HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH & RECOVERY SERVICES

POLICY AND PROCEDURE

Service Area: Mendocino County Behavioral Health and Recovery Services

Subject: Mental Health Services Act Prevention and Early Intervention Programs

Subject Matter Expert: Karen Lovato, BHRS Acting Deputy Director

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POLICY:

Mendocino County Health and Human Services Agency (HHSA) Behavioral Health and Recovery Services (BHRS) will support programs funded through the Mental Health Services Act (MHSA), also known as Proposition 63, which will be conducted in accordance with the California Department of Health Care Services guidelines and regulations for Mental Health Services Act Programs, Mental Health Services Oversight and Accountability Commission (MHSOAC), as well as all State and County guidelines that pertain to MHSA programs. Prevention and Early Intervention (PEI) Programs will meet Prevention and Early Intervention Plan criteria and will be outlined in the Mendocino County MHSA Three-Year Program and Expenditure Plan (and Annual Plan Updates). Prevention and Early Intervention programs are designed to prevent mental illnesses from becoming severe and disabling. Prevention and Early Intervention funding for programs must be identified in the Three-Year Program and Expenditure Plan, and the plan must be developed with MHSA Stakeholder involvement.

Definitions

Community Program Planning (CPP) Process: The Community Program Planning Process is defined by California Code of Regulations toward the development and review of MHSA programs. Community Planning Process utilizes community collaboration through clients, client family members, agencies, organizations, and other community members who work together to share information and resources in order to fulfill a shared vision and goals. The process is utilized to identify community issues related to mental illness resulting from lack of community services and supports, to identify issues related to implementation of Mental Health Services Act programs, to analyze the mental health needs in the community, and to identify and re-evaluate priorities and strategies to meet mental health needs. MHSA providers are expected to participate in the MHSA Community Program Planning processes.

Stakeholder Definition: Stakeholders are defined by the Department of Health Care Services (DHCS) and the Mental Health Services Oversight and Accountability Commission (MHSOAC) as individuals or entities with an interest in mental health services in the State of California including but not limited to: individuals with serious mental illness, clients of MHSA programs, providers of mental health or related services, family members, educators, representatives of law enforcement, and other agencies or other community members that interact with individuals with mental illness (primary care providers, social service agencies, substance use treatment services, etc.), that have an interest in the mental health issues, consumers or their families, or an interest in Mental Health Services Act programs.

Client Definition: For the purposes of this Policy, the terms client, consumer, participant, beneficiary, person with serious mental illness, and person with lived experience can be used interchangeably. A client is an individual of any age who is or has received mental health services to represent the individual that is receiving services through an MHSA program.

Prevention Program: Activities designed to reduce risk factors for developing a potentially serious mental illness and to build protective factors. The goal of this program type is to bring about mental health including the reduction of negative outcomes associated with untreated mental illness such as suicidal ideation, incarceration, school failure or dropout, unemployment, prolonged suffering, homelessness, removal of children from their homes. Risk factors to be reduced can include, but are not limited to, adverse childhood experiences, chronic medical conditions, severe trauma, exposure to drugs or toxins in the womb, poverty, family conflict, social inequality, prolonged isolation, previous suicide attempts, or having a family member with serious mental illness. Prevention program services may include relapse prevention for individuals in recovery from a serious mental illness.

Early Intervention Program: Treatment and other services and intervention (including relapse prevention), to address and promote recovery and related functional outcomes for a mental illness early in its emergence, including the applicable negative outcomes that result from untreated mental illness. Early Intervention services shall not exceed eighteen months, unless the individual receiving services is identified as experiencing first onset of a serious mental illness or emotional disturbance with psychotic features. If that is the case, early intervention services shall not exceed four years. Early Intervention services may include services to parents, caregivers and other family members of the person with early onset mental illness, as applicable.

Program for Outreach for Increasing Recognition of Early Signs of Mental Illness: Programs that engage, encourage, educate, train, and or learn from potential responders about ways to recognize and respond effectively to early signs of potentially severe and disabling mental illness. Potential responders include but are not limited to families, employers, health care providers, school personnel, peer providers, cultural brokers, law enforcement personnel, faith based leaders, emergency responders, homeless services, and other individuals in a position to identify early signs of potentially severe and disabling mental illness.

Stigma and Discrimination Reduction Program: Directed 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 seeking mental health services, and activities to increase acceptance, dignity, inclusion, and equity for individuals with mental illness, and members of their families. Examples include social marketing campaigns, targeted education and training, anti-stigma advocacy. Stigma and discrimination reduction programs shall include approaches that are culturally congruent with the values of the population for whom changes in attitudes, knowledge, and behavior are intended.

Access and Linkage to Treatment Program: Activities to connect individuals with mental illness to services as early in the onset of the conditions as practicable to medically necessary care and treatment. Examples include programs with a focus on screening, assessment, referral, telephone helplines, and mobile response. Programs targeted toward specific underserved populations will be designed to address the needs and barriers of that specific population. Strategies shall be identified to provide services in convenient, accessible, culturally appropriate settings to enhance access to quality services for underserved populations. Strategies will be designed to be nondiscriminatory and non-stigmatizing.

Suicide Prevention Program: Organized activities designed to prevent suicide as a consequence of mental illness in the community. Activities include but are not limited to

public information campaigns, suicide prevention networks, capacity building programs, survivor informed models, suicide prevention hotlines, suicide prevention training, education, and resources. Note: Programs that target specific individuals at risk for suicide will be considered a Prevention Program.

PROCEDURE:

1. **Mendocino County shall have at least one of each of the six types of PEI programs (Prevention, Early Intervention, Outreach for increasing Recognition of Early Signs of Mental Illness, Stigma and Discrimination Reduction, Access and Linkage to Treatment, Suicide Prevention).**
    a. If Mendocino County, as a small county opts out of having a Prevention or Suicide Prevention Program, the BHRS MHSA shall discuss the decision to opt out of these programs with Stakeholders, during MHSA Forums or other MHSA Stakeholder events. BHRS will obtain Board of Supervisors' approval and declaration that the County cannot meet the requirement for these programs. BHRS MHSA program will outline in the Three-Year Plan or Annual Plan Update the rationale for the decision.

2. **Prevention and Early Intervention Programs**: Programs shall be outlined in the Mental Health Services Act Three-Year Plan and Annual Plan Updates. Input from stakeholders regarding programs will be collected through the Community Planning Process.
    a. PEI programs shall use at least 51% of PEI funding to serve individuals aged 25 years or younger (or families of individuals aged 25 or younger).
    b. All MHSA age groups will be represented in at least one PEI program type.
    c. PEI programs will identify target populations served in the Three Year Plan or Annual Update.

3. **PEI Annual Report**: PEI programs must conduct and evaluation and report annually regarding PEI Programs. The report shall be due to the Oversight and Accountability Commission on or before December 30ths for the year prior. The report shall exclude any personally identifiable information. The report shall include each PEI program type and the information required for that program type.
    a. Prevention Programs shall include:
        i. Program Name
        ii. Unduplicated numbers of individuals (or families if the program serves families) served in the preceding year
    b. Early Intervention Programs shall include:
        i. Program Name

   ii. Unduplicated numbers of individuals (or families if the program serves families) served in the preceding year

c. Outreach for Increasing Recognition of Early Signs of Mental Illness shall include:
   i. Program Name
   ii. Number of potential responders
   iii. Settings in which responders were engaged, including but 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, residences, shelters, and clinics
   iv. Types of potential responders engaged in each setting (e.g. nurses, parents, teachers, etc.)
d. Access and Linkage to Treatment programs shall include:
   i. Program Name
   ii. Number of individuals with serious mental illness referred to treatment and the kind of treatment to which the individual was referred
   iii. Number of individuals that followed through on the referral and engaged, at least once, in the program to which they were referred
   iv. Average duration of untreated mental illness
   v. Average interval between the referral and participation in treatment and standard deviation
e. Access and Linkage to Treatment programs that target underserved populations shall additionally include:
   i. The specific underserved population
   ii. Description of the ways the program encouraged access to services and follow through on the referrals
f. Information reported shall be disaggregated by the categories outlined in CCR Title 9 Section 5846 and W&I Code 5840, 5845(d)(6), and 5847:
   i. Age- follow MHSA Age group categories
   ii. Race
   iii. Ethnicity
   iv. Primary Language
   v. Sexual Orientation
   vi. Disability
   vii. Veteran Status
   viii. Gender
   ix. Other data relevant to the population being served (for example elevated risk factors)
g. Stigma and Discrimination Reduction Programs shall include:
   i. Number of individuals reached, by demographic breakdown

ii. Number of individuals trained where applicable
iii. Number of individuals that clicked a website where applicable

h. Suicide Prevention Programs shall include:
i. Number of individuals reached, by demographic breakdown
ii. Number of individuals trained where applicable
iii. Number of individuals that clicked a website where applicable

4. **Three-Year Program and Evaluation Report**: Programs shall produce data for a report that answers questions about the impacts of Prevention and Early Intervention Component Programs on early onset of mental illness and mental health systems.
   a. The report is due December 30th, 2018 and every three years thereafter.
   b. The program shall not include personally identifying information.
   c. The report shall include evaluation of each Prevention and Early Intervention program, including:
      i. Program Name, Outcome indicators;
      ii. Approaches used to select outcome indicators;
      iii. How often data was collected for evaluation of each program.
   d. The results and analysis of the results will pertain to the three fiscal years prior to the due date including whether the program served the targeted population.
   e. The report in the Three-Year Program and Evaluation Report will include information that otherwise would have been submitted in the PEI Annual Report for the year prior.
   f. The Three-Year Program and Evaluation Report shall additionally include the strategies of Access and Linkage to Treatment Improving Timely Access for Services for Underserved Populations. Note: In this usage, the strategy means a planned specified method within a program intended to achieve a defined goal (as differentiated from a Program, or program type).

5. **Effective Methods**: PEI programs shall use a standard of practice that uses either evidence based practices, promising practices, or community/practice based standard.
   a. Evidence-based Practice Standard: Activities for which there is scientific evidence consistently showing improved outcomes for the intended population.
   b. Promising Practice Standard: Practices for which there is research demonstrating effectiveness, including quantitative and qualitative data, but the research is not sufficient to meet standards for evidenced based practice or replication.

c. Community or Practice-based Evidence Standard: Practices a community has used and determined yields positive results by community consensus over time. The positive outcomes may or may not have been measured empirically. Community or practice defined standards take worldview, historical, and social contexts of the community into consideration.

6. **Program Evaluation**: PEI Programs shall evaluate the success of the program, based on program type.
   a. Prevention Programs shall measure the reduction in risk factors, or the increased number of protective factors facilitated by the program.
   b. Early Intervention programs shall measure and evaluate the reduction of prolonged suffering and/or improved recovery that were impacted by the program.
   c. Stigma and Discrimination Reduction Programs shall measure changes in attitudes knowledge or behavior related to mental illness or seeking mental health services.
   d. Outreach for increasing Recognition of Early Signs of Mental Illness Programs shall measure and evaluate the numbers and types of responders reached and the methods used to engage responders.
   e. Access and Linkage to Treatment Programs (or strategies) shall measure and evaluate the impact of program on referrals to treatment, success of follow through on treatment, impact on duration of untreated illness, and the impact of other mental health related systems by referral to services.
   f. Suicide Prevention Programs shall measure changes in attitude, knowledge or behavior related to reducing mental illness related suicide. Evaluation will specify how the proposed method was likely to reduce suicide risk, and the fidelity of the practice used.

7. **Mendocino County shall ensure that 51% of PEI funds are used to serve individuals 25 years or younger.**
   a. The County shall demonstrate that at least 51% of the PEI funds used shall be used to serve individuals 25 years or younger on the ARER for each fiscal year.

REFERENCES:

CCR, Title 9, Sections 3200.245, 3320(a), 3705, 3706, 3735, 3750(d), 3750(f)(3)(A), 3755

Welfare and Institutions Code Section 5840, 5846, 5892