WELFARE AND INSTITUTIONS CODE - WIC

DIVISION 5. COMMUNITY MENTAL HEALTH SERVICES [5000 - 5987] *(Division 5 repealed and added by Stats. 1967, Ch. 1667.)*

PART 3.6. PREVENTION AND EARLY INTERVENTION PROGRAMS [5840 - 5840.7] *(Part 3.6 added November 2, 2004, by initiative Proposition 63, Sec. 4.)*

CHAPTER 2. Prevention and Early Intervention Program Planning [5840.5 - 5840.7] *(Chapter 2 added by Stats. 2018, Ch. 843, Sec. 3.)*

5840.5. It is the intent of the Legislature that this chapter achieve all of the following:

(a) Expand the provision of high quality Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) programs at the county level in California.

(b) Increase the number of PEI programs and systems, including those utilizing community-defined practices, that focus on reducing disparities for unserved, underserved, and inappropriately served racial, ethnic, and cultural communities.

(c) Reduce unnecessary hospitalizations, homelessness, suicides, and inpatient days by appropriately utilizing community-based services and improving timely access to prevention and early intervention services.

(d) Increase participation in community activities, school attendance, social interactions, physical and primary health care services, personal bonding relationships, and rehabilitation, including employment and daily living function development for clients.

(e) Increase collaboration and coordination among primary care, mental health, and aging service providers, and reduce hesitance to seek treatment and services due to mental health stigma.

(f) Create a more focused approach for PEI requirements.

(g) Increase programmatic and fiscal oversight of county MHSA-funded PEI programs.

(h) Encourage counties to coordinate and blend funding streams and initiatives to ensure services are integrated across systems.

(i) Encourage counties to leverage innovative technology platforms.

(j) Reflect the stated goals as outlined in the PEI component of the MHSA, as stated in Section 5840.

(k) This section shall be repealed on January 1, 2026, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

(Amended by Stats. 2023, Ch. 790, Sec. 51. (SB 326) Effective April 17, 2024. Approved in Proposition 1 at the March 5, 2024, election. Operative January 1, 2025, pursuant to Sec. 117 of Proposition 1. Repealed as of January 1, 2026, by its own provisions.)

5840.6. For purposes of this chapter, the following definitions shall apply:

(a) “Commission” means the Mental Health Services Oversight and Accountability Commission established pursuant to Section 5845.

(b) “County” also includes a city receiving funds pursuant to Section 5701.5.

(c) “Prevention and early intervention funds” means funds from the Behavioral Health Services Fund allocated for prevention and early intervention programs pursuant to paragraph (3) of subdivision (a) of Section 5892.

(d) “Childhood trauma prevention and early intervention” refers to a program that targets children exposed to, or who are at risk of exposure to, adverse and traumatic childhood events and prolonged toxic stress in order to deal with the early origins of mental health needs and prevent long-term mental health concerns. This may include, but is not limited to, all of the following:

(1) Focused outreach and early intervention to at-risk and in-need populations.

(2) Implementation of appropriate trauma and developmental screening and assessment tools with linkages to early intervention services to children that qualify for these services.

(3) Collaborative, strengths-based approaches that appreciate the resilience of trauma survivors and support their parents and caregivers when appropriate.

(4) Support from peer support specialists and community health workers trained to provide mental health services.

(5) Multigenerational family engagement, education, and support for navigation and service referrals across systems that aid the healthy development of children and families.

(6) Linkages to primary care health settings, including, but not limited to, federally qualified health centers, rural health centers, community-based providers, school-based health centers, and school-based programs.

(7) Leveraging the healing value of traditional cultural connections, including policies, protocols, and processes that are responsive to the racial, ethnic, and cultural needs of individuals served and recognition of historical trauma.

(8) Coordinated and blended funding streams to ensure individuals and families experiencing toxic stress have comprehensive and integrated supports across systems.

(e) “Early psychosis and mood disorder detection and intervention” has the same meaning as set forth in paragraph (2) of subdivision (b) of Section 5835 and may include programming across the age span.

(f) “Youth outreach and engagement” means strategies that target secondary school and transition age youth, with a priority on partnerships with college mental health programs that educate and engage students and provide either on-campus, off-campus, or linkages to mental health services not provided through the campus to students who are attending colleges and universities, including, but not limited to, public community colleges. Outreach and engagement may include, but is not limited to, all of the following:

(1) Meeting the mental health needs of students that cannot be met through existing education funds.

(2) Establishing direct linkages for students to community-based mental health services.

(3) Addressing direct services, including, but not limited to, increasing college mental health staff-to-student ratios and decreasing wait times.

(4) Participating in evidence-based and community-defined best practice programs for mental health services.

(5) Serving underserved and vulnerable populations, including, but not limited to, lesbian, gay, bisexual, transgender, and queer persons, victims of domestic violence and sexual abuse, and veterans.

(6) Establishing direct linkages for students to community-based mental health services for which reimbursement is available through the students’ health coverage.

(7) Reducing racial disparities in access to mental health services.

(8) Funding mental health stigma reduction training and activities.

(9) Providing college employees and students with education and training in early identification, intervention, and referral of students with mental health needs.

(10) Interventions for youth with signs of behavioral or emotional problems who are at risk of, or have had any, contact with the juvenile justice system.

(11) Integrated youth mental health programming.

(12) Suicide prevention programming.

(g) “Culturally competent and linguistically appropriate prevention and intervention” refers to a program that creates critical linkages with community-based organizations, including, but not limited to, clinics licensed or operated under subdivision (a) of Section 1204 of the Health and Safety Code, or clinics exempt from clinic licensure pursuant to subdivision (c) of Section 1206 of the Health and Safety Code.

(1) “Culturally competent and linguistically appropriate” means the ability to reach underserved cultural populations and address specific barriers related to racial, ethnic, cultural, language, gender, age, economic, or other disparities in mental health services access, quality, and outcomes.

(2) “Underserved cultural populations” means those who are unlikely to seek help from any traditional mental health service because of stigma, lack of knowledge, or other barriers, including members of ethnically and racially diverse communities, members of the gay, lesbian, bisexual, and transgender communities, and veterans, across their lifespans.

(h) “Strategies targeting the mental health needs of older adults” means, but is not limited to, all of the following:

(1) Outreach and engagement strategies that target caregivers, victims of elder abuse, and individuals who live alone.

(2) Suicide prevention programming.

(3) Outreach to older adults who are isolated.

(4) Early identification programming of mental health symptoms and disorders, including, but not limited to, anxiety, depression, and psychosis.

(i) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on July 1, 2026, and as of January 1, 2027, is repealed.

(Amended (as amended by Stats. 2023, Ch. 790, Sec. 52) by Stats. 2024, Ch. 40, Sec. 40. (SB 159) Effective June 29, 2024. Operative January 1, 2025, pursuant to Sec. 85 of Stats. 2024, Ch. 40. Inoperative July 1, 2026, by its own provisions. Repealed as of January 1, 2027, by its own provisions. See later operative version added by Sec. 53 of Stats. 2023, Ch. 790.)

5840.6. For purposes of this chapter, the following definitions shall apply:

(a) “County” includes a city receiving funds pursuant to Section 5701.5.

(b) “Early intervention funds” means funds from the Behavioral Health Services Fund allocated for early intervention services and programs pursuant to clause (ii) of subparagraph (A) of paragraph (3) of subdivision (a) of Section 5892.

(c) “Childhood trauma early intervention” refers to a program that targets eligible children and youth exposed to, or who are at risk of exposure to, adverse and traumatic childhood events and prolonged toxic stress in order to deal with the early origins of mental health and substance use disorder needs and prevent long-term mental health and substance use disorder concerns. This may include, but is not limited to, all of the following:

(1) Focused outreach and early intervention to at-risk and in-need populations, including youth experiencing homelessness, justice-involved youth, LGBTQ+ youth, and child welfare-involved youth.

(2) Implementation of appropriate trauma and developmental screening and assessment tools with linkages to early intervention services to eligible children and youth who qualify for these services.

(3) Collaborative, strengths-based approaches that appreciate the resilience of trauma survivors and support their parents and caregivers when appropriate.

(4) Support from peer support specialists, wellness coaches, and community health workers trained to provide mental health and substance use disorder treatment services with an emphasis on culturally and linguistically tailored approaches.

(5) Multigenerational family engagement, education, and support for navigation and service referrals across systems that aid the healthy development of children and youth and their families.

(6) Collaboration with county child welfare agencies and other system partners, including Medi-Cal managed care plans, as defined in subdivision (j) of Section 14184.101, and homeless youth service providers, to address the physical and behavioral health-related needs and social needs of child-welfare-involved youth.

(7) Linkages to primary care health settings, including, but not limited to, federally qualified health centers, rural health centers, community-based providers, school-based health centers, school-linked providers, and school-based programs and community-based organizations specializing in serving underserved communities.

(8) Leveraging the healing value of traditional cultural connections and faith-based organizations, including policies, protocols, and processes that are responsive to the racial, ethnic, and cultural needs of individuals served and recognition of historical trauma.

(9) Blended funding streams to provide individuals and families experiencing toxic stress comprehensive and integrated supports across systems.

(10) Partnerships with local educational agencies and school-based behavioral health professionals to identify and address children exposed to, or who are at risk of exposure to, adverse and traumatic childhood events and prolonged toxic stress.

(d) “Early psychosis and mood disorder detection and intervention” has the same meaning as set forth in paragraph (2) of subdivision (b) of Section 5835 and may include programming across the age span.

(e) “Youth outreach and engagement” means strategies that target out-of-school youth and secondary schoolage youth, including, but not limited to, all of the following:

(1) Establishing direct linkages for youth to community-based mental health and substance use disorder treatment services.

(2) Participating in evidence-based practices and community-defined evidence programs for mental health and substance use disorder treatment services.

(3) Providing supports to facilitate access to services and programs, including those utilizing community-defined evidence practices, for underserved and vulnerable populations, including, but not limited to, members of ethnically and racially diverse communities, members of the LGBTQ+ communities, victims of domestic violence and sexual abuse, and veterans.

(4) Establishing direct linkages for students to community-based mental health and substance use disorder treatment services for which reimbursement is available through the students’ health coverage.

(5) Reducing racial disparities in access to mental health and substance use disorder treatment services.

(6) Providing school employees and students with education and training in early identification, intervention, and referral of students with mental health and substance use disorder needs.

(7) Strategies and programs for youth with signs of behavioral or emotional problems or substance misuse who are at risk of, or have had, contact with the child welfare or juvenile justice system.

(8) Integrated youth mental health and substance use disorder programming.

(f) “Culturally competent and linguistically appropriate intervention” refers to a program that creates critical linkages with community-based organizations, including, but not limited to, clinics licensed or operated under subdivision (a) of Section 1204 of the Health and Safety Code and clinics exempt from clinic licensure pursuant to subdivision (c) of Section 1206 of the Health and Safety Code. The community-based organizations include facilities and providers licensed or certified by the State Department of Health Care Services, including, but not limited to, residential substance use disorder facilities licensed pursuant to Section 11834.01 of the Health and Safety Code or certified pursuant to Section 11830.1 of the Health and Safety Code and narcotic treatment programs licensed pursuant to Section 11839 of the Health and Safety Code. Community-based organizations may also include those organizations that provide community-defined evidence practices.

(1) “Culturally competent and linguistically appropriate” means the ability to reach underserved cultural populations and address specific barriers related to racial, ethnic, cultural, language, gender, age, economic, or other disparities in mental health and substance use disorder treatment services access, quality, and outcomes.

(2) “Underserved cultural populations” means those who are unlikely to seek help from providers of traditional mental health and substance use disorder services because of stigma, lack of knowledge, or other barriers, including members of ethnically and racially diverse communities, members of the LGBTQ+ communities, victims of domestic violence and sexual abuse, and veterans, across their lifespans.

(g) “Strategies targeting the mental health and substance use disorder needs of older adults” means, but is not limited to, all of the following:

(1) Outreach and engagement strategies that target caregivers, victims of elder abuse, and individuals who live alone.

(2) Outreach to older adults who are isolated.

(3) Programs for early identification of mental health disorders and substance use disorders.

(h) “Community-defined evidence practices” is defined as an alternative or complement to evidence-based practices, that offer culturally anchored interventions that reflect the values, practices, histories, and lived-experiences of the communities they serve. These practices come from the community and the organizations that serve them and are found to yield positive results as determined by community consensus over time.

(i) This section shall become operative on July 1, 2026, if amendments to the Mental Health Service Act are approved by the voters at the March 5, 2024, statewide primary election.

(Repealed (in Sec. 52) and added by Stats. 2023, Ch. 790, Sec. 53. (SB 326) Effective April 17, 2024. Approved in Proposition 1 at the March 5, 2024, election. Operative July 1, 2026, by its own provisions.)

5840.7. (a) On or before January 1, 2020, the commission shall establish priorities for the use of prevention and early intervention funds. These priorities shall include, but are not limited to, the following:

(1) Childhood trauma prevention and early intervention to deal with the early origins of mental health needs.

(2) Early psychosis and mood disorder detection and intervention, and mood disorder and suicide prevention programming that occurs across the lifespan.

(3) Youth outreach and engagement strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs.

(4) Culturally competent and linguistically appropriate prevention and intervention.

(5) Strategies targeting the mental health needs of older adults.

(6) Other programs the commission identifies, with stakeholder participation, that are proven effective in achieving, and are reflective of, the goals stated in Section 5840.

(b) On or before January 1, 2020, the commission shall develop a statewide strategy for monitoring implementation of this part, including enhancing public understanding of prevention and early intervention and creating metrics for assessing the effectiveness of how prevention and early intervention funds are used and the outcomes that are achieved. The commission shall analyze and monitor the established metrics using existing data, if available, and shall propose new data collection and reporting strategies, if necessary.

(c) The commission shall establish a strategy for technical assistance, support, and evaluation to support the successful implementation of the objectives, metrics, data collection, and reporting strategy.

(d) (1) The portion of funds in the county plan relating to prevention and early intervention shall focus on the established priorities, and shall be allocated, as determined by the county, with stakeholder input. A county may include other priorities, as determined through the stakeholder process, either in place of, or in addition to, the established priorities. If the county chooses to include other programs, the plan shall include a description of why those programs are included and metrics by which the effectiveness of those programs is to be measured.

(2) Counties may act jointly to meet the requirements of this section.

(e) If the commission requires additional resources for these purposes, it may prepare a proposal for consideration by the appropriate policy committees of the Legislature.

(f) If amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election, this section shall become inoperative on July 1, 2026, and as of January 1, 2027, is repealed.

(Amended by Stats. 2023, Ch. 790, Sec. 54. (SB 326) Effective April 17, 2024. Approved in Proposition 1 at the March 5, 2024, election. Operative January 1, 2025, pursuant to Sec. 117 of Proposition 1. Inoperative July 1, 2026, by its own provisions. Repealed as of January 1, 2027, by its own provisions. See later operative version added by Sec. 55 of Stats. 2023, Ch. 790.)

5840.7. (a) The State Department of Health Care Services, in consultation with the Behavioral Health Services Oversight and Accountability Commission, shall establish priorities for the use of early intervention funds. These priorities shall include, but are not limited to, the following:

(1) Childhood trauma early intervention to deal with the early origins of mental health and substance use disorder treatment needs, including strategies focused on eligible children and youth experiencing homelessness, justice-involved children and youth, child welfare-involved children and youth with a history of trauma, and other populations at risk of developing a mental health disorder or condition as specified in subdivision (d) of Section 14184.402 or substance use disorders. Childhood trauma early intervention services shall not be limited to individuals enrolled in the Medi-Cal program.

(2) Early psychosis and mood disorder detection and intervention and mood disorder programming that occurs across the lifespan.

(3) Outreach and engagement strategies that target early childhood 0 to 5 years of age, inclusive, out-of-school youth, and secondary school youth. Partnerships with community-based organizations and college mental health and substance use disorder programs may be utilized to implement the strategies.

(4) Culturally competent and linguistically appropriate interventions.

(5) Strategies targeting the mental health and substance use disorder needs of older adults.

(6) Strategies targeting the mental health needs of eligible children and youth, as defined in Section 5892, who are 0 to 5 years of age, including, but not limited to, infant and early childhood mental health consultation.

(7) Strategies to advance equity and reduce disparities.

(8) Programs that include community-defined evidence practices and evidence-based practices and mental health and substance use disorder treatment services similar to those provided under other programs that are effective in preventing mental illness and substance use disorders from becoming severe and components similar to programs that have been successful in reducing the duration of untreated severe mental illness and substance use disorders to assist people in quickly regaining productive lives.

(9) Other programs the State Department of Health Care Services identifies that are proven effective in preventing mental illness and substance use disorders from becoming severe and disabling, consistent with Section 5840.

(10) Strategies to address the needs of individuals at high risk of crisis.

(b) (1) (A) The portion of funds in the county plan relating to early intervention shall focus on the established priorities and shall be allocated as determined by the county with stakeholder input.

(B) (i) A county may include other priorities, as determined through the stakeholder process, in addition to the established priorities.

(ii) If a county chooses to include other programs, the plan shall include a description of why those programs are included and metrics by which the effectiveness of those programs is to be measured.

(2) Counties may act jointly to meet the requirements of this section.

(c) This section shall become operative on July 1, 2026, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

(Repealed (in Sec. 54) and added by Stats. 2023, Ch. 790, Sec. 55. (SB 326) Effective April 17, 2024. Approved in Proposition 1 at the March 5, 2024, election. Operative July 1, 2026, by its own provisions.)