

Mental Illness Policy Org.

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Mental Health Services Act Oversight and Accountability Commission
1300 17th Street, Suite 1000
Sacramento, CA 95811

Re: Draft Proposed PEI Regulations

Dear Ms. Yeroshek and Ms. Lee,

Thank you for your attention to MIPO's proposed changes to the first draft of the draft proposed PEI regulations. Accompanying this letter are proposed changes to the second draft.

DJ Jaffe, and I have worked hard to avoid duplicating each other's observations, so bear with us, please. His proposed changes to the latest draft PEI regulations are based on what is there. Mine are based on what is not.

The heart of the program PEI provisions, as you know, is the following language:

The program shall include mental health services similar to those provided under other programs effective in preventing mental illnesses from becoming severe, and shall also include components similar to programs that have been successful in reducing the duration of untreated severe mental illnesses and assisting people in quickly regaining productive lives. W.I.C. 5840(c).

I have highlighted the language I want to emphasize at present, and separated the two clauses spatially to distinguish them.

The MHSA repeatedly makes clear that the voters expected its programs to be "effective," "successful" and "proven." This is nowhere clearer than in the above-quoted provision, which uses the "similar to programs" that have been "effective" and "successful" language twice in the same sentence. I also attach a highlighted version of the original statute, containing voter findings, purpose and intent, as the best evidence of the voters' more general mandate in this regard.

Please note that there are *two* separate mandates in the two clauses of the above provision, (emphasized as separate mandates by the use of the term, "shall" in the first clause, followed by the use of the term, "shall also" in the second). The second mandate, specifically referring to individuals with "severe" mental illness who need help "regaining productive lives," is necessarily about early intervention in, and prevention of relapses.

This second mandate has been ignored by regulators and denied funding since the statute's inception, as has the emphatically repeated requirement to use "successful" and "effective" programs as models.

Your obligation, obviously, is to follow *all* statutory mandates. The best way is to give the counties examples of programs that have already "proven effective" and "successful" in meeting the two separate programmatic mandates in this provision, then giving them the option of demonstrating to you that they have found other programs that have "proven effective" and "successful" if they don't want to use the options in regulation.

Your rejection of examples in responding to our earlier draft is both inconsistent with the constant use of examples throughout the draft regulations, and with your statutory obligation to provide "guidelines" to counties. These draft regulations represent a dramatic change of direction from earlier directives and pseudo-regulations, which

accomplished precisely the opposite of what the statute emphatically requires. The counties will need help getting turned around and actually following the law.

I agree with D.J. that your attempts to separate “prevention” from “early intervention” in these early drafts aren’t working. I couldn’t make them work, so I simply followed the statutory language, with what I believe are improved results.

The MHSA drafters didn’t attempt to separate prevention from early intervention (probably because they couldn’t make it work either), so neither should you. This is logical: prevention programs, the subject of the first clause in the above-quoted language (“*preventing* mental illnesses from becoming severe)¹ do early intervention once symptoms become severe enough to treat, and early intervention programs, the subject of the second clause (“reducing the *duration* of severe mental illness . . . assisting people to quickly *regain* . . .”) do a lot of prevention work. For example, Laura’s Law recipients received intensive case management as “prevention” as well as early intervention in relapses when they are “deteriorating” and “likely” to become dangerous. It makes no sense to pigeonhole these programs as either “prevention” or “early intervention” because both approaches are always needed together.

For these reasons, I am again including examples of programs that fit under the above-quoted mandatory clauses. In footnotes, I have added data which I believe demonstrates that all of them are “successful” and “effective” programs.

The draft regulations, to date, do not remotely follow the methodology described above, which is required by the statute. Were they to do so, it would simplify the data-gathering you are contemplating. While data is not my area, it seems logical and necessary, if counties are modeling on “successful” programs, that they gather data in the same way the earlier program gathered it, so you can draw comparisons between their track record and the successful program they are imitating. Though it would be enormously helpful to give them concrete options, you could also allow them to pick other “effective” and “successful” programs that meet the statutory criteria, in part according to whether the county can follow the earlier data-gathering methodology closely enough to draw meaningful comparisons. “Successful” and “effective” programs should be eager to cooperate and guide counties in such an effort, because they will want the followup data, too. This will also allow you to “roll in” other, increasing data requirements over time, giving counties time to prepare for them, as discussed in the previous meeting.

I have accordingly drafted such a recordkeeping requirement for you, at the end of the accompanying proposed changes to the prevention/early intervention portion of the regulations..

One last word on the problem of measuring results: it appears obvious that the highly subjective attempt to measure “reduced suffering” which Mr. Jaffe rightly struck at present Section 2(a)(1)(A) won’t work, and will waste tremendous amounts of valuable time. With PEI, by definition, you are eliminating symptoms, and/or severe symptoms, before they happen. It is logically impossible to measure suffering that hasn’t happened yet. Moreover, even if people with emerging thought and mood disorders would give you straight answers about their suffering—which they absolutely won’t—the measures are meaningless because their moods cycle, sometimes rapidly. And you can’t possibly create a good control group because you can’t deny services. This is intellectual quicksand, and best avoided.

Per Mr. Jaffe’s suggested language, stick with the objective statutory measures of suffering in WIC 5840(d), which follows voter intent and will vastly simplify your processes. If you must add factors, add the usual, very

¹ While the terms “prevention” and “early intervention” are used interchangeably in the MHSA PEI provisions, the word “prevention” from the Latin, “to come before,” literally means “To keep from occurring.” So it fits better with people who have not yet been diagnosed with “severe mental illness,” the subject of the first clause (and the place where “prevent” is actually used). On the other hand, “intervention,” from the Latin, “to come between,” means “to fall or happen between other events or periods.” (Both definitions from American College Dictionary (Random House, 1966 Ed.) “Intervention” therefore, better describes processes used for people already diagnosed with “severe mental illness,” who are in relapse and need services to “regain productive lives” which the second clause requires. In my experience, “early intervention” in the context of severe mental illness means intervening in the process of relapse, before the individual becomes dangerous to self or others.

objective ones: arrest numbers, involuntary hospitalization numbers (referenced in the MHSA Findings at (c)) and so forth. And bear in mind that the “suffering” separately mentioned in WIC 5840(d) is “prolonged” suffering. The other measures in 5840(d) are *already* measures of suffering. To track reductions in “prolonged” suffering, you need to know things like the diagnosis (which you should obviously be gathering—the PEI provisions, in every subsection, repeatedly require a diagnosis of at least “mental illness” as a requisite to programmatic services), the age of onset, and the number and length of hospitalizations. That way, you can track whether you are reducing “prolonged” suffering by pushing forward the age of onset of severe mental illness, or decreasing involuntary hospitalizations, or stemming the increase in serious diagnoses like Bipolar II.

Thank you for your attention. We will be with you throughout the process.

Sincerely,

Mary Ann Bernard

Attachments:

Letter from DJ Jaffe. Executive Director of MentalIllnessPolicy.org

DJ Jaffe’s suggested changes to 2d draft of draft proposed PEI regulations

DJ Jaffe’s response to MHSOAC preferred rationale for refusing to make suggested changes to PEI regulations .
Supplemental suggested changes from Mary Ann Bernard, focused on “prevention” and “early intervention” mandates

Highlighted version of original MHSA, emphasizing statutory intent to adopt only “successful,” “effective” and “proven” programs

cc:

DJ Jaffe

Rocky Unruh, Esq.