MHSOAC

Mental Health Services
Oversight & Accountability Commission

Finding Solutions

Helping Counties Comply with Regulations Governing Innovation Projects and Prevention and Early Intervention Programs under the Mental Health Services Act

CONTENTS

I. Executive Summary

In 2004 California voters passed the Mental Health Services Act, directing the state and counties to undertake a sweeping transformation of how they deliver mental health care. The Act established the Mental Health Services Oversight and Accountability Commission (Commission) to guide implementation, develop strategies to reduce the stigma associated with mental illness, and advise the governor and legislators on policy as needed. In 2013, the Legislature expanded the Commission's role and asked it to draft regulations for two components of the Act – Prevention and Early Intervention and Innovation programs. In response, the Commission worked for two years to create the regulations, convening 15 public meetings and reviewing hundreds of pages of comments. The regulations were approved by the Office of Administrative Law and took effect in October 2015.

In the months since, representatives of California's county behavioral health agencies have raised multiple concerns about their ability to comply with the new regulations. Specifically, the County Behavioral Health Directors Association asked the Commission to provide guidance regarding three principal challenges:

- **How to report the demographics of people provided mental health services, including their race, ethnicity, sexual orientation, and gender identification**. Among other problems, the counties say the existing data system for transmitting mental health information from the counties to the California Department of Health Care Services is not equipped to receive the more detailed demographic data now required.
- **How to manage the new program and measurement requirements under the Access and Linkage to Treatment for people with a serious mental illness**. New regulatory requirements for how programs are organized and funded may be inconsistent with how counties were initially directed to establish programs funded under the Mental Health Services Act.
- **How to measure the duration of untreated mental illness.** The regulations require the counties to measure and report how long a person with untreated serious mental illness waits for services after a referral to care through a Prevention or Early Intervention Program. Yet there is no set standard for measuring that timeframe.

In response to these concerns, the Commission formed a subcommittee of three Commissioners to explore possible solutions. The subcommittee was guided by a diverse range of professionals from throughout the mental health community, including representatives from county behavioral health departments and the Department of Health Care Services. The subcommittee also received valuable input from people with mental illness and their families and representatives of diverse ethnic, racial, and cultural communities.

The subcommittee held six public meetings throughout California to better understand the challenges counties and providers have encountered under the new regulations, with a specific focus on the three concerns outlined above. This report summarizes the subcommittee's findings and recommends five actions the Commission should take:

1. Initiate collaborative processes

    - with county behavioral health agencies and other subject matter experts to ensure the use of best practices in the collection and reporting of sensitive demographic information;
    - with other state entities to coordinate the adoption of consistent standards and regulations for demographic data reporting;
    - with all parties involved, including stakeholders, to consider revisions to the current regulations.

2. Recognize the unique needs of very small counties that must carry out the Prevention and Early Intervention and Innovation regulations.

3. Develop technical assistance strategies to clarify the Access and Linkage to Treatment reporting requirements, including the measurement of duration of untreated mental illness.

4. Consider amending the regulations to clarify that an Access and Linkage to Treatment program or strategy administered under the Mental Health Services Act Community Services and Supports (CSS) component may be funded through CSS as long as the other program or strategy requirements specified in the Prevention and Early Intervention regulations are met.

5. Amend the Prevention and Early Intervention regulations to align counties' annual and periodic reporting deadlines with their budget-making timetables to maximize the value of the reports to local policymakers.

This report also provides background on how and why the Commission adopted the Prevention and Early Intervention and Innovation regulations as well as details regarding development of the subcommittee's five recommendations.

II. Background

The Mental Health Services Act

When California voters passed the Mental Health Services Act (the Act) in 2004, they laid the foundation for fundamental change in the state's mental health care system. The Act prioritized a focus on wellness, recovery, community consultation in decision-making, and a high level of public accountability. To achieve transformational change, the Act relies on three principal components:

- Community Services and Supports, which encompasses most direct mental health services, including an approach known as "whatever it takes" to support recovery;
- Prevention and Early Intervention (PEI), which emphasizes an early response to emerging needs before they become severe and disabling; and
- Innovation Programs, which propose new ways of operating on the mental health care landscape.

At the state level, California's mental health system is administered and overseen by the California Department of Health Care Services (DHCS) and the Mental Health Services Oversight and Accountability Commission (Commission). Additional state functions are administered by the Office of Statewide Health Planning and Development, which provides workforce development; the California Department of Education, which supports some school-based mental health programs; the California Department of State Hospitals, which provides hospital care to the most gravely disabled, and other state agencies.

While the state has an administrative and oversight role, mental health service delivery is handled by California's counties.[1] Many counties provide direct services to their residents, while others rely on contracts to deliver care, working with private, primarily nonprofit providers.

The Act includes a range of requirements that counties and their providers must meet. In 2013, the Legislature directed the Commission to adopt regulations governing programs and expenditures for PEI and Innovation programs (Assembly Bill 82, Committee on Budget, Chapter 23, Statutes of 2013). This change in the law meant that both the Commission and the DHCS now have authority to issue regulations to implement the Act. The DHCS is charged with issuing regulations for all of the components except for PEI and Innovation, which are under the authority of the Commission. The Legislature required that regulations adopted by DHCS be consistent with the regulations adopted by the Commission (Welfare and Institutions Code section 5846(b)).

The Regulatory Process

Regulations help clarify standards or expectations in the law. While they cannot modify or change the law, regulations provide clear language for carrying out the law or responding to it. For example, the law may require counties to submit to the state specific information on people served by the mental health system in order to document the range of needs being met. Regulations, meanwhile, would specify in what form, and how often, that information should be gathered and sent to the state. In California, the Office of Administrative Law is charged with ensuring that regulations are consistent with the law, are clear and necessary, and adequately meet the law's legal requirements.

To adopt regulations for California's PEI and Innovation programs, the Commission undertook an exhaustive public process, soliciting input between August 2013 and August 2015. Through 15 public meetings and the review of hundreds of pages of public comment, the Commission heard testimony from mental health consumers and family members, counties, representatives from diverse racial and ethnic communities, and other members of the public. In response to this extensive public input, the Commission developed regulations to provide a clear framework for the counties to execute, evaluate, and report on the PEI and Innovation projects they fund and operate. These regulations were reviewed and approved by the Office of Administrative Law and took effect in October 2015. By approving the regulations, the Office of Administrative Law determined that:

- the Commission has the authority to issue the regulations;
- the regulations correctly reference the specific law that they execute, interpret or make specific;
- the regulations are consistent with the law;
- the text of the regulations is clear;
- the regulations are necessary; and
- the Commission followed specified procedural requirements.

The Subcommittee Advisory Process

In response to the three specific concerns listed earlier in this report, the Commission formed a subcommittee – comprised of Commissioner Larry Poaster as chair and Commissioners Khatera Aslami-Tamplen and Richard Van Horn – to explore the issues and propose solutions. The subcommittee held six public meetings throughout the state to better understand the challenges faced by counties and providers operating under the new regulations.

More than 200 people representing more than 40 counties, as well as providers, community-based organizations, the California Behavioral Health Directors Association, the DHCS, and other stakeholders attended the subcommittee meetings. The first gathering, was a two-day meeting held in February 2016 in Sacramento. Additional meetings were held in Alameda County, Los Angeles County, and Calaveras County. At each meeting, participants explored the rationale behind the new regulatory requirements, the challenges associated with those requirements, and strategies the state and the counties could pursue to remedy the problems.

II. Findings and Recommendations

Finding One: Not all counties are sufficiently equipped to collect sensitive demographic information.

One indisputable goal of the Mental Health Services Act is improving access to care and the quality of that care for people who have historically been underserved. The Prevention and Early Intervention (PEI) portion of the Act, in particular, is intended to reduce the long-term, adverse impacts of untreated mental illness by reducing barriers to care prior to first onset of a mental illness or before that illness becomes severe and disabling.

The Mental Health Services Oversight and Accountability Commission (Commission) has adopted regulatory requirements for counties to report detailed demographic information on who is served by California's mental health system and whether they have difficulties getting the care they need. This information includes age, gender, race and ethnicity, sexual orientation, language used, veteran status, disabilities and other details. (See the Required Demographic Data chart at right.)

The Commission developed these demographic reporting requirements based on consultation with a range of stakeholders who presented information about groups who have historically faced barriers to care. For instance, research shows that veterans have a suicide rate higher than the rate for non-veterans.[2] And while it is commonly assumed that veterans can receive mental health care through the U.S. Department of Veterans Affairs, many veterans either lack eligibility or live far from a Veterans Affairs facility.

Similarly, the League of United Latin American Citizens has raised concerns that non-Spanish speaking Latino immigrants, who are eligible for county mental health services, are struggling to access care because few providers speak their indigenous languages.[3] Equally significant, there is growing evidence that California's lesbian, gay, bisexual, transgender, queer, and/or questioning communities (LGBTQ) have disproportionately higher rates of poverty, suicide, homelessness, isolation, substance abuse, and trauma associated with violence.[4] For certain groups, such as transgender people of color and women, health and mental health disparities are particularly severe.[5] The statistics are even more alarming for LGBTQ youth, who are particularly vulnerable to suicide. Lesbian, gay, and bisexual youth are more than twice as likely than their heterosexual peers to have attempted suicide.[6]

Required Demographic Data

(A) Age groups
1. 0-15 (children/youth)
2. 16-25 (transition age youth)
3. 26-59 (adult)
4. Ages 60+ (older adult)

(B) Race
1. American Indian or Alaska Native
2. Asian
3. Black or African American
4. Native Hawaiian or other Pacific Islander
5. White
6. Other
7. More than one race
8. Decline to answer

(C) Ethnicity
1. Hispanic or Latino:
    a. Caribbean
    b. Central American
    c. Mexican/Mexican-American/Chicano
    d. Puerto Rican
    e. South American
    f. Other
    g. Decline to answer
2. Non-Hispanic or Non-Latino:
    a. African
    b. Asian Indian/South Asian
    c. Cambodian
    d. Chinese
    e. Eastern European
    f. European
    g. Filipino
    h. Japanese
    i. Korean
    j. Middle Eastern
    k. Vietnamese
    l. Other
    m. Decline to answer
3. More than one ethnicity
4. Decline to answer

(D) Primary language used listed by threshold language for the individual county

(E) Sexual orientation
1. Gay or Lesbian
2. Heterosexual or Straight
3. Bisexual
4. Questioning or unsure of sexual orientation
5. Queer
6. Another sexual orientation
7. Decline to answer

(F) Disability
1. Yes
    - a. Communication domain
        - (i) Difficulty seeing
        - (ii) Difficulty hearing or having speech understood
        - (iii) Other (specify)
    - b. Mental domain not including mental illness
    - c. Physical/mobility domain
    - d. Chronic health condition
2. No
3. Decline to answer

(G) Veteran status
1. Yes
2. No
3. Decline to answer

(H) Gender
1. Assigned sex at birth
    - a. Male
    - b. Female
    - C. Decline to answer
2. Current gender identity
    - a. Male
    - b. Female
    - c. Transgender
    - d. Genderqueer
    - e. Questioning or unsure of gender identity
    - f. Another gender identity
    - g. Decline to answer

To better document and understand mental health disparities, the Commission regulations require the counties to report, by demographic category, information on who is served. To meet this new reporting requirement, both the counties and the mental health providers who deliver mental health care on their behalf must create policies and procedures to gather this detailed demographic information and transmit it to the state.

California's mental health system includes a diverse array of programs and services, ranging from mental health treatment provided in a clinical or office setting to home-based outreach and group meetings. Prevention services are particularly diverse and include school-based education and awareness services for youth as well as outreach services for older adults who are isolated due to loss, illness and/or substance abuse.

The regulations require that each county annually report specific information about its mental health services, including the number of people served in each Prevention and Early Intervention program, the number of referrals made for members of underserved communities, and the average time that passed between a referral and the recommended treatment.

Reflecting that diversity, California's network of providers use a variety of information-gathering tools to document the people they serve. Some programs use sophisticated electronic health records, which are common in traditional clinical settings, while others still gather information using pencil and paper. The latter group includes *promotoras,* community members with basic health education training who typically meet with small groups of residents in a private home, library or other community setting. Expanding data-reporting requirements that are applied equally across these diverse service settings and collection methods is a significant challenge.

To collect the required demographic information, counties and providers must overcome multiple obstacles:

1. Asking for information on sexual orientation and gender identity must be handled in a sensitive manner, and not all counties or providers have established appropriate policies and procedures. Complicating this task, it is unclear

whether there are best practices governing how to gather this information, particularly for racial, ethnic, religious, and cultural groups that may be less aware or accepting of sexual orientation and gender diversity.

2. The counties and their providers often serve young children. It is unclear what the acceptable age range is for asking children about their sexual orientation and gender identity.
3. For programs administered through or in partnership with California's elementary and secondary schools, federal and state law may limit the type of questions regarding sexual orientation and gender identify that may be asked of a child without written permission from a parent or guardian.
4. In addition to complying with the Commission regulations, California's counties must follow state and federal laws that establish similar and potentially conflicting data-gathering requirements. Creating consistent demographic reporting requirements would streamline and simplify their work.
5. The state lacks a data-reporting system that can accept the detailed demographic information required by the new regulations.

Failure to address each of these concerns could undermine regulatory compliance or the quality of the data submitted to the state. These challenges are discussed in more detail in the following pages.

Support culturally sensitive approaches to gathering information on sexual orientation and gender identity.

The Commission's regulations require providers to collect information on an individual's sexual orientation and gender identity, information deemed essential to documenting whether LGBTQ people are accessing care and the outcomes of that care. Advocates are concerned that collecting sexual orientation and gender information may cause offense in some cultures. For example, asking about anything other than the traditional male or female gender identities may clash with cultural, linguistic or religious values. Advocates report that some cultures do not have words to describe details related to lesbian, gay, bisexual, transgender or queer, as required by the regulations.[7] Failure to address that concern could lead to confusion and conflict between providers and mental health clients, ultimately producing invalid data. The Centers for Medicare & Medicaid Services Office of Minority Health is developing a web-based training to aid providers in the collection of sexual orientation and gender identity data. The federal agency also is working on a new best practices tool box for providing culturally and linguistically appropriate services with an emphasis on sexual and gender minorities and people with disabilities.[8]

In 2016 the U.S. Department of Health and Human Services Health Resources and Services Administration added sexual orientation and gender identity to its reporting requirements. Federal officials say the new data are necessary because "sexual orientation and gender identity can play a significant role in determining health outcomes. Gaining a better understanding of populations served by health centers, including sexual orientation and gender identity, promotes culturally competent care delivery and contributes to reducing health disparities overall."

U.S. Department of Health and Human Services, Health Resources and Services Administration, Program Assistance Letter. March 22, 2016. http://bphc.hrsa.gov/datareporting/pdf/pal201602.pdf

While those concerns are valid, gathering detailed information on sexual orientation and gender identity is not new and will become increasingly more common. Recent federal and state laws require the collection of this data in population health surveys.[9] This new requirement is intended to facilitate identification of health issues and the reduction of health disparities among LGBTQ communities. Gathering this data is consistent with key recommendations in Healthy People 2020, the 2011 Institute of Medicine report on LGBTQ health issues and research gaps, and the federal government's implementation of the Patient Protection and Affordable Care Act.[10]

Despite this trend, most counties have not established policies and procedures for gathering this information. Fortunately, some counties have considerable experience gathering detailed demographic information, including data on sexual orientation and gender identity. The City and County of San Francisco and San Mateo County have been collecting gender identification and sexual orientation data for years and have developed guidelines for the work.[11] In 2013, the San Francisco Department of Public Health issued guidelines for collecting and reporting sexual orientation and gender identity data (see "Sexual Orientation and Gender Identity Data Collection in San Francisco" on the next page). The Commission's regulations parallel the two-part question approach developed by San Francisco.

Despite these models, the vast majority of California counties lack the protocols and guidelines in place in San Francisco and San Mateo. To benefit from the work done in those counties and elsewhere, the state should support peer-to-peer learning. This would help each county develop protocols for the effective and culturally sensitive gathering of data.

The **New York City Commission on Human Rights has** made it illegal to discriminate on the basis of gender identity and gender expression in the workplace, in public spaces, and in housing –and **identified 31 different gender identities.**

New York City Commission on Human Rights. http://www1.nyc.gov/site/cchr/law/legal-guidances-gender-identity-expression.page

Sexual Orientation and Gender Identity Collection in San Francisco

In 2013, the San Francisco Department of Public Health issued guidelines for collecting and reporting sexual orientation and gender identity data. The stated purpose of the guidelines was to "promote accuracy, transparency and consistency" so "data collection and reporting on health by sex and gender reflect the spectrum of gender categories that are meaningful for identifying differences in health outcomes, conditions that impact health and delivery of health services."

The guidelines state that sex and gender should be self-identified and that a concise, feasible method for identifying a person's sex and gender identity involves asking these two questions:

1. What is your gender?
2. What was your sex at birth?

San Francisco Department of Public Health, *Policy and Procedure* – Principles for Collection, Coding, and Reporting Identity Data Sex and Gender Guidelines, September 1, 2014

Clarify the age threshold for gathering detailed information on sexual orientation and gender identity.

> Under California law, a minor who is 12 years of age or older may consent to outpatient mental health services.
> Health and Safety Code §124260

The core principle of PEI is to intervene early in the onset of mental illness to prevent it from becoming severe and disabling. (WIC §5840(a)) Half of all lifetime cases of diagnosable mental illnesses begin by age 14 and three-fourths begin by age 24.[12] Gathering demographic information from youth is key to tracking the effectiveness of programs serving young people. Such efforts are especially critical for California's LGBTQ community, for reasons described earlier. [13]

Given the evidence of the early onset of mental illness in youth, particularly youth from underserved communities, it is critical that the state identify which programs are effective for which youth. To make that determination, and to assess whether Californians continue to face barriers to care, the state needs demographic and other data. But as with state law, the PEI and Innovation regulations do not specify the age at which such information should be collected. Some providers have raised concerns about collecting sexual orientation and gender identification information from people younger than 18. But there is little research providing insights about whether some children are too young to be asked, or to answer, questions about their sexual orientation and gender identity.

In analyzing this issue, it's useful to look at what age a minor may consent to outpatient mental health services. Under California law, a minor who is 12 years of age or older may consent to mental health treatment or counseling on an outpatient basis if, in the opinion of the attending professional, the minor is mature enough to participate intelligently in the services (Health and

Safety Code section 124260). This law was enacted in 2010 to eliminate barriers faced by youths eligible for mental health services specifically under the Prevention and Early Intervention component of the Act.[14] Given that a minor as young as 12 can consent to receiving mental health services, it may be reasonable to conclude that minors of the same age are old enough to answer demographic questions, including those about sexual orientation and gender identity.

Because the regulations do not provide counties and providers an age range for the collecting of such information, the Commission should consider an amendment to the regulations that specifies an age threshold.

Ensure consistency with other laws for programs administered through or in partnership with California's elementary and secondary schools.

Mental health programs administered through or in partnership with California's elementary and secondary schools face another challenge related to sexual orientation and gender identity questions – a lack of consistency with other state and federal laws over what may be asked without a parent or guardian's written consent. Some parents have withdrawn their children from programs because of objections to the sexual orientation and gender identity question.[15] This issue raises two significant questions for programs administered through or in partnership with California's elementary and secondary schools:

1. Is parental permission required before youth may be asked their sexual orientation and gender identity?

Advocates have cited California Education Code section 51513 in support of obtaining parental consent prior to asking students about their sexual orientation and gender identity. Section 51513 prohibits a school from asking a student's personal beliefs or practices in sex, family life, morality, and religion in grades 1 to 12 unless a parent gives written permission (i.e. an "opt-in" requirement). There is a strong argument that section 51513 does not apply in this instance because questions about the student's race, ethnicity, sexual orientation and gender identity are not about the "student's beliefs or practices in sex, family life, morality, or religion." Nevertheless, some people insist that questions about sexual orientation and gender identity infringe on morality and religious beliefs.

Even if section 51513 were applicable, Education Code section 51938 provides for a specific exception to the opt-in requirement for students in grades 7 to 12 for anonymous, voluntary, and confidential research and evaluation tools to measure students' health behaviors and risks. This code section is part of the comprehensive health education programs and includes instruction on mental and emotional health and development. It provides for a passive consent (i.e. an "opt-out" process), meaning that parents or guardians must be notified that the survey is to be administered, given an opportunity to review the survey, and told that excusing their child from taking the survey requires a written request to the school district. Thus, depending on whether the PEI program fits within the boundaries of this Education Code section, parent or guardian permission may not be required.

Other than the two Education Code sections mentioned here, the Commission's research found no state or federal law that requires parental consent prior to collecting sexual orientation and gender identity information from a student. This conclusion is based upon an independent legal review as well as discussions with the California Department of Education and local and national experts on youth law.[16] According to these experts, considerable confusion persists around the laws governing parental consent in general. For example, although the law specifying that a 12-year-old minor may consent to outpatient mental health services has been in effect since 2010, many school districts are still unaware of it.[17]

Recognizing the need for more clarity on this topic, the National Center for Youth Law is working with law firms representing California school districts to convene a conference to provide technical assistance and training to local school district administrators on parental consent.[18]

There is considerable confusion in California regarding when parental consent is required for participation in mental health programs in schools.

Whether or not parental consent is legally required to obtain sexual orientation and gender identity information from students, it must be emphasized that participation in PEI programs is not contingent upon providing *any* demographic information. Put another way, while the regulations require the counties to report demographic information, they do not make its collection a condition for providing services. Even so, students and their parents or guardians deserve more information about why these questions are being asked and how the answers will be used.

2. Once sexual orientation and gender identity information is collected, can it be reported to the state without parental consent?

The answer to this question depends on whether the information is subject to the Family Educational Rights and Privacy Act (FERPA) or the Health Insurance Portability and Accountability Act (HIPAA). These two federal laws protect privacy and limit how certain personal information can be shared.

Generally, FERPA limits disclosure of information in education records maintained by schools while HIPAA limits disclosure of health information by health care providers. When health care providers work on school campuses, HIPAA or FERPA may apply to the provider's records depending on a number of complex variables.[19]

"Protected health information" is individually identifiable health information in any form, including oral communications as well as written or electronically transmitted information. (45 C.F.R. Part 162)

In addition to FERPA and HIPAA, California state law protects the confidentiality of information held by schools and mental health providers, and dictates how and when information can be shared.[20] These laws parallel HIPAA in many ways, but in some cases provide greater confidentiality protection. When that occurs, providers must follow the state law. California confidentiality law does apply to health information in an education record subject to FERPA; therefore, FERPA and California law may apply to the same information at the same time.

Identifying the applicable statute is important because the laws' requirements differ. Under FERPA, for example, a parent must sign a release authorizing the exchange of information on behalf of a minor child. Under HIPAA, a parent must sign for a minor except only the minor student must sign if the records pertain to health services (including mental health) the minor consented to, or could have consented to, under state law. This distinction is important because of the California law cited previously that authorizes 12-year-olds to consent to their own outpatient mental health services.

No matter which of the federal and state privacy protection laws apply, information omitting personal identifiers may be released without consent for purposes of research and evaluation.[21] The demographic information required by the PEI regulations is aggregated information (i.e. lacking personal identifiers) about the participants of each PEI program; this information can be released by the provider unless it is for such a small-sized group that an individual might reasonably be considered identifiable. Even so, given the complex maze of laws, the Commission should amend the regulations to provide clearer guidance on data collection for programs serving children in schools.

Create consistent demographic reporting requirements and streamline the data collection and reporting process.

While California's county mental health agencies and their private sector providers recognize the value of collecting the demographic information, they are hindered by several practical problems. These include the two following challenges:

1. The state-maintained computer system through which counties submit demographic information is not configured to accept the new data.
2. Recent legislation directed multiple state departments to gather sexual orientation and gender identity information, but there is no common protocol governing this data reporting.

The counties have noted that under previously adopted regulations, they are required to submit demographic information on people they serve through a computer system known as the Client & Service Information (CSI) system, which is maintained by the California Department of Health Care Services (DHCS). Because of its current configuration, however, the CSI is not able to accept the more detailed information on ethnicity required by the Commission's new regulations. For instance, the CSI uses only "Hispanic/Latino" and "Unknown" for ethnicity categories, but the regulations call for differentiating between six Latino identities and 12 non-Latino identities, including nine Asians identities. The more detailed information requested under the regulations mirrors the expanded set of data on ancestry or ethnic origin now required under recently approved legislation.[22] The intent of the broader reporting on ethnicity is to equip the state with more accurate data with which to meet the needs of its diverse communities.

The DHCS is working to update its data collecting capabilities, including the CSI, and ultimately it must develop an integrated system that allows counties to submit information in a timely, reliable, and efficient manner. In the interim, the new regulations call for the demographic data to be delivered directly to the Commission.

Despite concerns, the Commission concluded that gathering the more detailed information is necessary to determine whether diverse communities are accessing care and experiencing the positive mental health outcomes envisioned by the Mental Health Services Act.

On a related issue, the counties and providers have indicated that the more detailed demographic information required by the new regulations can create inconsistencies within a medical record. For instance, traditional demographic data in a file might list a patient as Asian or Latino, yet the recently adopted regulations call for differentiating between multiple categories of Asians or Latino identities, as discussed earlier. As a result, in addition to gathering greater demographic detail for new clients, providers will need to update the medical records of all clients.

While updating such medical records may create additional cost, most contracts governing electronic health records systems require the vendor to make updates at little or no cost to comply with regulations. Counties and providers should engage with their electronic health records vendors to clarify procedures for modifying and updating their data collection systems as a result of the new reporting requirements.

Following recent legislation, multiple state departments also are developing new sexual orientation and gender identity reporting requirements. Yet because there is no universal standard governing such data reporting, counties may be asked to comply with a variety of requirements. In 2015 the California Legislature enacted Assembly Bill 959 (Chiu, Chapter 565, Statutes of 2015), the Lesbian, Gay, Bisexual, and Transgender Disparities Reduction Act, to address the significant health and well-being disparities that affect LGBTQ individuals. The bill requires the collection of sexual orientation and gender identity data by departments that work in health and human services. Specifically, the DHCS, Department of Public Health, Department of Social Services, and Department of Aging must add sexual orientation and gender identity data to their current demographic data collection efforts as soon as possible, and no later than July 1, 2018.

Counties and providers are concerned that these four state departments will establish sexual orientation and gender identity reporting requirements that differ from or conflict with each other and those set by the Commission. The Mental Health Services Act requires that regulations adopted by DHCS be consistent with the regulations adopted by the Commission. Consistent with the law, the Commission should ensure that the DHCS adopts demographic reporting requirements that match its own.

The Mental Health Services Act requires that regulations adopted by the California Department of Health Services and the Mental Health Services Oversight and Accountability Commission be consistent.

Similarly, the Commission should work with the other state departments covered under Assembly Bill 959, to follow a consistent set of data collection requirements.

Despite these concerns, the Commission concludes that gathering the detailed demographic information – including sexual orientation and gender identity – is vital. Without it, California will not know whether its diverse communities are receiving mental health care and whether that care is producing the positive mental health outcomes envisioned by the Act.

Recommendation

The Commission should support collaborative processes with county behavioral health agencies and other subject matter experts to apply best practices to the collection and reporting of sensitive demographic information. It also should work with other state departments to ensure the adoption of consistent standards and regulations regarding demographic data reporting. Finally, the Commission should partner with all parties, including stakeholders, on potential revisions to current regulations.

- In keeping with the law, the Commission should ensure that DHCS demographic reporting requirements are consistent with its own.

- The Commission should support counties by facilitating learning collaboratives and peer-to-peer guidance on best practices for collecting sensitive, culturally and linguistically competent, and age appropriate data. Collaboratives would allow

    - counties with experience in collecting demographic information to share lessons learned and best practices; and
    - other subject matter experts, including those representing unserved and underserved communities, to share best practices for individual communities.

- In conjunction with the learning collaboratives, the Commission should develop training and guidance materials for counties and providers. This training should include

    - guidance on data collection in clinical and non-clinical programs; and
    - toolkits and training to explain the reasons behind data collection and how it will be used to support improved service delivery.

- For programs serving children or youth, the Commission should amend the regulations to clarify that data on youth shall be collected and reported to the extent permissible by federal and state law, including the California Education Code. The Commission should specify an age threshold for data collection.

- The Commission should work with the DHCS and the Department of Public Health, Department of Social Services, and Department of Aging which have been directed to collect sexual orientation and gender identification data (Assembly Bill 959 Chiu, Chapter 565, Statutes of 2015), and with the Health and Human Services Agency and the Legislature, to set a statewide uniform standard for collecting this data.

- As the state puts in place a statewide integrated data collection system, the Commission should amend its regulations to require individual-level and non-aggregated data, allowing it to better monitor who is served by California's mental health system and determine whether some Californians continue to face barriers to care.

In order to implement the reporting requirements, the Department of Health Care Services must develop an integrated data collection system that allows counties to submit data in a timely, reliable, and efficient manner.

Finding Two: The regulatory requirements create unique challenges for counties with a population of 100,000 or fewer.

The Mental Health Services Oversight and Accountability Commission subcommittee heard considerable testimony about the obstacles some of California's smallest counties face as they seek to comply with the regulations. Counties with a population at or below 100,000 typically lack the staff and resources to meet some of the regulatory requirements, which are designed for larger counties. In addition, programs in very small counties tend to serve few consumers, raising a high risk that individuals' identity would be disclosed through the collection of information.

Very small counties range in population from less than 2,000 to 100,000.[23] The chart on the lists the counties and the minimal funding for Prevention and Early Intervention (PEI) programs for each county. For example, in fiscal year 2014-2015 the PEI funds distributed to these counties ranged from less than $300,000 for Alpine County to approximately $900,000 for Nevada County.[24] Yet under the regulations, these counties have the same programs and reporting requirements as counties as large as San Diego and Los Angeles.

Table 1: Very Small Counties

County	Population	MHSA Distributed FY 2014-15	PEI Funds
Alpine	1,100	$ 1,577,732.00	$ 299,769.08
Amador	37,001	$ 2,839,999.00	$ 539,599.81
Calaveras	44,828	$ 3,070,840.00	$ 583,459.60
Colusa	21,482	$ 2,557,177.00	$ 485,863.63
Del Norte	27,254	$ 2,691,699.00	$ 511,422.81
Glenn	28,017	$ 2,706,216.00	$ 514,181.04
Inyo	18,260	$ 1,825,265.00	$ 346,800.35
Lake	64,591	$ 3,580,612.00	$ 680,316.28
Lassen	31,345	$ 2,695,924.00	$ 512,225.56
Mariposa	17,531	$ 1,839,276.00	$ 349,462.44
Mendocino	87,649	$ 4,356,166.00	$ 827,671.54
Modoc	8,965	$ 1,715,250.00	$ 325,897.50
Mono	13,909	$ 1,788,887.00	$ 339,888.53
Nevada	98,877	$ 4,769,934.00	$ 906,287.46
Plumas	18,409	$ 2,477,848.00	$ 470,791.12
San Benito	58,792	$ 3,458,004.00	$ 657,020.76
Sierra	2,967	$ 1,611,808.00	$ 306,243.52
Siskiyou	43,554	$ 2,995,957.00	$ 569,231.83
Sutter	96,463	$ 8,269,453.00	$ 1,571,196.07
Tehama	63,308	$ 3,470,770.00	$ 659,446.30
Trinity	13,069	$ 1,782,141.00	$ 338,606.79
Tuolumne	53,709	$ 3,316,766.00	$ 630,185.54
Yuba	74,492		

The regulatory program and reporting requirements.

Regulations, unlike statutes enacted by the Legislature, are limited to implementing, interpreting or increasing the specificity of existing law, and they cannot add or change a statute. The PEI regulations implement Welfare and Institutions Code section 5840 that established PEI to prevent mental illness from becoming severe and disabling.

Under section 5840, the PEI regulations require each county to provide five PEI-funded programs. In some cases, programs can be combined to maximize resources. For example, a single clinic might serve a preventive role by helping individuals at ultra-high risk for psychosis while also treating those with recent onset psychosis. The five required programs are:

- **Prevention:** A program that is focused on people or communities with greater than average risk factors (e.g. serious chronic medical condition, adverse childhood experience, experience of severe trauma) for developing potentially serious mental illness and is designed to reduce those risk factors.

- **Early Intervention:** A program designed to provide services to address and promote recovery for individuals with a mental illness early on to prevent that illness from becoming severe and disabling.

- **Outreach for Increasing Recognition of Early Signs of Mental Illness:** A program designed to educate and train families, employers, primary health care providers, school personnel, cultural brokers, law enforcement personnel, and others to identify and respond effectively to early signs of potentially severe and disabling mental illness.

- **Access and Linkage to Treatment:** A program that connects individuals with severe mental illness to medically necessary treatment.

- **Stigma and Discrimination Reduction:** A program to reduce the stigma associated with either being diagnosed with a mental illness and/or seeking mental health services, and to reduce discrimination against people with mental illness.

Each of the five required programs must be designed and operated in a non-stigmatizing, non-discriminatory fashion. Each program must also include **strategies** to

- help create access and linkage to treatment for people needing a higher level of services; and
- improve the timely access to mental health services for people and/or families from underserved populations.

Under the regulations each county must annually report specific information about each of the five programs. This information must include the unduplicated number of individuals served in prevention and early intervention programs, the number of people referred from underserved communities, and the average wait time between a referral and participation in the recommended treatment.[25]

Unique challenges and concerns of very small counties.

In addition to their small populations and limited funding, very small counties face two unique challenges related to the PEI regulations.

1. The program requirement. Officials in very small counties say they face an unfair burden under rules mandating that counties operate at least one of each of the five distinct programs. Given their size, these counties typically offer their residents more integrated mental health services, and the requirement for so many stand-alone programs creates a financial strain. [26] In addition, these counties struggle to cope with limited number of staff. Alpine County, with only about 1,100 residents, has a staff of 13, including 2.5 staff members working exclusively in programs created under the Act and three clinicians providing services in the county's comprehensive behavioral health care system.[27] Modoc County has 12 to 13 direct service staff for its population of about 9,100.[28]

Under the regulations, a process exists to allow small counties – those with a population under 200,000[29] – to opt out of offering a stand-alone prevention program.[30] This opt-out provision was created in response to concerns raised during the regulatory process about the limited resources of small counties, thereby providing them with greater flexibility in how they use their limited funds.

Given the continuing concern, the Commission may want to consider whether counties with a population of 100,000 or less need even more flexibility regarding the requirement for stand-alone programs. In addition, the Commission might want to explore other ways in which very small counties can achieve the transformational change envisioned by the Act.

2. The Reporting Requirement. The small size of the population also creates challenges with the Commission's reporting requirements, especially those requesting specific information about each of the five required PEI programs. Because such programs in very small counties tend to serve few consumers, summary statistics can vary wildly year to year and, thus, can be misleading. For example, Alpine County serves a total of 45 individuals per month in the county's mental health program – 45 individuals for the entire county, not for a particular program.[31] And Modoc County served just 396 clients during all of fiscal year 2014-2015.[32] Given such small countywide numbers, one person can make a huge impact on a summary report, skewing the data and creating an inaccurate picture. If the counties reported data by program instead of countywide, that effect would be magnified.

An additional concern voiced by officials from very small counties was that, due to the population size, the data reporting requirements cannot be completed without providing individually identifiable health information in violation of federal and state privacy laws, such as the Health Information Portability and Accountability Act (HIPAA), the Confidentiality of Medical Information Act (Civil Code §56 et seq.) or Welfare and Institutions Code §5328. These laws protect against the disclosure of health information that either specifically identifies an individual or, in combination with other information, can be used to make such an identification.

Currently, the regulations require counties to collect and report only aggregated program-level information, not client-level information. For example, a county is required to report the total number of people served by demographic category. But because very small counties have so few people in any single specific demographic group, even program-level reporting might inadvertently disclose individual identities. Modoc County serves as a useful case in point. Of the 396 Modoc residents served in fiscal year 2014-2015, 220 are female and 176 are male, and 101 are under the age of 18. Officials fear that these countywide numbers are already so small that any further breakdown by individual program could expose the identities of individual clients. As such, the regulations should be amended to allow very small counties to report data on a countywide basis, instead of by program.

Very small counties also face some of the same challenges besetting other counties when collecting sensitive demographic information, as discussed earlier in this report. As such, the Commission should support very small counties through learning collaboratives and peer-to-peer guidance on best practices for the collection of sensitive, culturally and linguistically competent, and age appropriate data.

Recommendation

The Commission should recognize the unique needs of very small counties working to comply with the PEI regulations.

- The Commission should amend the regulations to allow very small counties to report data on a countywide level instead of by program.

- The Commission should support very small counties by facilitating learning collaboratives and peer-to-peer guidance on best practices, including the collection of sensitive, culturally and linguistically competent, and age appropriate data. Collaboratives would provide an opportunity for

    - counties with expertise in collecting demographic information to share lessons learned and best practices; and
    - other subject matter experts, including those representing unserved and underserved communities, to share best practices for individual communities.

- Along with the learning collaboratives, the Commission should develop training and guidance materials for counties and providers. This training would include

    - guidance on data collection in clinical and non-clinical programs; and
    - toolkits and training on how to use them to explain why the data is being collected and how it will be used to support quality improvement.

- Recognizing the unique needs of very small counties, the Commission may want to consider a broader discussion, including possible amendments to the Act, to explore other ways in which such counties can work to achieve the transformational change envisioned by the Act.

Finding Three: Counties lack the tools to collect some of the required Access and Linkage to Treatment data, including information on referrals and the duration of untreated mental illness.

One driving goal of the Mental Health Services Act is a significant reduction in the number of Californians who are unable to get timely and appropriate mental health care. To ensure access to programs established under the Act, the Prevention and Early Intervention (PEI) regulations require counties to use an Access and Linkage to Treatment strategy in all PEI-funded programs. In short, that means every PEI program must connect people in need of a higher level of services with necessary treatment, typically through a referral. In addition, counties must operate at least one stand-alone Access and Linkage to Treatment program.

To document progress on Access and Linkage to Treatment efforts, counties are required to collect and report the following data:

1. The number of people with serious mental illness who were referred to treatment, and the kind of treatment recommended;
2. The number of people who followed through on the referral;
3. The average duration of untreated mental illness for people without prior treatment for serious mental illness; and
4. The average time that passed between the referral and participation in the recommended treatment program.

Counties and service providers say they face several technical challenges with collecting this information. The concerns include difficulties with defining the term, “referral” as well as challenges with measuring the average duration of untreated mental illness.

Clarify the meaning of “referral.”

The regulations do not define “referral” nor differentiate the tracking requirements for non-clinical and/or outreach-oriented programs from those for clinical programs. As a result, county officials worry that data may be collected by people who lack the expertise to determine if a person has serious mental illness and needs a referral. Advocates also are unsure if referrals to programs outside of the county mental health system must be tracked.

Given these concerns, the Commission should provide clarification. First, the Commission should clarify that the term “referral” as used in the regulations should be interpreted according to the word’s traditional meaning: to direct or redirect a person to services. As such, a referral does not include providing people with a list of resources for mental health services. Given that, outreach programs that supply lists of community resources would not have to document those activities because they do not constitute a “referral.” Along with clarifying definitions, the Commission should specify when referrals are to be documented for non-clinical and/or outreach-oriented programs and clinical programs. In addition, counties should be informed that they need only report referrals to other county programs (either county or provider operated).

An additional problem is the absence of an information technology system to track the referrals. One county working to resolve this challenge is Lake County. Recently, the Commission approved a Lake County innovation project that will test an on-line web portal to help track referrals and improve interagency coordination.

Offer guidance and technical assistance with measuring the duration of untreated mental illness.

As outlined above, the PEI regulations require counties to report the average duration of untreated mental illness for people with serious mental illness who have not previously received treatment, and counties can choose what metrics to use for measuring this across diagnostic mental disorders. While assessment tools for measuring the duration of untreated psychosis exist in some early intervention programs, there are no such tools for other disorders (e.g. non-psychotic affective disorders, personality disorders, post-traumatic stress disorder).

Staff from the Commission's Research and Evaluation Unit, along with representatives of the counties and the County Behavioral Health Directors Association, have begun exploring a possible pilot study to determine how counties are assessing duration of untreated psychosis. A longer-term goal would be to use the study findings to develop standardized methods for measuring the duration of untreated mental illness, and then sharing those methods with all counties and providers.

The Commission has a contract with the Department of Psychiatry at the University of California, Davis, to assess outcomes and cost savings resulting from the early psychosis programs operating in California. The contract could be expanded to include recruitment of the 29 active early psychosis programs for the proposed pilot study to illuminate how counties are assessing duration of untreated psychosis. Such a project would generate useful data and recommendations to help the Commission develop validated measurement procedures for counties to use.

Recommendation

The Commission should clarify the meaning of Access and Linkage to Treatment reporting requirements, including the measurement of the duration of untreated mental illness.

- The Commission and other statewide entities should organize learning collaboratives and develop training and guidance materials, including standardized metrics for measuring the duration of untreated mental illness.
    - ➢ As part of this effort, the Commission should partner with counties to identify the effectiveness of county strategies for measuring Access and Linkage to Treatment and the duration of untreated mental illness. This could include focused studies and/or pilot projects as part of a continuous effort to improve the quality of such measurement.

- The Commission should clarify the meaning of “referral,” and specify when referrals must be documented for non-clinical and/or outreach-oriented programs and clinical programs.

- The Commission should specify that a county is only responsible for reporting referrals made to other county programs, whether such programs are operated by counties or providers.

Finding Four: Some counties have trouble distinguishing referral data generated by Prevention and Early Intervention programs from data related to programs funded by Community Services and Support (CSS).

The purpose of the Access and Linkage to Treatment element of Prevention and Early Intervention (PEI) is to ensure that people with serious mental illness are matched with the most appropriate level of services, regardless of where they first sought help. This approach, anchored in the concept that there should be “no wrong door” into the mental health system, is key to reducing the number of Californians who fail to receive timely and appropriate care. As such, it is critical that every PEI program has a mechanism that ensures people are promptly connected to the services they need. Initially, the Mental Health Services Oversight and Accountability Commission’s regulations required only that each program had a strategy to assure linkage occurred. But the Office of Administrative Law subsequently required that counties complement that strategy by also operating a stand-alone Access and Linkage to Treatment program.

Because the guidelines and funding for each component of the Mental Health Services Act were rolled out sequentially, some counties integrated their referral services as part of the Outreach and Engagement program funded by Community Services and Supports (CSS).[33] Outreach and Engagement, one of four service categories required by regulations issued by the California Department of Mental Health, is intended to reach, identify, and engage unserved people with serious mental illness so they receive appropriate services.[34]

Consequently, some counties provide services similar to Access and Linkage to Treatment within their CSS program. For those counties, it can be difficult to differentiate PEI-funded referrals from CSS-funded referrals.

For example, the Los Angeles County Department of Mental Health has one point of entry for services delivered under the Act, and, depending on a needs assessment, an incoming client could be directed to either a CSS-funded program or a PEI-funded program.[35] In such cases, county officials say it is difficult to separate Access and Linkage to Treatment data funded under a PEI program from that funded by CSS. In addition, counties expressed a persistent concern that requiring an Access and Linkage to Treatment stand-alone program funded by PEI is duplicative and not an efficient use of funds.

Community Services and Supports (CSS) Funding Categories

1. **Full Service Partnership:** program to provide direct mental health services for people with serious mental illness through an approach known as "whatever it takes" to support recovery.[36]
2. **General System Development:** program to improve the mental health service delivery system for all clients.[37]
3. **Outreach and Engagement:** program to reach, identify, and engage unserved people with serious mental illness so they receive appropriate services.[38]
4. **Mental Health Services Act Housing Program:** program to acquire, rehabilitate or construct permanent supportive housing for clients with serious mental illness.[39]

Under the regulations a precedent exists to deal with overlapping PEI and CSS programs. The regulations allow counties to fund the PEI Outreach for Increasing Recognition of Early Signs of Mental Illness program through another MHSA funding stream such as CSS.[40] A similar approach could be used to address this challenge.

Recommendation

The Commission should consider amending the PEI regulations to allow a county to pay for Access and Linkage to Treatment Program through another Mental Health Services Act funding stream, such as Community Services and Supports, as long as the other requirements in the PEI regulations are met.

Finding Five: The Mental Health Services Oversight and Accountability Commission's timeline for developing and implementing new data collection system is too short, depriving counties of sufficient time to comply.

Until recently, there was no data collection and reporting requirement for individual PEI programs or Innovation projects established under the Mental Health Services Act. Instead, under the state Department of Mental Health guidelines issued in 2007, counties were required to provide an outcome evaluation of only one PEI program of the county's choosing.[41] With adoption of the Commission's regulations in October 2015, counties for the first time were directed to collect demographic information for people served by each PEI program or Innovation projects and to report that information annually.

For more than nine years, counties have been voluntarily collecting their PEI program data, but these efforts lacked a uniform, data collection and reporting approach. The Commission regulations created a standardized set of reporting expectations for counties. The new regulations also require that county reports be submitted as part of the Act's required Three-Year Program and Expenditure Plan (the Three-year Plan) and the Annual Update.[42] Under the Act, every county must prepare Three-Year Plans setting forth an integrated blueprint for all components required by law (i.e. programs for PEI, Innovation, Community Services and Supports, Workforce and Education, and Technological and Capital Facilities). The Three-Year Plans must be updated annually, and those plans as well as the Annual Updates must be presented to and approved by each county's Board of Supervisors prior to submission to the Commission.[43]

The Three-year Plans and Annual Updates are reporting documents intended to meaningfully reflect counties' budget and programming plans and rationales, as well as the outcomes such programs have produced in preceding years. During the planning process, county behavioral health officials are required to work closely with community stakeholders to identify mental health needs and strategies to meet those needs.[44] The Three-Year Plans and Annual Updates thus are to reflect meaningful stakeholder involvement in program selection, including choices about monitoring, quality improvement, performance evaluation, and budget prioritization.[45]

Three-Year Plans and Annual Updates are prepared and submitted to county supervisors as part of the annual budgeting process. The documents should provide supervisors with evidence about behavioral health program operation, support for or concerns about programs and the County Behavioral Health Department's performance by community stakeholders, and recommendations.

The Mental Health Services Act requires an extensive community planning process – complete with ample stakeholder involvement – prior to Board of Supervisor approval. County officials report that this approval process can last as long as six to nine months because of the required 30-day public comment period, the scheduling of a public hearing by the local mental health board, and the time required to get on the Board of Supervisors' agenda.[46] This timetable, and the intention that the Three-year Plan or Annual Update shape local decisions about mental health program budgets and priorities, confirm that the reports should be delivered to county supervisors in time for them to use the documents in their annual budget deliberations.

The PEI regulations require counties to submit annually either an Annual Program and Evaluation Report or a Three-Year Program and Evaluation Report. These reports are required to be a part of each county's Three-Year Plan or Annual Update.[47] That requirement was intended to support meaningful stakeholder involvement in county decision-making regarding the design, funding, and implementation of behavioral health services. One key example is the need for stakeholder involvement in the Community Planning Process, where input can shape county supervisors' decision-making about Behavioral Health Department budgets and integrated service plans.

In order for Three-Year Program and Expenditure Plans and Annual Updates to affect supervisors' annual budget deliberations, they must be delivered in time to be included in those deliberations and they must provide up-to-date, relevant information. These factors suggest that the Commission may wish to revisit and revise due dates for PEI Program and Evaluation Reports. Furthermore, because the regulations did not become effective until several months into fiscal year 2015-2016, the Commission may wish to revise the due dates and data reporting periods required to be included in the initial reports. (See Table 2, "Required County Data Reports and Recommended Changes," at the end of this section).

Clearly, establishing data collection systems to comply with these regulations in a timely manner is challenging. Although some counties may be able to meet the deadlines for the first reports, other counties may lack sufficient time to design the evaluation, create data collection protocols, and obtain and analyze the required data.

Recommendation

The Commission should amend the Prevention and Early Intervention regulations to align counties' annual and periodic reporting deadlines with their budget-making timetables to maximize the value of the reports to local policymakers.

- The Commission should provide a waiver for the initial Annual Report, which is due no later than December 30, 2017. Under the waiver, a county would report whatever data it had collected thus far, would explain the obstacles to meeting its reporting deadline, and would provide an implementation plan and timeline for complying fully with future Annual Reports.

- For subsequent Annual Reports and the initial and subsequent Three-Year Evaluation Reports, the Commission should amend the regulations to modify due dates, aligning them with the county budgeting process. These reports would be due within 30 days of board of supervisor approval but no later than June 30.

Table 2: Required County Data Reports and Recommended Changes

Report	Current	Recommended
Annual Report	**Initial Annual Report** ➢ Due 12/30/17 ➢ Data from FY 2016-2017 **Second Annual Report** ➢ Due12/30/19 ➢ Data from FY 2018-2019	**Initial Annual Report** ➢ Due 12/30/17 ➢ Data from FY 2016-2017 to extent available and implementation plan for future reports **Second Annual Report** ➢ Due 06/30/20 ➢ Data from FY 2018-2019
Report	**Current**	**Recommended**
Three-Year Report	**Initial Three-Year Report** ➢ Due 12/30/18 ➢ Data from FY 2017-2018; Prior fiscal years only if available **Second Three-Year Evaluation Report** ➢ Due December 30th every third year thereafter ➢ Data from three prior fiscal years	**Initial Three-Year Report** ➢ Due 6/30/19 ➢ June 30th every third year thereafter **Second Three-Year Evaluation Report** ➢ Due December 30th every third year thereafter ➢ Data from three prior fiscal years

Endnotes

[1] California has 59 local mental health agencies that include 56 California counties, a joint county entity (Sutter-Yuba) and two city-run agencies: City of Berkeley and TriCities, which includes the cities of Pomona, Claremont, and La Verne.

[2] Han K. Kang DrPH, Tim A. Bullman MA, Derek J. Smolenski MPH, PhD, Nancy A. Skopp PhD, Gregory A. Gahm PhD, Mark A. Reger PhD *Suicide risk among 1.3 million veterans who were on active duty during the Iraq and Afghanistan wars*, Annals of Epidemiology 25 (2015) 96-100

[3] League of United Latin American Citizens (LULAC), *An investigative report on perceived mismanagement and inequitable distribution of behavioral health services and resources to the Latino/a community*, November 21, 2014

[4] Grant, J.M., Mottet, L.A., Tanis, J., Harrison, J., Herman, J.L., Keisling, M. (2011). *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey.* Washington, DC: National Center for Transgender Equality and National Gay and Lesbian Task Force.

[5] Kellan E. Baker, MA, MPH. (2014). *Identifying Transgender and Other Gender Minority Respondents on Population-Based Surveys: Why Ask?* In J.L. Herman (Ed.), *Best Practices for Asking Questions to Identify Transgender and Other Gender Minority Respondents on Population-Based Surveys*. (01- 08) Los Angeles, CA: The Williams Institute.

[6] Grossman AH, D'Augelli AR. Transgender youth and life-threatening behaviors. Suicide & life-threatening behavior 2007;37:527-537.

[7] Kiran Sahota, Behavioral Health Manager, Proposition 63, Ventura County Behavioral Health Department. April 14, 2016 testimony to the California Mental Health Services Oversight and Accountability Commission Subcommittee.

[8] The July 28, 2016 official blog for the Centers for Medicare & Medicaid Services (CMS)] can be found at https://blog.cms.gov/2016/06/28/advancing-health-equity-for-sexual-and-gender-minorities/

[9] U.S. Department of Health and Human Services, Health Resources and Services Administration, Program Assistance Letter 2016-02; Chapter 565, Statutes of 2015 (Assembly Bill 959, Chiu)

[10] Bradford, J.; Cahill, S; Grasso, C.; and Makdon, H. “Policy Focus: Why gather data on sexual orientation and gender identity in clinical settings.” The Fenway Institute, 2012; and Health People 2020. “Lesbian, Gay, Bisexual and Transgender Health: Objectives.” U.S. Department of Health and Human Services, 2012. http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=25

[11] Juan G Ibarra, DrPH, MPH, MSW, Epidemiologist, San Francisco Department of Public Health and Jei Africa, Director, Office of Diversity and Equity, County of San Mateo. March 23, 2016 testimony to the California Mental Health Services Oversight and Accountability Commission Subcommittee.

[12] National Institute of Mental Health, June 2005 press release, “Mental Illness Exacts Heavy Toll, Beginning in Youth” https://www.nimh.nih.gov/news/science-news/2005/mental-illness-exacts-heavy-toll-beginning-in-youth.shtml.

[13] Grant, J.M., Mottet, L.A., Tanis, J., Harrison, J., Herman, J.L., Keisling, M. (2011). *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey.* Washington, DC: National Center for Transgender Equality and National Gay and Lesbian Task Force.

[14] Senate Bill 543 (Leno), Chapter 503, Statutes of 2010. Senate Third Reading Analysis.

[15] Mark Sorensen, Outreach Consultant, Ontario-Montclair School District. April 14, 2016 testimony to the California Mental Health Services Oversight and Accountability Commission Subcommittee.

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[16] Personal communication between Commission staff and Bruce Yonehiro, Deputy General Counsel and Jim Alford, Special Education Consultant from California Department of Education; Teresa Stinson, Chief Counsel, Sacramento County Office of Education; and Rebecca Gudeman, Senior Attorney, National Center for Youth Law.

[17] Rebecca Gudeman, Senior Attorney, National Center for Youth Law, personal communication with Commission staff.

[18] *ibid*.

[19] The main variable is the relationship between the provider and the school. This variable sounds simpler than it is. That is, the records are not subject to the Family Educational Rights and Privacy Act (FERPA) if the PEI program provider is funded, administered and operated by or on behalf of a public or private health, social services, or other non-educational agency. (U.S. Dept of Education, Family Policy Compliance Office, Letter to Ms. Melanie P. Baise, University of New Mexico, November 29, 2004, available at www.ed.gov/policy/gen/guid/fpco/ferpa/libray/baiseunmisslc.html.) However, if the PEI program is administered or operated by or on behalf of a school, the provider's records may be considered education records and subject to FERPA. For example, if a school mental health provider is hired by the district with funds from an agency not subject to FERPA, such as a community-based mental health agency or department of behavioral or mental health that provider's records may be subject to FERPA depending on whether the provider is acting as a school employee. It is important to note that HIPAA explicitly states that its rules do not apply to health information in an education record subject to FERPA. (45 C.F.R. section 160.103 ("Protected Health Information… excludes individually identifiable health information in: (i)Education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. section 1232g:…") Therefore, FERPA and HIPAA can never apply to the same information at the same time.

[20] California Civil Code section 56 et seq; Welfare and Institutions Code sections 5328 and 5329; and Education Code sections 49060 et seq.

[21] 34 C.F.R. Section 99.31(b); California Education Code sections 49074 and 49076.

[22] Assembly Bill 1088, Chapter 689, Statutes of 2011; Assembly Bill 1726, Chapter 607, Statutes of 2016.

[23] Title 9, California Code of Regulations, section 3750.

[24] California State Controller's Office website at http://www.sco.ca.gov/ard_payments_mentalhealthservicefund_fy1415.html

[25] Title 9, California Code of Regulations, section 3560.010.

[26] Karen Stockton, Ph.D., MSW, BSN, Director Modoc County Behavioral Health. April 27, 2016 testimony to the California Mental Health Services Oversight and Accountability Commission Subcommittee.

[27] Alissa R. Nourse, Director, Alpine County Behavioral Health Services. February 11, 2016 written testimony to California Mental Health Services Oversight and Accountability Commission Subcommittee.

[28] Karen Stockton, Ph.D., MSW, BSN, Director Modoc County Behavioral Health. February 23, 2016 testimony to the California Mental Health Services Oversight and Accountability Commission Subcommittee.

[29] The regulations issued by the state Department of Mental Health and still in effect define "Small County". (Title 9, California Code of Regulations, section 3200.260.)

[30] Title 9, California Code of Regulations, sections 3705 and 3706. A small county that opts out of the requirement must include in its Three-Year Program and Expenditure Plan and/or Annual Update documentation describing the rationale for the county's decision and how the county ensured meaningful stakeholder involvement in the decision to opt out.

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[31] Alissa R. Nourse, Director, Alpine County Behavioral Health Services. See endnote 26.

[32] Karen Stockton, Ph.D., MSW, BSN, Director Modoc County Behavioral Health. See endnote 27.

[33] Department of Mental Health Letter 05-05, August 1, 2005, Mental Health Services Act Community Services and Supports Guidelines; Department of Mental Health Information Notice 07-19, September 25, 2007, Mental Health Services Act Prevention and Early Intervention Components Guidelines.

[34] Title 9, California Code of Regulations, sections 3200.240, 3615, and 3640.

[35] Debbie Innes-Gomberg, Ph.D., Program Manager III, Los Angeles County Department of Mental Health Program Support Bureau, MHSA Implementation and Outcomes Division. February 23, 2016 testimony to California Mental Health Services Oversight and Accountability Commission Subcommittee.

[36] Title 9, California Code of Regulations, sections 3200.130, 3620, 3620.05, and 3620.10.

[37] Title 9, California Code of Regulations, sections 3200.170 and 3630.

[38] Title 9, California Code of Regulations, sections 3200.240 and 3640.

[39] Title 9, California Code of Regulations, sections 3200.225 and 3615.

[40] Title 9, California Code of Regulations, section 3715(f).

[41] Department of Mental Health Information Notice 07-19, September 25, 2007, Mental Health Services Act Prevention and Early Intervention Components Guidelines.

[42] Title 9, California Code of Regulations, sections 3560, 3560.010, and 3560.020.

[43] Welfare and Institutions Code section 5847.

[44] Welfare and Institutions Code sections 5847 and 5848.

[45] Welfare and Institutions Code section 5848(a).

[46] Debbie Innes-Gomberg, Ph.D., Program Manager III, Los Angeles County Department of Mental Health Program Support Bureau, MHSA Implementation and Outcomes Division. June 29, 2016 testimony to California Mental Health Services Oversight and Accountability Commission Subcommittee.

[47] Title 9, California Code of Regulations, sections 3560, 3560.010, and 3560.020.