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REACTION TO SUGGESTIONS NOT INCORPORATED BY DRAFTERS OF PEI REGS
 October 30, 2013

MHSAOC posted suggestions they are not incorporating in their draft regs. Many are problematic and seem contrary to the legislative intent and likely to result in misuse of funds.

Following are changes we would ask the drafters to reconsider
http://www.mhsoac.ca.gov/Meetings/docs/Meetings/2013/OAC_102413_Handout_Tab2_SuggestionsNOTIncorporatedPEI.pdf.

PROPOSED CHANGE THAT WAS REJECTED BY MHSOAC	REASON MHSOAC GAVE FOR REJECTING CHANGE THEY SHOULD HAVE ACCEPTED	WHY MHSOAC IS PREVENTING FUNDS FROM BEING USED AS LEGISLATIVELY DIRECTED BY NOT IMPLEMENTING THE PROPOSED CHANGE
<p>3. Include Laura's Law in early intervention services.</p>	<p>This is not within PEI section of statute. The new statutory language passed by SB 585 which allowed MHSOAC funds to be used for services under Laura's Law was added to the section of the MHSOAC dealing with CSS and not PEI.</p>	<p>There is no proscription in MHSOAC before SB 585 that prevented MHSOAC Funds, including PEI Funds from being used for Laura's Law. On this, we are in agreement with Disability Rights California which wrote, "There is no language in MHSOAC that prohibits the use of any funds for Laura's Law. (Disability Rights California "Memo to Interested Persons", 5/3/2005). There was no proscription inserted in SB 585 that prevents MHSOAC funds, including PEI from being used for Laura's Law.</p> <p>We encourage the drafters to read "Proposition 63 proceeds may be used to fund services to individuals eligible for Laura's Law" by Mental Illness Policy Org at http://mentalillnesspolicy.org/states/california/ok2usemhsa4II.pdf. Also read "Mental Health Services Act and funding AB 1421 implementation" by Treatment Advocacy Center at http://mentalillnesspolicy.org/states/california/tac-mhsa-ok-4-II.pdf Read an analysis by West Coast MIPO office at http://mentalillnesspolicy.org/states/california/maryannbernardmhsa4II.pdf</p> <p>Following is a small excerpt from one of those documents that clearly documents that MHSOAC PEI Funds should be used for AB 1421 Programs</p> <p>Counties may use Prevention and Early Intervention (PEI) proceeds to provide treatment to individuals in Laura's Law</p> <p>(O)ther than perhaps the Adult System of Care services provisions, the Prevention and Early Intervention (PEI) sections of Proposition 63 are most closely aligned with and properly used for Laura's Law.¹ PEI funding is intended to go to programs that "emphasize strategies to reduce the...negative outcomes that may result from untreated mental illness".² That is a good description of Laura's Law.</p> <p>Individuals who need Laura's Law are a subset of those PEI funds are intended to help. "The [PEI] program <i>shall</i> include the following components ...Access and linkage to medically necessary care provided by county mental health programs ... for adults and seniors with severe mental illness, as defined in Section 5600.3.³ Laura's Law provides "access and linkage to medically necessary care provided by county</p>

		<p>mental health programs” for individuals who are a subset of that group, specifically, “suffering from a mental illness as defined in paragraphs (2) and (3) of subdivision (b) of Section 5600.3”⁴</p> <p>Further, PEI funding is intended to “prevent mental illnesses from becoming severe and disabling”.⁵ Laura’s Law prevents mental illness from becoming severe and disabling.⁶</p> <p>PEI funding is intended to help the underserved.⁷ Individuals eligible for Laura’s Law are an underserved population.⁸</p> <p>PEI funds are intended to fund outreach⁹. Laura’s Law provides outreach.¹⁰</p> <p>PEI Programs are intended to reduce stigma.¹¹ Providing services to people under court orders reduces stigma.¹²</p> <p>PEI funding is intended to reduce suicide.¹³ Laura’s Law reduces suicide.¹⁴</p> <p>PEI funding is intended to reduce incarcerations.¹⁵ Laura’s Law reduces incarceration.¹⁶</p> <p>PEI funding is intended to reduce school failure or dropout.¹⁷ Laura’s Law may reduce school failure or dropout.¹⁸</p> <p>PEI funding is intended to reduce unemployment.¹⁹ Laura’s Law reduces unemployment.²⁰</p> <p>PEI funding is intended to reduce prolonged suffering.²¹ Laura’s Law reduces prolonged suffering.²²</p> <p>PEI funding is intended to reduce homelessness.²³ Laura’s Law reduces homelessness.²⁴ PEI funding is intended to prevent removal of children from their homes.²⁵ Laura’s Law likely prevents removal of children from their homes.²⁶</p> <p>MHSA PEI programs “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”.²⁷ Laura’s Law meets this criteria of being “effective in preventing mental illnesses from becoming severe” and is “successful in reducing the duration of untreated severe mental illnesses and assisting people in quickly regaining productive lives”.²⁸</p> <p>###</p> <p>Finally, we point out that Title 9, California Code of Regulations, section 3400 states “No person shall be denied access based solely on his/her voluntary or involuntary legal status.” The refusal to admit patients in AB1421 programs to PEI funded services would be a denial based solely on his or her voluntary or involuntary legal status.</p> <p>PEI funds may be and should be used for programs to assist those who are subject to a Laura’s Law court order.</p>
<p>No time limit for early interventions services if the county does not have a prevention program.</p>	<p>A time limit is necessary to differentiate between early intervention and CSS programs.</p>	<p>There is no necessity to differentiate between prevention programs and early intervention programs. The legislation says counties shall have ‘a’ program. There is nothing in the legislation that requires services needed to prevent mental illness from becoming severe and disabling to be withdrawn. Requiring the services to be withdrawn flies in the face of the intent of the legislation. It is ironic and discriminatory that regulators would place time limits on services genuinely needed by mentally ill persons who are at risk of severe mental illness, while in the past placing no such limits on services like Hmong gardening.</p>
<p>Risk factors for mental illness should be primarily focused on biological or genetic.</p>	<p>Draft regulations document a range of risk factors, including biological and genetic, validated by research.</p>	<p>A stated purpose (e) of the legislation is “To ensure that all funds are expended in the most cost effective manner and services are provided in accordance with recommended best practices subject to local and state oversight to ensure accountability to taxpayers and to the public” The other factors included are not known to cause serious mental illness and therefore do not represent a cost effective expenditure. The failure to use</p>

		evidence based practices was a criticism of the auditor that MHSOAC should not ignore. If MHSOAC disagrees with our conclusion that genetic and biological factors are the primary cause of serious mental illness and therefore the ones that for efficiency and effectiveness should be focused on, we respectfully ask that they produce research that the other risk factors cause the types of illnesses MHSOAC is intended to ameliorate.
Focus stigma and discrimination efforts on individuals with psychotic features.	Kept the broader definition to be consistent with the MHSOAC.	The problem the drafters are facing are caused by the (1) bifurcation of stigma and discrimination campaigns into two components; and (2) a failure to stick to the clear language of the legislation. The language allows "Reduction in stigma associated with either being diagnosed with a mental illness or seeking mental health services." The legislation defines those illnesses in 5600. Regulations must ensure that stigma efforts are not targeted to those without mental illness or are not seeking services. This change should be accepted or replaced by one that accomplishes the same purpose: ensure expenditures on stigma are consistent with the regulations.
2. Delete practice-based evidence option.	Eliminating the option of practice-based evidence precludes many programs for communities of color, with whom practices have not been tested using formal clinical trials.	We frankly found this explanation for ignoring the legislation offensive. There are many practices that have not been tested on communities of color or communities without color. The fact that a program has not been tested nor proven does not make it eligible for PEI funding. This flies in the face of a stated purpose (e) of the legislation "To ensure that all funds are expended in the most <i>cost effective manner</i> and services are provided in accordance with recommended <i>best practices</i> subject to local and state oversight to ensure accountability to taxpayers and to the public" The drafters of the regulations noted this when rejecting a different change proposed by CMHDA when the drafters responded "Requiring "effective" methods of services is consistent with the MHSOAC." Requiring services be effective is as true for populations of color as it is for those who are not. An argument could be made that practices for which there is not evidence, only alleged 'consensus' could be funded with INN funds. No valid argument can be made they should be funded with PEI funds. It treats people of color as second class citizens to deprive them of evidence-based services that are made available to the majority. If the drafters insist on this tortured explanation to allow, foster and encourage spending on non-evidence based programs, because they have special application to communities of color then they should limit those expenditure to the communities there is alleged to be consensus they work in. However, we believe that is illegal discrimination, and it is wrong to substitute proven treatments for communities of color with unproven ones (ex. more Hmong Gardens). As we previously noted, there is nothing in the legislation that allows 'consensus' to substitute for 'evidence'. The issue of not using validated techniques and not evaluating them was a core part of the auditors findings and we are disappointed to see the commission rejected this.

REACTION TO SUGGESTIONS INCORPORATED IN DRAFT PEI REGS

http://www.mhsoac.ca.gov/Meetings/docs/Meetings/2013/OAC_102413_Handout_Tab2_SuggestionsIncPEIRegs.pdf

MHSOAC posted suggestions they are incorporating in their draft regs. Many are problematic and seem designed to encourage misuse of funds. Following are changes we would ask the drafters to reject rather than accept

PROPOSED CHANGE THAT WAS ACCEPTED BY MHSOAC	REASON MHSOAC GAVE FOR ACCEPTING THE CHANGE THEY SHOULD HAVE REJECTED	WHY MHSOAC IS PREVENTING FUNDS FROM BEING USED AS LEGISLATIVELY DIRECTED BY ACCEPTING THE PROPOSED CHANGE
3. Add to list of Gatekeepers the	None	We have no problem with adding leaders of faith based organizations and individuals who support those who are homeless to the list of

following: community leaders, leaders of faith-based organizations, cultural brokers, people who support individuals who are homeless.		gatekeepers as they are disproportionately likely to interact with those with mental illness. However MHSA is intended to support evidence based practices and support services that are effective. MHSOAC is charged with being stewards of the public purse. There is no evidence that 'community leaders' or 'cultural brokers' are any more or less likely than members of the general public to interact with persons with serious mental illness. Gatekeeper programs must be targeted at those disproportionately likely to interact with persons with mental illness in order to be considered effective and efficient.
4.Add concept that persons with signs and symptoms can be their own gatekeepers.	None	The clear purpose of the gatekeeper provisions are to help those likely to interact with persons with mental illness to identify and help those with mental illness. This will result in diversion of funds from those who are in position to identify multiple individuals who need help, to those who will spend the money on identifying themselves. This provision seems like a way to divert funds from gatekeepers.
2. Clarify that the regulation applies to counties and not the PEI Statewide Stigma and Discrimination Reduction Project.	None	We have no problem with counties pooling funds into statewide entities to achieve the objectives of MHSA. But those entities, like the counties, must comply with the regulations that ensure the funds are spent properly. MHSOAC responsibility is to see all funds are spent effectively and efficiently. By allowing counties to transfer funds to a statewide project and then absolve the statewide entity from having to comply with the legislation, facilitates misspending not proper spending. MHSOAC should not be setting up processes that allow counties to circumvent legislation. This is particularly true, for Stigma and Discrimination Reduction Projects. In spite of the clear legislative language that Stigma Campaigns focus on those with mental illness or seeking services the JPA created campaigns that don't. And diverted money to elsewhere. They also created campaigns that focus on the 1 in 4 with a mental health issue rather than the 5-9% defined in the legislation. In light of past abuse and waste in JPAs, it is critical that counties not be allowed to use it as a forum to facilitate spending outside the goals of the legislation.
4. Add "efforts to combat multiple stigmas to the list of examples of stigma and discrimination reduction programs.	None	The only stigma mentioned in the legislation is the stigma that comes from having a mental illness or seeking services. By accepting this, MHSOAC is facilitating the diversion of funds from legislatively allowable programs to those that are not.
1. Add an optional program category for county's suicide efforts that do not focus on or have intended outcomes for specific individuals.	None	The legislation is clear that it is supposed to reduce suicide caused by untreated serious mental illness. By accepting this, MHSOAC is facilitating the diversion of funds from legislatively allowable programs to those that are not. That is also why the measurement for this program must be a reduction in suicide or suicide attempts and not other measures.
3. Add "combat multiple social stigmas."	None	The only stigma mentioned in the legislation is the stigma that comes from having a mental illness or seeking services. By accepting this, MHSOAC is facilitating the diversion of funds from legislatively allowable programs to those that are not.
For Suicide Prevention Programs, add changes in knowledge about the relationship to untreated mental illness and suicide to the examples of change in knowledge that counties can measure.	None	The purpose of suicide campaigns is to reduce suicides. The metric that ensures evidence based practices are used and funds are spend efficiently is a reduction in suicide or suicide attempts. Any other metric is likely to lead to a diversion of funds and programs that don't reduce suicide being deemed 'successful' based on a false metric.
Delete requirement	None	Due to the past history of abuse within MHSA programs whereby funds

<p>that county specify how each participant's early onset of a potentially serious mental illness will be verified.</p>		<p>were diverted to worthy social service programs that were not related to serious mental illness, it is important counties have a valid procedure to ensure funds are only spent on eligible individuals. Again, this was a point made by the State Auditor. There was no way to validate expenditures as being effective because, among other reasons, there was no way to know who was being served.</p>
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¹ Currently, PEI money is being used for purposes arguably contrary to the Mental Health Services Act, which designated PEI funds to “prevent mental illness from becoming severe and disabling” (5840(a)). This diversion is partially due to regulatory failures that could and should be fixed. DJ Jaffe “Myriad problems with Mental Health Services Act funding”, Capitol Weekly, January 30, 2012. Legislative Fix Needed To Stop Waste of Millions Earmarked For Severe Mental Illness,” <http://www.californiaprogressreport.com/site/print/9704> (December 29, 2011), D.J. Jaffe, Mary Ann Bernard, “In California’s system of care for the mentally ill, leadership is lacking” Capitol Weekly, August 25, 2011.

² Section 5840.

³ Section 5840(b)(2).

⁴ Section 5346.2.

⁵ Section 5840(a).

⁶ Providing services to individuals who are under court orders “prevent(s) mental illness from becoming severe and disabling”. “The effect of sustained outpatient commitment, according to the Duke study, was particularly strong for people with schizophrenia and other psychotic disorders. When patients with these disorders were on outpatient commitment for an extended period of 180 days or more, and also received intensive mental health services, they had 72 percent fewer readmissions to the hospital and 28 fewer hospital days than the nonoutpatient commitment group”. (Laura’s Law Section 1(b)(6) findings). Statistics on reduced hospitalization, reduced incarceration, reduced homelessness, and higher “Milestones of Recovery Scores” achieved by implementing Laura’s Law in Nevada and Los Angeles counties are in Appendix A.

⁷ Prevention and Early Intervention programs “shall emphasize improving timely access to services for underserved populations.” (Section 5840(a)).

⁸ Individuals eligible for Laura’s Law are underserved. “Thirty-seven and two-tenths percent, or 19,118, had no record of outpatient service use in the previous 12 months.” (Laura’s Law Section 1(b)(1)(D)).

⁹ Section 5840(b)(1).

¹⁰ The Proposition 63 Protection and Early Interventions program shall include the following components: *Outreach to families*, employers, primary care health care providers, and others to recognize the early signs of potentially severe and disabling mental illnesses. (Section 5840 (b)(1)). Laura’s Law provides that outreach. County plans should include “Plans for services, including *outreach to families whose severely mentally ill adult is living with them*... Recipients of outreach services may include families, the public, primary care physicians, and others who are likely to come into contact with individuals who may be suffering from *an untreated severe mental illness* who would be likely to become homeless if the illness continued to be untreated for a substantial period of time.” (Section 5348(a)(2)(B)).

¹¹ Prevention and Early Intervention “program(s) shall include the following components: Reduction in stigma associated with either being diagnosed with a mental illness or seeking mental health services. Reduction in discrimination against people with mental illness. (Section 5840(b)(3 and 4)).

¹² AOT reduces stigma. “Researchers also noted that people who underwent mandatory treatment reported higher social functioning and slightly less stigma” (February 2010 Columbia University. Phelan, Sinkewicz, Castille and Link. Effectiveness and Outcomes of Assisted Outpatient Treatment in New York State Psychiatric Services, Vol. 61. No 2).

Reducing violence by individuals with mental illness leads to a reduction in stigma. (Torrey, Stigma and Violence: Isn’t it time to connect the dots? Schizophrenia Bulletin. June 7, 2011) “Why is stigma so strong despite better public understanding of mental illness? The answer appears to be fear of violence: people with mental illness, especially those with psychosis, are perceived to be more violent than in the past”. (*Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Center for Mental Health Services, National Institute of Mental Health, 1999).

Laura’s Law is designed to reduce violence. “In view of the person’s treatment history and current behavior, the person is in need of assisted outpatient treatment in order to prevent a relapse or deterioration that would be likely to result in grave disability or serious harm to himself or herself, or to others, as defined in Section 5150.” (Section 5346(a)(8)) AOT reduces violence (Appendix A).

¹³ Section 5840(d)(1).

¹⁴ As no study has been done on Laura’s Law impact on suicide rates, research on suicide is from New York’s Kendra’s Law which has been more extensively studied and which Laura’s Law was modeled on. Assisted Outpatient Treatment reduces suicide attempts 55 percent (N.Y. State Office of Mental Health “Kendra’s Law: Final Report on the Status of Assisted Outpatient Treatment. March 2005).

¹⁵ Section 5840(d)(2).

¹⁶ In Nevada County, Laura’s Law reduced the Number of Incarceration Days decreased 65.1 percent from 1824 days vs. 637 days post-treatment. In Los Angeles County Laura’s Law reduced incarceration 78 percent from 388 days during the six months prior to enrollment in AOT to 85 days during the six months after. (Los Angeles County data: Marvin Southard, Director of County of Los Angeles, Department of Mental Health “Outpatient Treatment Program Outcomes Report April 1, 2010 – December 31, 2010” sent to Cliff Allenby, Acting Director California Department of Mental Health February 24, 2011. Nevada County data: Behavioral Health Director Michael Heggarty “The Nevada County Experience,” Nov. 15, 2011. These also represent the source data for reducing the following negative consequences).

¹⁷ Section 5840(d)(3).

¹⁸ We are unaware of specific studies on this.

¹⁹ Section 5840(d)(4).

²⁰ Nevada County found ‘higher employment rates’ (They did not quantify).

²¹ Section 5840(d)(5).

²² In Los Angeles Laura’s Law reduced hospitalization from 345 days to 49 (86% reduction) percent comparing six months prior to AOT and during AOT. Only one person was hospitalized. Researchers then looked at the question of, “Does the beneficial effect of Laura’s Law end after enrollment in Laura’s Law ends?” They found Laura’s Law reduced hospitalization 77 percent even after discharge from Laura’s Law. Since discharge from Laura’s Law participants had 81 days of hospitalization, or a reduction of 77 percent in days of hospitalization. In Nevada County, under Laura’s Law, the number of Psychiatric Hospital Days decreased 46.7 percent from 1404 days vs. 748 days post-treatment.

²³ Section 5840(d)(6).

²⁴ In Nevada County, Number of Homeless Days decreased 61.9 percent from 4224 days vs. 1898 days post-treatment.

²⁵ Section 5840(d)(7).

²⁶ By providing care for parents before they become gravely disabled or dangerous it avoids inpatient commitment and incarceration both of which could lead to removal of children from the home.

²⁷ Section 5840(c).

²⁸ See Appendix A.