding a Prevention and Early Intervention Program Change.

Section 2. Program Evaluation

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

(1) For programs to Intervene Early in the Onset of a Mental Illness as defined in Section 1(d)(1)

(A) The County shall measure the reduction of prolonged suffering as referenced in Section 5840(d) that may result from untreated mental illness by measuring reduced symptoms and/or improved recovery, including mental, emotional, and relational functioning.

(B) For a program that the County designates as intended to reduce any of the other MHSA negative outcomes referenced in Section 5840(d) that may result from untreated mental illness, the county shall select, define, and measure appropriate indicators that the county selects that are applicable to the program.

(2) For Programs to Reduce Risk Related to Mental Illness as defined in Section 1(e)(1), that serve individuals, including families:

(A) The County shall measure the reduction of prolonged suffering as referenced in Section 5840(d) that may result from untreated mental illness by measuring reduced risk factors and/or increased protective factors.

(B) For a program that the county designates as intended to reduce any of the other MHSA negative outcomes referenced in Section 5840(d) that may result from untreated mental illness, the county shall select, define, and measure appropriate indicators that the county selects that are applicable to the program.

(3) For Outreach for Increasing Recognition of Early Signs of Mental Illness as either a stand-along program or a strategy within another program, referenced in subdivision (d)(2) of Section 1, the County shall track:

(A) The number and kind of potential responders engaged differentiated by type of setting.

(i) Types of settings include, but are not limited to, family resource centers, senior centers, schools, cultural organizations, churches, faith-based organizations, primary health care, recreation centers, libraries, public transit facilities, support groups, law enforcement departments, residences, shelters, and clinics.

(4) For Stigma and Discrimination Reduction Program referenced in subdivision (e)(2) of Section 1, the County shall select and use a validated method to measure:

(A) Changes in attitudes, knowledge, and/or behavior related to mental illness: for example, more accurate information about mental illness and recovery, increased awareness of the effectiveness of prevention and treatment for mental illness, increased comfort and openness to interacting with people with mental illness.

(B) Changes in attitudes, knowledge, and/or behavior related to seeking mental health services

(5) For Suicide Prevention Program referenced in subdivision (e)(3) of Section 1, the County shall select and use a validated method to measure changes in attitudes, knowledge, and/or behavior regarding suicide related to mental illness:

(A) Changes in knowledge about suicide related to mental illness include, but are not limited to, knowledge about suicide's relationship to mental illness, 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 include, but are not limited to, decreased suicides and suicidal attempts, increased identification of individuals with mental illness at risk of suicide, increased referrals and support, increased positive self-care and help-seeking by individuals who are feeling suicidal.

(6) For PEI strategy or program to provide Access and Linkage to Treatment referenced in subdivision (f)(1) of Section 1, the County shall measure:

(A) Number of referrals to treatment, kind of treatment to which person was referred, and duration of untreated mental illness.

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

(B) Number of persons who followed through on the referral.

(C) Number of referrals that resulted in successful engagement in treatment defined as the number of individuals who participated at least once in the program to which the person was referred.

(D) How long the person received services in the program to which the person was referred

(7) For PEI strategy to Improve Timely Access to Services for Underserved Populations referenced in subdivision (f)(2) of Section 1, the County shall measure:

(A) Number of referrals of members of underserved populations to a program to Reduce Risk Related to Mental Illness, a program to Intervene Early in the Onset of a Mental Illness, and or treatment (beyond early onset) including the kind of care, and the timeliness of care.

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

(ii) Timeliness of care for individuals with risk factors for a mental illness is measured by the duration between onset of indicators of risk of mental illness and initial receipt of services.

(B) Number of persons who followed through on the referral.

(C) Number of referrals that resulted in successful engagement in treatment defined as the number of individuals who participated at least once in the program to which the person was referred.

(D) How long the person received services in the program to which the person was referred.

(b) Evaluation designs shall be culturally appropriate and shall include the perspective of diverse people with lived experience of mental illness, including their family members.

(c) In addition, to the required evaluations listed in this section, a county may 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 education, physical healthcare, law enforcement and justice, social services, homeless shelters and other services, and community supports specific to age, racial, ethnic, and cultural groups. Examples of system outcomes include, but are not limited to, increased provision of services by ethnic and cultural community organizations, hours of operation, integration of services including co-location, involvement of clients and families in key decisions, identification and response to co-occurring substance-use disorders, staff knowledge and application of recovery principles, collaboration with diverse community partners, or funds leveraged.

Section 3. Prevention and Early Intervention Program Plan

(a) The requirements set forth in this section shall apply to the annual update for fiscal year 2015/16 and each annual update and/or Three-Year Program and Expenditure Plan thereafter.

(b) 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 Prevention and Early Intervention part of the MHSA.

(2) A description of the county's plan to involve community stakeholders meaningfully in all phases of the Prevention and Early Intervention part of the MHSA, including program planning and implementation, monitoring, quality improvement, evaluation, and budget allocations.

(3) A brief description, with specific examples of how each program and/or strategy funded by Prevention and Early Intervention funds will reflect and be consistent with all MHSA General Standards set forth in Title 9 CCR section 3320.

(4) For each program to Intervene Early in the Onset of a Mental Illness as defined in Section 1(d)(1), the county shall include a description of the program including but not limited to:

(A) Identification of the target population for the intended mental health outcomes.

(i) Specify demographics including, but not limited to, age, race/ethnicity, gender and if relevant, primary language spoken, military status, and LGBTQ identification.

(ii) Specify the mental illness or illnesses for which there is early onset.

(iii) Specify how each participant's early onset of a potentially serious mental illness will be determined.

(B) Specify the type of problem(s) and need(s) for which the program will be directed and the activities to be included in the program that are intended to bring about mental health and related functional outcomes including reduction of the negative outcomes referenced in 5840(d) for individuals with early onset of potentially serious mental illness.

(C) Specify the MHSA negative outcomes as a consequence of untreated mental illness referenced in Section 5840(d) that the program is expected to affect, including the reduction of prolonged suffering as a consequence of untreated mental illness, which is defined for individuals with early onset of a mental disorder as reduced symptoms and/or improved recovery, including mental, emotional, and relational functioning.

(i) List the indicators that the county will use to measure reduction of prolonged suffering as defined in Section 2(a)(1)(A).

(ii) For any other specified MHSA negative outcome as a consequence of untreated mental illness, 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.

(D) Specify how the program to Intervene Early in the Onset of a Mental Illness is likely to reduce the relevant MHSA negative outcomes as referenced in Section 5840(d) by using one of the three standards or a combination of standards specified in subdivision (h) of Section 1 as follows:

(i) For evidence-based and promising practice standards, provide a brief description of or reference to the relevant evidence applicable to the specific intended outcome, explain how the practice's effectiveness has been demonstrated for the intended population, and explain how the county will ensure fidelity to the evidence-based practice in implementing the program.

(ii) For community and/or practice-based standard, describe the evidence that the approach is likely to bring about MHSA outcomes for the intended population.

(5) For each program to Reduce Risk Related to Mental Illness as defined in Section 1(e)((1), the county shall include a description of the program including but not limited to:

(A) Identification of the target population for intended mental health outcomes.

(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 the risk of a potentially serious mental illness will be defined and determined.

(B) Specify the type of problem(s) and need(s) for which the program to Reduce Risk Related to Mental Illness will be directed and the activities to be included in the program that are intended to bring about mental health and related functional outcomes including reduction of the negative outcomes referenced in 5840(d) for individuals with higher than average risk of potentially serious mental illness.

(C) Specify any MHSA negative outcomes as a consequence of untreated mental illness as referenced in Section 5840(d) that the program is expected to affect, including reduction of prolonged suffering, which is defined for individuals at risk of mental illness as reduced risk of a mental disorder and/or improved protective factors related to mental, emotional, and relational functioning.

(i) List the indicators that the county will use to measure reduction of prolonged suffering as defined in Section 2(a)(2)(A).

(ii) If the county intends the program to reduce any other specified MHSA negative outcome as a consequence of untreated mental illness as referenced in Section 2(a)(2)(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.

(D) Specify how the program to Reduce Risk Related to Mental Illness is likely to bring about reduction of relevant MHSA negative outcomes referenced in Section 5840(d) for the intended population by using one of the three standards or a combination of standards specified in subdivision (h) of Section 1 as follows:

(i) For evidence-based and promising practice standards, provide a brief description of or reference to the relevant evidence applicable to the specific intended outcome, explain how the practice's effectiveness has been demonstrated for the intended population, and explain how the county will ensure fidelity to the evidence-based practice in implementing the program.

(ii) For community and or practice-based standard, describe the evidence that the approach is likely to bring about MHSA outcomes for the intended population.

(6) For each Outreach for Increasing Recognition of Early Signs of Mental Illness program or strategy within a program, the county shall include a description of the program including but not limited to:

(A) Identify the kinds of potential responders the program intends to reach.

(i) Describe briefly the potential responder's setting as referenced 2(a)(3)(A)(i) and opportunity to identify diverse individuals with signs and symptoms of potentially serious mental illness.

(B) Specify the methods to be used to reach out and engage potential responders and the methods to be used for potential responders and public mental health service providers to

learn together about how to identify and respond supportively to signs and symptoms of potentially serious mental illness.

(7) For each Stigma and Discrimination Reduction Program, the county shall include a description of the program including but not limited:
  (A) Identify whom the campaign intends to influence.
  (B) Specify the methods and activities to be used to change attitudes, knowledge, and/or behavior regarding being diagnosed with mental illness, having mental illness and seeking mental health services, consistent with requirements in Section 2 (a)(4)(A) and (B), including timeframes for measurement.
  (C) Specify how the proposed method is likely to bring about the selected outcomes using one of the three standards or a combination of standards specified in Section 1(h) as follows:
    (i) For evidence-based and promising practice standards, 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) For community and or practice-based standard, describe the evidence that the approach is likely to bring about MHSA outcomes.

(8) For each Suicide Prevention Program related to mental illness, the county shall include a description of the program including but not limited:
  (A) Specify the methods and activities to be used to change attitudes and behavior to prevent mental illness-related suicide.
  (B) Indicate how the county will measure changes in attitude, knowledge, and /or behavior related to reducing mental illness-related suicide consistent with requirements in Section 2(a)(5)(A), including timeframes for measurement.
  (C) Specify how the proposed method is likely to bring about suicide prevention outcomes selected by the county using one of the three standards or a combination of standards specified in Section 1(h) as follows:
    (i) For evidence-based and promising practice standards, 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) For community and or practice-based standard, describe the evidence that the approach is likely to bring about MHSA outcomes.

(9) For all programs referenced in subdivisions (4) through (8) above, explain how the program will be implemented to help 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 program to Intervene Early in the Onset of a Mental Illness.

(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.

(D) Indicate if the county intends to measure outcomes other than those required in Section 2 (a)(6).

(10) For all programs referenced in subdivisions (4) through (8) above, indicate how the program will use strategies to Improve Access to Services for Underserved Populations, as required in Section 1(f).

(A) For each program, the county shall indicate the intended setting(s) and why the setting enhances access for specific, designated underserved populations. If the county intends to locate the program in a mental health setting, explain why this choice enhances access to quality services and outcomes for the specific underserved population.

(B) Indicate if the county intends to measure outcomes other than those required in Section 2 (a) (7) and, if so, what outcome and how will it be measured, including timeframes for measurement.

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

(12) For all programs the county shall include the following information for the fiscal year after the plan is submitted.

(A) Estimated number of children, adults, and seniors to be served in each program to Reduce the Risk Related to Mental Illness and each program to Intervene Early in the Onset of a Mental Illness.

(B) The county may also include estimates of the number of individuals who will be reached by Outreach for Increasing Recognition of Early Signs of Mental Illness Program or strategy within a program, Suicide Prevention Programs, and Stigma and Discrimination Reduction Programs.

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

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

(B) The county shall identify each program funded with Prevention and Early Intervention funds as a program to Reduce Risk Related to Mental Illness, a program to Intervene Early in the Onset of a Mental Illness, Outreach for Increasing Recognition of Early Signs of Mental Illness program, Stigma and Discrimination Reduction Program, or Suicide Prevention Program and shall estimate expected expenditures for each program. If a program includes more than one element, the County shall estimate the percentage of funds dedicated to each element.

(i) The county shall estimate the amount of Prevention and Early Intervention funds for Administration of the Prevention and Early Intervention Program.

(14) The previous fiscal years' unexpended funds and the amount of those funds which will be used to pay for the programs listed in the annual update and/or Three-year Program and Expenditure Plan.

(b) The county shall estimate the amount of Prevention and Early Intervention funds voluntarily assigned by the County to California Mental Health Services Authority or any other organization in which counties are acting jointly.

(c) Prevention and Early Intervention Program Change Report: If a county determines a need to make a substantial change to a program, strategy, or target population as described in subdivision (i) of Section 1, the county shall in the next Three-Year Program and Expenditure Plan or annual update, whichever is closest in time to the planned change, include the following information:

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

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

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

Section 4. Annual Prevention and Early Intervention Report

(a) The requirements set forth in this section shall apply to the Annual Prevention and Early Intervention Report to be included in the annual update for fiscal year 2015/16 and each annual update and/or Three-Year Program and Expenditure Plan thereafter.

(b) 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 program to Reduce Risk Related to Mental Illness and program to Intervene Early in the Onset of a Mental Illness list:

(A) Unduplicated numbers of individuals served annually

(i) If a program serves both individuals at risk of (program to Reduce Risk Related to Mental Illness) and individuals with early onset of (program to Intervene Early in the

Outset of a Mental Illness) a potentially serious mental illness, the county shall report numbers served separately for each category.

(ii) Programs that serve families shall report information for each individual family member served.

(2) For each Outreach for Increasing Recognition of Early Signs of Mental Illness program or strategy within another program, the county shall provide the number of potential responders as defined in Section 1(d)(2)(A) engaged differentiated by kind of settings as referenced in Section 2(a)(3)(A)(i).

(3) Access and Linkage to Treatment Strategy:

(A) Number of individuals with serious mental illness referred to treatment, kind of treatment to which individual was referred, and duration of untreated mental illness as defined in Section 2(a)(5)(A)(i).

(B) Number of individuals who followed through on the referral.

(C) Number of individuals who participated at least once in the program to which they were referred.

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

(4) Improve Timely Access to Services for Underserved Populations Strategy:

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

(B) Number of referrals of members of underserved populations to a program to Reduce Risk Related to Mental Illness, a program to Intervene Early in the Onset of a Mental Illness and/or to treatment beyond early onset including kind of care that resulted from the outreach.

(C) Number of individuals who followed through on the referral.

(D) Number of referrals that resulted in successful engagement defined as the number of individuals who participated at least once in the program to which they were referred.

(E) How long the individual received services in the program to which the individual was referred.

(F) Interval between onset of risk indicators or initial symptoms of a mental illness as self-reported (or parent/family member-reported) or as identified by medical records and if applicable, entry into treatment or services of a program to Reduce Risk Related to Mental Illness or program to Intervene Early in the Onset of a Mental Illness..

(G) Interval between referral and 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 as follows:
  (i) American Indian or Alaska Native
  (ii) Asian
  (iii) Native Hawaiian or other Pacific Islander
  (iv) Black or African American
  (v) White by descent
    (a) Eastern European
    (b) European
    (c) Nordic
    (d) Other

(C) Ethnicity as follows:
  (i) Hispanic or Latino by country or region of origin
    (a) Mexico
    (b) Central America
    (c) Caribbean
    (d) South America
  (ii) Non-Hispanic or Non- Latino
    (a) Middle Eastern
    (b) African
    (c) Other

(D) Primary language spoken listed by threshold languages

(E) Sexual orientation, if known,

(F) Disability, if any,

(G) Veteran status,

(H) Gender identity

(I) Any other data the County considers relevant

(6) For Stigma and Discrimination Reduction Programs and Suicide Prevention Programs, counties may report available numbers of individuals reached, including demographic breakdowns. An example would be the number of individuals who received training and education or who clicked on a web site.

(7) For all programs and strategies, counties may report implementation challenges, successful approaches, lessons learned, and relevant examples.

Section 5. Three Year 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 risk or early onset of serious mental illness and on the mental health and related systems.

(1) The Evaluation Report is due to the MHSOAC on or before December 30, 2018 and shall report on evaluation(s) for fiscal years 2015/16 through 2017/18. An Evaluation Report shall be due

December 30th every three years thereafter and shall report on the evaluation(a) for the three fiscal years prior to the due date.

(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 program funded with Prevention and Early Intervention funds by the following funding source: MHSA Prevention and Early Intervention funds, Medi-Cal FFP, 1991 Realignment, Behavioral Health Subaccount, and other funds.

a. The county shall identify ~~PEI~~ each program funded with Prevention and Early Intervention funds as a program to Reduce Risk Related to Mental Illness, program to Intervene Early in the Onset of a Mental Illness, Outreach for Increasing Recognition of Early Signs of Mental Illness program, Stigma and Discrimination Reduction Program, or Suicide Prevention Program. If a program includes more than one element, the county shall estimate the percentage of funds dedicated to each element.

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

(3) The amount of funding expended for evaluation of programs funded by Prevention and Early Intervention funds by the following funding source: MHSA Prevention and Early Intervention funds, Medi-Cal FFP, 1991 Realignment, Behavioral Health Subaccount, and other funds.

(4) The amount of Prevention and Early Intervention funds voluntarily assigned by the County to California Mental Health Services Authority or any other organization in which counties are acting jointly.