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MAY 3, 2012

To: Interested Officials and Their Attorneys
From: Mary Ann Bernard
Of Counsel, Mental Illness Policy. org

Re: There Is No Threat of Suit Based on Adoption of Laura's Law

I write on behalf of the California Chapter of Mental Illness Policy.org (“MIPO”) a non-profit think tank founded to provide unbiased information on serious mental illness to the media and policymakers. Formerly a Minnesota Assistant Attorney General whose clients included state psychiatric hospitals, I volunteer for MIPO in hopes of ending the neglect and mistreatment of the sickest mentally ill individuals in California, my present home, and that of my mentally ill son.

This letter responds to correspondence from Disability Rights California (“DRC”), formerly Protection and Advocacy Inc., which has been widely interpreted as threatening a lawsuit-- though it does not do so. Although two counties are already funding Laura's Law with Mental Health Services Act (“MHSA”) funds with approval from the California Department of Mental Health --one of them since 2007¹--DRC nonetheless argues that use of MHSA funds for Laura's Law is prohibited because Laura's Law is allegedly an “involuntary” program. (DRC memo to “Interested Persons” dated 12/2/2010 (attached)).

This letter outlines the reasons, legal and otherwise,² that a suit against a county by DRC is unlikely. It will demonstrate that DRC is not only mistaken, but is essentially advocating illegal discrimination itself. Moreover, its argument denies funding to a group that the voters targeted in enacting MHSA.

We therefore strongly urge you to ignore pressures from DRC and implement Laura's Law to ensure a mechanism is in place to prevent tragedies that will otherwise occur as a result of the transfer of mentally ill state prisoners to local control stemming from *Brown v Plata*, 563 U.S.____ (2011).

¹ 1 “ It is my pleasure to inform you and all the members of the Nevada County Mental Health stakeholders group that your CSS plan has been approved. The Department would like to assure you that those individuals eligible for Mental Health Services Act (MHSA) programs, such as the approved Assertive Community Treatment Team may have voluntary or involuntary legal status. (Stephen Mayberg, Director, California Department of Mental Health to Michael Heggarty, Director, Nevada County Behavioral Health Services, May 22, 2007).

² Besides having a weak position on the merits, as shown in this letter, DRC faces an ethical quandary that makes a lawsuit even less likely, *see infra.* at n. 52.

FACTUAL BACKGROUND

A. The problem: many of the sickest people cannot “volunteer” for treatment

DRC’s emphasis on “voluntary” treatment assumes that a “voluntary” system will adequately meet the needs of California’s mentally ill. In fact, many severely mentally ill individuals, though they benefit greatly from treatment, cannot or will not volunteer for it. Three groups with limited insight cannot “volunteer” for treatment:

1. First, “15% of patients will do anything they can to avoid taking medications under any circumstances, and may require coercion to remain compliant.”³ These individuals often equate medication with “poison” when in the throes of their illnesses, or have “deep-seated delusional beliefs about it.”⁴ Many or most suffer from anosognosia, an inability to recognize they are ill.⁵ These individuals will not take medications voluntarily because they do not think they are sick.
2. A second group of patients do not “volunteer” for treatment because, while they may recognize their need for medication when they are taking it, they soon persuade themselves they no longer need it when they feel well, then relapse into illness and inability to recognize how much it helps. “It is a common phenomenon that a patient functions well with medication, yet, because of the mental illness itself, lacks the discipline or capacity to follow the regime the medication requires.” *Olmstead v L.C.*, 527 US 581, 610 (1999) (Justice Kennedy, concurring).
3. Finally, many untreated severely mentally ill individuals are not legally competent to “volunteer” for anything, because their symptoms preclude proper understanding of what “volunteering” means. Categorizing them as “voluntary” treatment recipients violates their constitutional rights, and subjects government personnel to suits for damages, see *Zinermon v Burch*, 494 U.S. 113 (1990). Good risk management requires treating these individuals as treatment-refusers, even if they are willing to sign documents “volunteering” for treatment. *Id.*

Treatment-refusers with severe mental illness are often a public safety problem, because they frequently injure themselves, attempt suicide, set fires or destroy property, or become violent towards others. Most episodes of violence committed by seriously mentally ill people are associated with a failure to treat them.⁶ Numerous studies have shown that seriously mentally ill individuals who refuse

³ Dr. E. Fuller Torrey, *The Insanity Offense: How America’s Failure to Treat the Seriously Mentally Ill Endangers Its Citizens* (W.W. Norton & Company, New York 2008) at 117, quoting Joseph McEvoy, “one of the foremost psychiatric researchers on this issue.”

⁴ Torrey at 117-118, citing multiple studies.

⁵ Anosognosia afflicts nearly 60% of individuals with schizophrenia, and nearly 50% with manic depression, results that have been “replicated more than 100 times in the research literature.” See Amador, X.F., *I Am Not Sick I Don’t Need Help* (Vida Press, 2d Ed. 2007) p. 6.

⁶ This has been demonstrated in multiple studies. Following are five:

- (1) Two meta-analyses of individuals with serious mental illness who commit acts of violence, including homicides, reported that a disproportionate number of these acts occur during the person’s initial psychotic episode, before they have been treated. (Large MM, Nielssen O. Violence in first-episode psychosis: a systematic review and meta-analysis. *Schizophr Res.* 2010;125:208–220. Nielsson O, Large M. Rates of homicide during the first episode of psychosis and after treatment: a systematic review and meta-analysis. *Schizophr Bull.* 2010;36:702–712.)
- (2) A study of 60 seriously mentally ill men charged with violent crimes reported that medication noncompliance played a significant causal role. (Alia-Klein N, O’Rourke TM, Goldstein RZ, Malaspina D. Insight into illness and adherence to psychotropic medications are separately associated with violence severity in a forensic sample. *Aggress Behav.* 2007;33:86–96.)
- (3) A study of 1011 seriously mentally ill outpatients reported that “community violence was inversely related to treatment adherence.” (Elbogen EB, Van Dorn RA, Swanson JW, Swartz MS, Monahan J. Treatment engagement and violence risk in mental disorders. *Br J Psychiatry.* 2006;189:354–360.)

treatment are more likely to be aggressive and violent than other mentally ill people, particularly when they also abuse drugs or alcohol,⁷ which is unfortunately very common in this small population.⁸ Police now spend inordinate amounts of time on mental health issues instead of crime, and a disproportionate percentage of ‘officer involved shootings’ involve untreated, seriously mentally ill individuals.⁹

In counties that have not implemented Laura’s Law, there is no way to help treatment-refusers until they become dangerous to themselves or others, or so gravely disabled that they cannot provide for their most basic needs. At that point, if they are fortunate, they will end up legally committed to a locked hospital ward. If they are unfortunate, they will end up in jail for crimes they commit because of their mental illness, or dead--by suicide¹⁰ or simple failure to avoid hazards that are obvious to most of us. Their crimes of violence are most often directed at family members.¹¹ They end up homeless, being far too sick to work when they are untreated.

We emphasize the link between serious mental illness and incarceration, because of the ironic and terrible consequences of the complete reliance on “voluntary” treatment resulting from failure to implement Laura’s Law. The statistics are incontrovertible: California is “caring” for the sickest

(4) A study of 802 adults with serious mental illnesses found that those who were violent were 1.7 times more likely to have been noncompliant with medication.(Swanson JW, Swartz MS, Essock SM, et al. The social- environmental context of violent behavior in persons treated for severe mental illness. Am J Public Health. 2002;92: 1523–1531.)

(5) Multiple older studies have also demonstrated this association, including one that reported an inverse correlation between blood level of antipsychotic medication and propensity to violence among inpatients. (Yesavage JA. Inpatient violence and the schizophrenic patient: an inverse correlation between danger-related events and neuroleptic levels. Biol Psychiatry. 1982;17:1331–1337.)

Dr Thomas Insel, the director of the National Institute of Mental Health, recently summarized: “The data support the proposition that people with schizophrenia are more likely to be involved in violence either toward others or toward themselves unless they’re treated.”(Insel Thomas, Schizophrenia Research Forum, August 9, 2007, available at <http://www.schizophreniaforum.org/for/int/Insel/insel.asp>. Accessed May 17, 2011.)

I acknowledge and thank my colleague D.J Jaffee for these and many of the other citations to psychiatric studies in this letter. Though I am well-versed in this area, I cannot claim to have read all of them.

7 See studies cited by Torrey, pp. 161, 180-181; Van Dorn, Richard; Volavka, Jan; Johnson, Norman “Mental disorder and violence: is there a relationship beyond substance use?” Soc Psychiatry Psychiatr Epidemiology, 2/26/11. Original paper available at <http://mentalillnesspolicy.org/consequences/mental-disorder-violence-2011.pdf> .

8 According to the National Alliance for the Mentally Ill (NAMI), “It is now generally agreed that as much as 50% of the mentally ill population also has a substance abuse problem.” See http://www.nami.org/Content/ContentGroups/HelpLine1/Dual_Diagnosis_-_Substance_Abuse_and_Mental_Illness.htm.

9 Michael C. Biasotti, VP, NYS Chiefs of Police, “Management of the Severely Mentally Ill and its Effects on Homeland Security, Naval Postgraduate School, (2011), t <http://mentalillnesspolicy.org/crimjust/homelandsecuritymentalillness.html>. Chief Biasotti’s findings specific to California are available at <http://lauras-law.org/states/california/biasotticastats.html>.

10 10-13% of individuals with schizophrenia and 15% of individuals with bipolar disorder kill themselves. Caldwell C, Gottesman I. Schizophrenics kill themselves too: a review of risk factors for suicide. Schizophrenia Bulletin 1990;16:571–589. Goodwin FK, Jamison KR. Manic-Depressive Illness (New York: Oxford University Press, 1990), p. 230. Suicide attempts are harder to quantify; however, it is estimated that 40%-60% of schizophrenics and 25%-50% of those with bipolar disorder attempt suicide. See respectively, <http://www.schizophrenia.com/szfacts.htm>, and <http://www.suicide.org/bipolar-disorder-and-suicide.html>. Many of these individuals (including my own son) survive multiple attempts.

11 “Multiple studies have confirmed that ‘between 50 and 60 percent of the victims’” of violence induced by mental illness are family members. According to one study, 11% of families report that their mentally ill family member has assaulted other family member(s) in the *two weeks* preceding hospital admission. Torrey, pp. 148-149 (citations omitted).

mentally ill in prisons,¹² where conditions for the mentally ill are often horrific.¹³ As a direct result of lack of treatment, seriously mentally ill individuals in California are 3.8 times as likely to be incarcerated with mental illness as hospitalized for it.¹⁴ Counties will soon be dealing with thousands of severely mentally ill state prisoners locally as the result of *Brown v Plata*, 563 U.S. ____ (2011).

Treatment-refusers are not just a problem for their families and local government. They are also a problem for the vast majority of the mentally ill—including my adopted son—who are treatment-compliant and have never injured anyone. This is because the stigma of mental illness stems primarily from the small, often violent group of severely sick individuals who refuse treatment.¹⁵ The best way to address stigma is therefore to see to it that these individuals receive treatment.

B. A Solution: Laura's Law

“Laura's Law,” W.I.C. 5345 *et seq.*, is an “assisted outpatient treatment” program (“AOT”) designed for treatment-refusers, named for a young woman who was killed by one. Laura's Law was adopted by the California legislature after it commissioned a study by the Rand Corporation that showed multiple benefits of AOT in multiple states.¹⁶ Laura's Law was modeled on New York State's successful Kendra's Law, which, according to legislatively-requested studies, has saved public funds by reducing hospitalization by 77%, arrests by 83%, and incarceration by 87%; promoted public safety by reducing violence toward others by 47% and property destruction by 46%; and helped treatment-refusers by reducing homelessness by 74%, suicide attempts by 55%, and substance abuse by 48%.¹⁷

Though only two California counties have adopted Laura's Law, their statistics are as impressive as New York's. Nevada County has saved \$1.81-\$2.52 for every dollar spent on Laura's Law, through a 46% reduction in hospital days, 65.1% reduction in incarceration days, and 44.1% decrease in emergency interventions.¹⁸ In Los Angeles, costs for this patient population decreased by an estimated

¹² For statistics concerning the correlation between the emptying of state psychiatric hospitals and the filling of state prisons with mentally ill inmates, see Raphael, Steven, *The Deinstitutionalization of the Mentally Ill and Growth in the U.S. Prison Populations: 1971 to 1996* (Goldman School of Public Policy, University of California at Berkeley), <http://listsocrates.berkeley.edu/~raphael/raphael2000.pdf>. Some 20% of state prisoners in California are mentally ill, an extraordinarily high percentage. Torrey, *supra*, pp. 61-62, 128. As of 1995 (and probably still), the largest mental institution in the United States is the Los Angeles County jail. *Id.* at p. 57. *See also*, “Cuts to Mental Health Programs Shift Burden to Law Enforcement, Tsai, Gary, Sacramento Bee, January 28, 2012.

¹³The U.S. Supreme Court was particularly appalled by California's use of cages for psychotic prisoners, who are forced to stand upright for long periods, soaked in their own urine and feces. Slip Op. at 5.

¹⁴ “More Mentally Ill Persons Are in Jails and Prisons Than Hospitals: A Survey of the States” E. Fuller Torrey, M.D., Sheriff Aaron D. Kennard (retired), M.P.A., Sheriff Don Eslinger, Seminole County (Fla.) Sheriff's Office, Richard Lamb, M.D., Professor of Psychiatry, University of Southern California Keck School of Medicine (Treatment Advocacy Center, May 2010), Table 1, p. 19.

¹⁵ 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), Chapter 1 Public Attitudes About Mental Illness: 1950s to 1990, p. 1.

¹⁶ Study conducted for the California Senate Committee on Rules, titled, “*The Effectiveness of Involuntary Outpatient Treatment: Empirical Evidence and the Experience of Eight States.*” (Rand Corporation, 2002).

¹⁷ Phelan, Sinkewicz, Castile and Link, Columbia University, *Effectiveness and Outcomes of Assisted Outpatient Treatment in New York State*, Psychiatric Services, Vol. 61 No.2 (February 2010).

¹⁸ Michael Heggarty, Nevada County Behavioral Health Director, “*The Nevada County Experience*,” (November 15, 2011). Available at <http://lauras-law.org/states/california/nevada-aot-heggarty-8.pptx.pdf>.

40%¹⁹ due to a 78% reduction in days of incarceration, an 86% decrease in days of hospitalization, and a 77% reduction in hospitalization even after Laura's Law discharge.²⁰

To be Laura's Law eligible, individuals must be severely mentally ill²¹ and meet a number of other strict criteria. Among them, and most relevant here: they must be offered, and refuse, the same services on a voluntary basis, must be “unlikely to survive in the community without supervision,” have a “history of noncompliance with treatment,” and have either a history of recent involuntary hospitalizations or of serious and violent behavior. Further, the individual's condition must be “substantially deteriorating” and AOT must be “the least restrictive placement necessary to ensure the person's recovery and stability.”²²

Though it is a program for treatment-refusers, Laura's Law services are almost entirely voluntary. As DRC has conceded,²³ the services offered by Laura's Law are virtually identical to those offered under

19. Savings data of 40 percent comes from Michael D. Antonovich, Los Angeles County Fifth District Supervisor to Los Angeles Daily News published December 12, 2011 available at http://www.dailynews.com/news/ci_19531616.

20 “Outpatient Treatment Program Outcomes Report April 1, 2010 – December 31, 2010” sent under cover of Marvin Southard, Director of County of Los Angeles, Department of Mental Health to Cliff Allenby, Acting Director California Department of Mental Health February 24, 2011

21 Laura's Law incorporates the definition of severe mental illness at W.I.C.5600.3(b)(2) and(3), set forth *infra* at n 35. See W.I.C Section 5346(a)(2).

22 Qualifying criteria, including those mentioned above, are in W.I.C. Section 5346:

5346. (a) In any county in which services are available as provided in Section 5348, a court may order a person who is the subject of a petition filed pursuant to this section to obtain assisted outpatient treatment if the court finds, by clear and convincing evidence, that the facts stated in the verified petition filed in accordance with this section are true and establish that all of the requisite criteria set forth in this section are met, including, but not limited to, each of the following:

(1) The person is 18 years of age or older.

(2) The person is suffering from a mental illness as defined in paragraphs (2) and (3) of subdivision (b) of Section 5600.3.

(3) There has been a clinical determination that the person is unlikely to survive safely in the community without supervision.

(4) The person has a history of lack of compliance with treatment for his or her mental illness, in that at least one of the following is true:

(A) The person's mental illness has, at least twice within the last 36 months, been a substantial factor in necessitating hospitalization, or receipt of services in a forensic or other mental health unit of a state correctional facility or local correctional facility, not including any period during which the person was hospitalized or incarcerated immediately preceding the filing of the petition.

(B) The person's mental illness has resulted in one or more acts of serious and violent behavior toward himself or herself or another, or threats, or attempts to cause serious physical harm to himself or herself or another within the last 48 months, not including any period in which the person was hospitalized or incarcerated immediately preceding the filing of the petition.

(5) The person has been offered an opportunity to participate in a treatment plan by the director of the local mental health department, or his or her designee, provided the treatment plan includes all of the services described in Section 5348, and the person continues to fail to engage in treatment.

(6) The person's condition is substantially deteriorating.

(7) Participation in the assisted outpatient treatment program would be the least restrictive placement necessary to ensure the person's recovery and stability.

(8) 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.

(9) It is likely that the person will benefit from assisted outpatient treatment.

23 “One component of the required array of services [under Laura’s Law] is intensive case management as defined in Welfare and Institutions Code Section 5348(a)(1). . . The remaining services that a county is required to set up in order to

the pre-existing Adult and Older Adult Systems of Care, which DRC labels “voluntary.”²⁴ In Nevada County, for example, Laura’s Law clients, are co-mingled with non-AOT clients, receive services from the same providers, and have choices including whether to take medications, participate in groups, and/or see a therapist or counselor. There is no use of restraints or seclusion, no locks and no forced medication. Laura’s Law clients are not handcuffed in the courtroom and taken to jail for a “violation of the treatment plan” as is the process in Mental Health Court when expectations are not met. Whether Laura’s Law individuals show up is their choice. They can get up and walk out at any time.²⁵

What is the difference between Laura's Law and the existing Adult/Older Adult Systems of Care? First, Laura's Law clients benefit from a higher staff-to-client ratio, and rightly so. They are sicker than the rest of the population helped through Adult Systems of Care. Second, Laura's Law services are court-ordered (though the order may be agreed to by the client), see W.I.C. Section 5347(a). However, the court’s only enforcement power is to order a recalcitrant individual to be evaluated for emergency hospitalization, see W.I.C. Section 546(d)(6). Given that Laura’s Law clients must be “substantially deteriorating” to be eligible, they are already on the edge of involuntary hospitalization anyway.

The judge and the court order, however, are critical to the success of AOT. Research in New York State on AOT (Kendra’s Law) shows that for treatment-refusers, neither improved access to services nor a court order works as well as a combination of the two.²⁶ It appears that the mere possibility of being ordered to undergo a court-ordered evaluation for inpatient commitment is enough to get individuals who are balking at their treatment regimen back on track.²⁷ This “black robe effect” is key to success with treatment-refusers, and far less restrictive of their rights and freedom than involuntary hospitalization, jail or death.

Moreover, despite being under court order, AOT recipients feel positive about their treatment, with feelings very similar to all other treatment recipients²⁸ They also know AOT works better for them.²⁹ Opposition to “involuntary treatment” comes not from AOT recipients themselves, but from well-

implement [Laura’s Law] are virtually identical to the AB 34/2034 array of services.” Memo dated May 3, 2005 from attorney Daniel Brzovic of Protection and Advocacy, Inc. (now DRC), p. 5.

²⁴ *Id.* pp. 2-3, *see also*, attached memo from Mr. Brzovic.

²⁵ “*Assisted Outpatient Treatment: The Nevada County Experience*” January 6, 2012 supplemented by Carol Stanchfield, MS, LMFT, Director, Turning Point Providence Center (which supplies in Nevada County), found at <http://www.mynevadacounty.com/nc/hhsa/bh/docs/Laura%27s%20Law/AOT%20The%20Nevada%20County%20Experience.pdf>.

²⁶ Swartz, et al, *Assessing Outcomes for Consumers in New York’s Assisted Outpatient Treatment Program*, found at <http://mentalillnesspolicy.org/kendras-law/research/aot-reduces-hospital-admission-swartz.pdf>.

²⁷ Busch, Alisa B. MD: “*Changes in Guideline-Recommended Medication Possession After Implementing Kendra's Law in New York*” (Psychiatric Services Vol. 61 No. 10, October 2010) found at psychiatryonline.org.

²⁸ New York has done elaborate studies of consumer satisfaction under AOT, running comparisons with other treatment with mean item scores ranging from 1 to 5 from “strongly disagree” to “strongly agree”. Findings on this scale indicate frameworks, such as “enhanced voluntary services.” “Treatment satisfaction was measured using a 9-item standardized scale, similarly positive levels of satisfaction with treatment across all three subsamples—close to 4 out of 5 on average.” Swartz, Swanson, Steadman, Robbins and Monahan, *New York State Assisted Outpatient Treatment Program Evaluation* (joint publication of the Duke University School of Medicine, Policy Research Associates, and the MacArthur Foundation Research Network on Mandated Community Treatment at the University of Virginia School of Law, June 30, 2009). p. 36

²⁹ *Id.* In the above study, current and recent AOT recipients scored much higher in perceived effectiveness, “with higher scores indicating greater agreement that AOT was effective in helping people keep scheduled outpatient treatment appointments, take prescribed medication, and remain in the community without being hospitalized.” *Id.* at pp. 35, 38 and Exhibit 4.3.

intentioned people who project their own feelings onto individuals who cannot think straight, much less think like them.³⁰

The judicial aspects of Laura's Law are funded by the court system, and not with mental health funds. California Attorney General Opinion No. 05-1007 (February 23, 2006). However, California now has ample money to fund the programmatic aspects, due to the "millionaire's tax" imposed by the Mental Health Services Act, which will bring in an estimated \$1.15 billion in 2011-2012.³¹

The California Department of Mental Health has specifically approved the use of MHSA funds for Laura's Law programs. DRC nonetheless argues that use of MHSA funds for Laura's Law is illegal. Their argument is essentially that the court order makes Laura's Law an "involuntary" program which MHSA was not intended to fund.

As shown below, DRC is mistaken.

AT LEAST FOUR MHSA FUNDING STREAMS ARE AVAILABLE TO FUND LAURA'S LAW.

The California Mental Health Services Act ("MHSA") was passed as a voter initiative, Proposition 63, in 2004. It creates different funding streams for a variety of programs. DRC's letter addressed only one MHSA funding segment, for the "Adult System of Care." This letter will demonstrate that at least four of the six funding streams created by MHSA, including that for the "Adult System of Care," are available to fund Laura's Law programs.³²

A. Principles Applicable in Construing a Voter Initiative

In construing a voter initiative, courts discern voter intent by looking to the enactment as a whole, with particular emphasis on its findings and statement of purposes. See *Westley v. Board of Administration* (2003) 105 Cal.App.4th 1095, 130 Cal.Rptr.2d 149. "Absent ambiguity, [courts] presume that the voters intend the meaning apparent on the face of an initiative measure." *Leshar Communications, Inc. v City of Walnut Creek* (1990) 52 Cal.3d 531, 543. If the language of the initiative is clear, there is no need to resort to other sources to discern voter intent. *People v. Rizo* (2000) 22 Cal.4th 681, 94 Cal.Rptr.2d 375, 996 P.2d 27.

30 Studies show that the untreated seriously mentally ill often do not know whether they are in "voluntary" or "involuntary" status. When asked why they are in a locked psychiatric ward, many patients give "bizarre" explanations, such as claiming they are receiving medical check-ups. Amador, X, *I Am Not Sick I Don't Need Help!* (Vida Press, 2d Ed. 2007) p.6. Data from the MacArthur Coercion Studies shows that 22% of involuntary psychiatric patients polled after admission believed it was their idea to come to the hospital, 35% of them did not perceive they had been coerced, 47% of them agreed there were no reasonable alternatives to hospitalization, and 56% reported they would have entered voluntarily if given the opportunity. Treffert, *The MacArthur Coercion Studies: A Wisconsin Perspective*, 82 Marquette L. Rev. 759, 778 (1999). "The findings here usefully show that there is a low level of perceived coercion if: persuasion and inducement are used rather than threats or force; others, including friends and family, are involved in the decision making as a form of caring; the patient believes others acted out of genuine concern; the patient believes he or she was treated respectfully and in good faith; and the patient was afforded a chance to tell his or her side of the story." *Id.* at 779.

31 Governor's 2012-2013 Budget Summary, <http://www.ebudget.ca.gov/pdf/BudgetSummary/FullBudgetSummary.pdf>, page 51 (January 5, 2012).

32 We concede that funding for juveniles cannot presently be used, because Laura's Law applies only to adults, and that funding for education and training is not available for Laura's Law programming, though of course it could be used to educate and train concerning Laura's Law.

MHSA also provides at Section 18 that “[t]his act shall be broadly construed to accomplish its purpose. . . .” Thus, any ambiguity within MHSA or inconsistency with prior law must be resolved to effectuate the voters’ intent in enacting MHSA.

B. The Voters Expressly Authorized Involuntary Treatment using MHSA Funding

It is clear from the text of MHSA that California voters intended to fund “involuntary” programs. The voters expressly authorized MHSA money for locked facilities, when patient needs “cannot be met in a less restrictive or more integrated setting.” W.I.C. Section 5847(b)(5). Moreover, as DRC properly conceded on the first page of its May 3, 2005 memo, “[t]here is no [other] language in Proposition 63, itself, that either prohibits or authorizes the use of funds for involuntary services.”

DRC cites no statutory support for its assertion that MHSA funding cannot be used for “involuntary” programs for good reason: as it has conceded, there is none. There is, however, plenty of evidence elsewhere in MHSA that the voters intend treatment-refusers to receive help.

C. MHSA Funds Were Intended To Help Treatment-Refusers

A further examination of MHSA's text shows that MHSA funds were intended to help all mentally ill people, including treatment-refusers, regardless of their legal status.

Because the voters' Findings and Statement of Purposes are critical to an understanding of their intent, both are set forth in full below.³³ They demonstrate that the voters were focused on “severe, ”

³³ SECTION 2. Findings and Declarations

The people of the State of California hereby find and declare all of the following:

(a) Mental illnesses are extremely common; they affect almost every family in California. They affect people from every background and occur at any age. In any year, between 5% and 7% of adults have a **serious mental illness** as do a similar percentage of children — between 5% and 9%. Therefore, more than two million children, adults and seniors in California are affected by a potentially **disabling mental illness** every year. People who become **disabled by mental illness** deserve the same guarantee of care already extended to those who face other kinds of disabilities.

(b) Failure to provide timely treatment can destroy individuals and families. No parent should have to give up custody of a child and no adult or senior should have to become **disabled or homeless** to get mental health services as too often happens now. No individual or family should have to suffer inadequate or insufficient treatment due to language or cultural barriers to care. **Lives can be devastated** and families can be financially ruined by the costs of care. Yet, for too many Californians with mental illness, the mental health services and supports they need remain fragmented, disconnected and often inadequate, frustrating the opportunity for recovery.

(c) **Untreated mental illness is the leading cause of disability** and suicide and imposes high costs on state and local government. Many people left untreated or with insufficient care see their mental illness worsen. Children left untreated often become unable to learn or participate in a normal school environment. Adults lose their ability to work and be independent; many become **homeless** and are subject to frequent hospitalizations or jail. State and county governments are forced to pay billions of dollars each year in **emergency medical care**, long-term nursing home care, unemployment, housing, and law enforcement, including juvenile **justice, jail and prison costs**. (Emphasis added.)

(d) In a cost cutting move 30 years ago, California drastically cut back its services in state hospitals for people with **severe mental illness**. Thousands ended up on the streets homeless and incapable of caring for themselves. Today thousands of suffering people remain on our streets because they are afflicted with **untreated severe mental illness**. We can and should offer these people the care they need to lead more productive lives.

(e) With effective treatment and support, recovery from mental illness is feasible for most people. The State of California has developed effective models of providing services to children, adults and seniors with serious mental illness. A recent innovative approach, begun under Assembly Bill 34 in 1999, was recognized in 2003 as a model program by the President’s Commission on Mental Health. This program combines prevention services with a full range of integrated services to treat the whole person, with the goal of self-sufficiency for those who may have otherwise faced homelessness or dependence on the state for years to come. Other innovations address services to other underserved populations such as

disabling” or “serious” mental illness, phrases repeated eleven times in these first provisions alone, and many more times elsewhere in the Act. This focus is re-emphasized by the statistics on “serious mental illness” quoted in the voters' first finding,³⁴ and by repeated references in the Findings and Purposes sections to the consequences of treatment refusal already discussed here: homelessness (four times), alienation from family (three times), involuntary hospitalization (three times), suicide (two times), unemployment (one time) and incarceration (four times).

From reading their Findings and Purposes, it is obvious that the voters were focused on the most seriously mentally ill who are not receiving treatment. “Today thousands of suffering people remain on our streets because they are afflicted with *untreated severe mental illness*.” MHSA Section 2(d). Many or most are untreated because they are treatment-refusers, and in counties that have not adopted Laura’s Law, they will receive no help until they are dangerous to themselves or others, or so gravely disabled that they cannot provide for their most basic needs.

The text of the voters' Findings and Purposes makes clear their intent to extend treatment to *all* such individuals, regardless of “voluntary” or “involuntary” status:

traumatized youth and isolated seniors. These successful programs, including prevention, emphasize client-centered, family focused and community-based services that are culturally and linguistically competent and are provided in an integrated services system.

(f) By expanding programs that have demonstrated their effectiveness, California can save lives and money. Early diagnosis and adequate treatment provided in an integrated service system is very effective; and by **preventing disability**, it also saves money. Cutting mental health services wastes lives and costs more. California can do a better job saving lives and saving money by making a firm commitment to providing timely, adequate mental health services.

(g) To provide an equitable way to fund these expanded services while protecting other vital state services from being cut, very high-income individuals should pay an additional one percent of that portion of their annual income that exceeds one million dollars (\$1,000,000). About 1/10 of one percent of Californians have incomes in excess of one million dollars (\$1,000,000). They have an average pre-tax income of nearly five million dollars (\$5,000,000). The additional tax paid pursuant to this represents only a small fraction of the amount of tax reduction they are realizing through recent changes in the federal income tax law and only a small portion of what they save on property taxes by living in California as compared to the property taxes they would be paying on multi-million dollar homes in other states.

SECTION 3. Purpose and Intent.

The people of the State of California hereby declare their purpose and intent in enacting this act to be as follows:

(a) To define **serious mental illness among children, adults and seniors as a condition deserving priority attention**, including prevention and early intervention services and medical and supportive care.

(b) To reduce the long-term adverse impact on individuals, families and state and local budgets resulting from **untreated serious mental illness**.

(c) To expand the kinds of successful, innovative service programs for children, adults and seniors begun in California, including culturally and linguistically competent approaches for underserved populations. These programs have already demonstrated their effectiveness in providing outreach and integrated services, including medically necessary psychiatric services, and other services, to **individuals most severely affected by or at risk of serious mental illness**.

(d) To provide state and local funds to adequately meet the needs of **all children and adults who can be identified** and enrolled in programs under this measure. State funds shall be available to provide services that are not already covered by federally sponsored programs or by individuals’ or families’ insurance programs.

(e) 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.

34 The voters' first Finding states that “In any year, between 5% and 7% of adults have a serious mental illness as do a similar percentage of children, between 5% and 9%.” MHSA Sec. 2(a). This statistic mirrors the ones found at the National Institute of Mental Health website, which places adult “serious mental illness” at 5% overall; 7% between ages 18-25. NIMH also puts the adult incidence of schizophrenia at 1% of the population, of severe mood disorders at 4.3% of the population, and of severe post traumatic stress disorders at 1.3% (adding up to 7.8%). In contrast, when “any” disorder is considered, the NIMH statistics show incidence among adults is 26.2% of the population. See <http://www.nimh.nih.gov/statistics/index.shtml>.

People who become disabled by mental illness deserve *the same guarantee of care* already extended to those who face other kinds of disabilities. (MHSA Section 2(a).

No individual or family should have to suffer *inadequate or insufficient treatment*. . . . Yet, for too many Californians with mental illness, the mental health services and supports they need remain fragmented, disconnected and often inadequate, frustrating the opportunity for recovery. MHSA Section 2(b).

Today thousands of suffering people remain on our streets because they are afflicted with *untreated severe mental illness*. *We can and should offer these people the care they need to lead more productive lives*. MHSA Section 2(d).

SECTION 3. Purpose and Intent.

The people of the State of California hereby declare their purpose and intent in enacting this act to be as follows:

* * *
(b) To reduce the long-term adverse impact on individuals, families and state and local budgets resulting from *untreated serious mental illness*.
* * *

(c) To expand the *kinds of* successful, innovative service programs for children, adults and seniors . . . to *individuals most severely affected by or at risk of serious mental illness*.

(d) To provide state and local funds to adequately meet the needs of *all children and adults* who can be identified and enrolled in programs under this measure. (Emphasis added.)

In sum, the text of MHSA makes it clear that its funds were intended to reach *all* severely mentally ill persons, including treatment-refusers. This point was forcefully made by the primary author of Proposition 63, Senator Darrell Steinberg, who stated that he is “very clear” that MHSA funds can be used for Laura’s Law. “The services are available to everyone who meets the definition of serious mental illness.” (“Care, Not Excuses,” San Francisco Chronicle, February 21, 2008.)

We now address the individual funding streams that are available to fulfill the voters’ intent, beginning with the only one that DRC has addressed: the portion of MHSA funding devoted to “the Adult System of Care.”

D. Adult Care Funds are Available for Laura's Law-eligible clients

1. Adult Care MHSA Funding is not limited to “voluntary” programs

Under Section 7 of MHSA, “Services *shall be available to adults and seniors with severe illnesses who meet the eligibility criteria in subdivisions (b) and (c) of Section 5600.3 of the Welfare and Institutions Code*. . . . Funding *shall be provided* at sufficient levels to ensure that counties can provide *each adult and senior* served pursuant to this part with the medically necessary mental health services, medications and supportive services set forth in the applicable treatment plan.” (Emphasis added.)

The “eligibility criteria” in W.I.C 5600.3 (b) and (c) simply define serious mental illness according to diagnostic and behavioral criteria--the identical criteria used as a factor in determining Laura's Law eligibility.³⁵ Nothing

35 See W.I.C. Section 5346(a)(2) at n, 22 *supra*. W.I.C. 5600.3 provides, in relevant part:

(b) (1) Adults and older adults who have a serious mental disorder.

(2) For the purposes of this part, "serious mental disorder" means a mental disorder that is severe in degree and persistent in duration, which may cause behavioral functioning which interferes substantially with the primary activities of daily living, and which may result in an inability to maintain stable adjustment and independent functioning without

in these provisions suggests that “eligibility” is based on whether or not recipients “volunteer” for services. No “broad construction” of these provisions is necessary to apply them to treatment-refusers. The statutory language clearly does so already.

Nonetheless, DRC argues that MHSA funding must be limited to “voluntary” programs, based on the following provision in law that pre-dates MHSA:

The client should be fully informed and volunteer for all treatment provided, unless danger to self or others or grave disability requires temporary involuntary treatment. W.I.C. Section 5801(b)(5)

This argument is meritless, for at least three separate reasons. First, the above-quoted language uses the term, “should,” rather than “shall.” This means that the provision DRC relies on is not mandatory, but optional for counties.³⁶ Second, DRC is attempting to construe a voter initiative with language not part of the initiative, but buried in pre-existing statute. This violates the requirement that “voters intend

treatment, support, and rehabilitation for a long or indefinite period of time. Serious mental disorders include, but are not limited to, schizophrenia, bipolar disorder, post-traumatic stress disorder, as well as major affective disorders or other severely disabling mental disorders. This section shall not be construed to exclude persons with a serious mental disorder and a diagnosis of substance abuse, developmental disability, or other physical or mental disorder.

(3) Members of this target population shall meet all of the following criteria:

(A) The person has a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a substance use disorder or developmental disorder or acquired traumatic brain injury pursuant to subdivision(a) of Section 4354 unless that person also has a serious mental disorder as defined in paragraph (2).

(B) (i) As a result of the mental disorder, the person has substantial functional impairments or symptoms, or a psychiatric history demonstrating that without treatment there is an imminent risk of decompensation to having substantial impairments or symptoms. (ii) For the purposes of this part, "functional impairment" means being substantially impaired as the result of a mental disorder in independent living, social relationships, vocational skills, or physical condition.

(C) As a result of a mental functional impairment and circumstances, the person is likely to become so disabled as to require public assistance, services, or entitlements.

(4) For the purpose of organizing outreach and treatment options, to the extent resources are available, this target population includes, but is not limited to, persons who are any of the following:

(A) Homeless persons who are mentally ill. (B) Persons evaluated by appropriately licensed persons as requiring care in acute treatment facilities including state hospitals, acute inpatient facilities, institutes for mental disease, and crisis residential programs.

(C) Persons arrested or convicted of crimes.

(D) Persons who require acute treatment as a result of a first episode of mental illness with psychotic features.

(5) California veterans in need of mental health services and who meet the existing eligibility requirements of this section, shall be provided services to the extent services are available to other adults pursuant to this section. Veterans who may be eligible for mental health services through the United States Department of Veterans Affairs should be advised of these services by the county and assisted in linking to those services.

(A) No eligible veteran shall be denied county mental health services based solely on his or her status as a veteran.

(B) Counties shall refer a veteran to the county veterans service officer, if any, to determine the veteran's eligibility for, and the availability of, mental health services provided by the United States Department of Veterans Affairs or other federal health care provider.

(C) Counties should consider contracting with community-based veterans' services agencies, where possible, to provide high-quality veteran specific mental health services.

(c) Adults or older adults who require or are at risk of requiring acute psychiatric inpatient care, residential treatment, or outpatient crisis intervention because of a mental disorder with symptoms of psychosis, suicidality, or violence.

³⁶ In order to construe a statute as imposing a mandatory duty, the mandatory nature of the duty must be phrased in explicit and forceful language. " *Quackenbush v. Superior Court (Lyons)* (1997) 57 Cal.App.4th 660 , 67 Cal.Rptr.2d 300. "The word 'shall' is ordinarily used in laws, regulations, or directives to express what is mandatory. 'May,' on the other hand, is usually permissive." *Hogya v. Superior Court* (1977) 75 Cal.App.3d 122 , 133.

the meaning apparent on the face of an initiative measure,” *Leshar Communications, supra*. Finally, even assuming the above-quoted provision applies here, Laura's Law falls into the exception created in the last clause. Assuming *arguendo* that Laura's Law is involuntary, “danger to self or others or grave disability requires temporary involuntary treatment.” This is because, by definition, all individuals who are Laura's Law-eligible must be “substantially deteriorating” and “likely” to become gravely disabled or commit “serious harm” to self or others. W.I.C. 5346(a). The court order that helps them co-operate with treatment is “temporary,” because it cannot last more than six months. W.I.C. 5346(d)(5)(b).

DRC would require us to believe that the purpose and intent of MHSA was to deny services to individuals who are not presently dangerous or gravely disabled, but are now “likely” to become so. That argument requires the most tortured and cruel interpretation of the voters’ intent. Their purpose was not to require people to become gravely disabled, but to prevent it. “California can do a better job saving lives and saving money by making a firm commitment to providing *timely*, adequate mental health services. Voters’ Findings and Declarations, MHSA Section 2(f) (emphasis added) .

2. DMH Regulations Permit Use of Adult Service Funds for Laura's Law Programs

DRC further relies on a DMH regulation which DMH itself has read as authorizing use of MHSA funds for Laura's Law programs, see n.1. DMH’s interpretation of its own regulation is, of course, entitled to “consideration and respect by the courts. . .” *Yamaha Corp. of America v. State Bd. of Equalization* 19 Cal.4th 1,7 (1998). Moreover, the Department's reading of its own regulation is the only logical one.

We assume the regulation was validly promulgated, though this is questionable.³⁷ It provides:

All programs and/or services provided with MHSA funds shall:

* * *

Be designed for voluntary participation. No person shall be denied access based solely on his/her voluntary/involuntary legal status.

C.C.R. Title 9, Section 3400 (b)(1)(A)(2).

It is also questionable whether this regulation has any bearing here, because MHSA funds are not used to pay for the only aspect of Laura's Law that is even arguably involuntary, the court order, *see* California Attorney General Opinion No. 05-1007 (February 23, 2006). However, assuming *arguendo* that the regulation applies,

³⁷ The above-quoted provision was originally added as emergency regulation in 2006; however, DMH’s authority to enact emergency regulations under MHSA was expressly limited by the voters to regulations promulgated in 2005. *Compare* the regulatory history, as found on the Office of Administrative Hearings website, and W.I.C. Section 5898, which states: “*In 2005*, the director may adopt all regulations pursuant to this Act as emergency regulations in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. For the purpose of the Administrative Procedure Act, the adoption of regulations, *in 2005*, shall be deemed an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare . . . Regulations adopted pursuant to this section shall be developed with the maximum feasible opportunity for public participation and comments..” (Emphasis added.) Moreover, the California Administrative Procedure Act provides that “[t]he office [of Administrative Law] may approve not more than two readoptions, each for a period not to exceed 90 days, of an emergency regulation that is the same as or substantially equivalent to an emergency regulation previously adopted by that agency. Readoption shall be permitted only if the agency has made substantial progress and proceeded with diligence to comply with subdivision (e).” Government Code Section 11346.1(h). The regulatory history indicates that the original 2005 emergency regulations—which did not include the above-quoted provision-- were republished as emergency regulations with new variations six times after January of 2006, at intervals longer than 90 days. A Certificate of Compliance was not filed until the end of December, 2007.

Nonetheless, we proceed on the assumption that the above-quoted provision is valid.

Laura's Law programs fit within the first sentence because the services are “*designed* for voluntary participation.” Laura's Law clients must first be offered voluntary participation, and may agree to the court order. W.I.C. 5346(a)(5), 5346(e)(2), 5347(a). Moreover, as DRC has conceded, the services funded by Laura's Law are “virtually identical to those currently provided under 'Full Service Partnerships’” which it labels “voluntary.” (DRC Memorandum dated May 3, 2005).³⁸ In Nevada County, Laura's Law clients are co-mingled with non-AOT clients and whether they show up for treatment is their choice. □ There is no use of restraints or seclusion, no locks and no forced medication. See p. 4 *supra*.

Laura's Law services also fit the second sentence of this regulation. Laura's Law beneficiaries cannot be denied participation, “based solely on their voluntary/involuntary legal status.” Though Laura's Law service recipients are under court order, this regulation forbids discriminating against them. In contrast, reading the regulation to bar funding for alleged “involuntary” treatment would be contrary to the DMH reading of its own regulation, as well as the purposes and literal language of MHSA.

3. Excluding Treatment-Refusers from MHSA funding is discriminatory and illegal

Moreover, excluding severely mentally ill treatment-refusers from participation in MHSA-funded programs based on their inability to “volunteer” for treatment—an inability due solely to the symptoms of their illnesses-- would be disability discrimination, violative of the ADA and arguably, the state and federal constitutions. 42 U.S.C. Sec. 12132, 28 C.F.R.35.30(b)(8), *cf. Perry v Brown, No. 11-17255* (9th Cir., filed February 1 2012) (“the Equal Protection Clause requires the state to have a legitimate reason for withdrawing a benefit from *one group but not others*.”)(Slip. Op. at 51; emphasis in original.)). Discriminating against the sickest mentally ill people stands MHSA on its head, as that is clearly the group the statute was intended to help. A court will avoid such a construction, just as the Department of Mental Health did, in permitting Nevada County and Los Angeles to use MHSA Adult Services funds for their Laura's Law programs. In advocating for such a construction, DRC is essentially advocating illegal discrimination. Its position must therefore be rejected.

4. Laura's Law services must only be offered to persons who are Laura's Law eligible.

DRC also argues that before treatment-refusers can receive MHSA funds, counties must first offer Laura's Law services to a variety of individuals who are not Laura's Law eligible. (DRC letter dated February 1, 2012 p. 3.) Their argument is based on the following language in law that predates MHSA:

Any county that provides assisted outpatient treatment services pursuant to this article shall also offer the same services on a voluntary basis. W.I.C. Section 5348(c).

This argument is meritless, for several reasons. First, as previously shown, Laura's Law already complies with this requirement by requiring county officials to offer Laura's Law services to treatment-refusers on a voluntary basis, and requiring the court to make a specific finding that such an offer has been made and refused. DRC is essentially arguing that a provision within Laura's Law makes a host of other people Laura's Law eligible without saying so. Obviously, it doesn't. Laura's Law clients must meet Laura's Law criteria. Conversely, individuals who are not being considered for Laura's Law programs do not derive rights from a provision that is specific to Laura's Law itself.

DRC next attempts to limit the use of MHSA funds to “voluntary” programs using pre-existing W.I.C. Section 5349, which provides that county boards must make a finding :

38 DRC's argument that a court order is “involuntary” and inconsistent with the pre-existing Adult Services program is strained at best. There are many individuals in that program who are also subject to a variety of court orders, including court wards and dependents, individuals on probation, parents from dependency court, conservatees, and others .

We do not address this weakness at any length because it is immaterial whether Laura's Law is considered “voluntary,” given that MHSA makes no distinction between “voluntary” and “involuntary” programs.

that no voluntary mental health program serving adults, and no children's mental health program, may be *reduced* as a result of the implementation of [Laura's Law]." (Emphasis added.)

Such a finding, however, is easy to make and support. By definition, MHSA funding is *new* money. Funding programs with MHSA funds therefore does not "reduce" anything. Moreover, MHSA explicitly provides for maintaining pre-existing funding "as is" :

The funding established pursuant to this act shall be utilized to *expand* mental health services. These funds shall not be used to supplant existing state or county funds utilized to provide mental health services. The state shall continue to provide financial support for mental health programs with not less than the same entitlements, amounts of allocations from the General Fund and formula distributions of dedicated funds as provided in the last fiscal year which ended prior to the effective date of this act. The state shall not make any change to the structure of financing mental health services, which increases a county's share of costs or financial risk for mental health services unless the state includes adequate funding to fully compensate for such increased costs or financial risk. . . . The state shall not make any change to the structure of financing mental health services, which increases a county's share of costs or financial risk for mental health services unless the state includes adequate funding to fully compensate for such increased costs or financial risk." W.I.C. 5891(a) .

There is thus no possibility of reducing funding for existing programs by using new funding to establish Laura's Law.³⁹ DRC's contrary argument is confusing and circular.

Moreover, even assuming a conflict between the language of MHSA and pre-existing law, MHSA would obviously govern, both because it is a superceding statute and because the voters provided that MHSA "shall be broadly construed to accomplish its purposes." The voters were very clear about their spending priorities, which differ drastically from those contained in pre-existing W.I.C. Section 5349, quoted above. The voters made no distinction between voluntary and involuntary programs. They simply wanted programs "similar to . . . programs shown to be effective , , ,," MHSA Sections 2(f), 3(c), 4(c) and 4(e). As previously shown, Laura's Law is an "effective" program. There is no need to develop this argument at any length, however, because the statutes can be harmonized, as shown above.

E. MHSA Prevention/Early Intervention Funds Can Be Used to Fund Laura's Law

The second MHSA funding stream that may be used for Laura's Law is the 20% allocated to "Prevention/Early Intervention." Simple division puts PEI funding available in 2011-2012 at \$230,000,000.00 see n. 31. Counties' PEI allocations may also "be increased in any county which the department determines that such increase will decrease the need and cost for additional services to severely mentally ill persons in that county by an amount at least commensurate with the proposed increase." W.I.C. Section 5892(a)(4). Based on the data generated in Nevada and Los Angeles counties, a Laura's Law program would be eligible for these extra funds.

The Prevention/Early Intervention provisions mandate funding for programs "designed to prevent mental illnesses from becoming severe and disabling."⁴⁰ From the statutory language, it is apparent the voters had two

39 Although it does not do so itself, Nevada County has suggested that counties could move AOT clients into service slots as other clients graduate to different levels of service, die, or move out of county, if they insist on worrying about a possible lawsuit by DRC.

40 The relevant language provides:

PART 3.6 PREVENTION AND EARLY INTERVENTION PROGRAMS

5840 (a) The State Department of Mental Health shall establish a program designed to *prevent mental illnesses from becoming severe and disabling*. The program shall emphasize improving timely access to services for underserved populations.

kinds of prevention/early intervention in mind: programs that would intervene on behalf of those with “mental illness” and the prodromal (early) symptoms of “severe mental illness,” to keep their illness from becoming “severe and disabling,”⁴¹ and programs that would intervene early to prevent or shorten the duration of *relapses* into “severe mental illness,”⁴² *ie*, “reducing the duration of untreated severe mental illnesses and assisting people in quickly regaining productive lives”:

(c) 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*. MHSa Section 4, now W.I.C. Section 5840(c).

Laura's Law fits the second funding mandate exactly. Laura's Law recipients must be “substantially deteriorating” and “in need of assisted outpatient treatment in order to prevent *a relapse or deterioration* that would likely result in grave disability or serious harm” to self or others, W.I.C. 5346(a)(6) and(8) (emphasis added). As required by the MHSa PEI provisions, Laura's Law “reduces the duration of untreated severe mental illness and assists people in quickly regaining productive lives” by ensuring treatment for a group that pre-existing programs did not: treatment-refusers. It is “similar to” the pre-existing Adult System of Care, a successful program, differing only in that it is court-ordered, an essential element of its history of success. And it is “effective,” as shown, *inter alia*, by studies of Kendra's Law demonstrating dramatic reductions in hospitalizations, arrests, incarceration, homelessness, suicide, violence and substance abuse; and by data from Nevada and Los Angeles counties demonstrating substantial savings in public funds due to dramatic reductions

(b) The program shall include the following components:

(1) Outreach to families, employers, primary care health care providers, and others to *recognize the early signs of potentially severe and disabling mental illnesses*.

(2) Access and linkage to medically necessary care provided by county mental health programs for children *with severe mental illness*, as defined in Section 5600.3, and for adults and seniors *with severe mental illness*, as defined in Section 5600.3, *as early in the onset of these conditions as practicable*.

(3) Reduction in stigma associated with either being diagnosed with a mental illness or seeking mental health services.

(4) Reduction in discrimination against people with mental illness.

(c) 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*.

(d) The program shall emphasize strategies to reduce the following negative outcomes that may result from *untreated mental illness*:

(1) Suicide.

(2) Incarcerations.

(3) School failure or dropout.

(4) Unemployment.

(5) Prolonged suffering.

(6) Homelessness.

(7) Removal of children from their homes.

(e) In consultation with mental health stakeholders, the department shall revise the program elements in Section 5840 applicable to all county mental health programs in future years to reflect what is learned about the most effective prevention and intervention programs for children, adults, and seniors. (Emphasis added).

⁴¹ Prevention and Early Intervention programs “shall include the following components. . . Access and linkage to medically necessary care provided by county mental health programs for children *with severe mental illness*, as defined in Section 5600.3, and for adults and seniors *with severe mental illness*, as defined in Section 5600.3, *as early in the onset of these conditions as practicable*.” W.I.C. Section 5840(b) (emphasis added).

⁴² “Early intervention” provisions designed to prevent or minimize relapses exist in other states. *See, e.g.*, Minn. Stat.253B.065, “court-ordered early intervention.”

in hospital days, incarceration days, and emergency interventions. See p.4, *supra*.

There is a complication created by MHSOAC and the now-defunct Department of Mental Health through abuses of the regulatory process enumerated below. The one regulation that is found on the official Office of Administrative Law site, and is therefore facially valid,⁴³ purports to exempt PEI funded-programs from any connection with “serious mental illness.”⁴⁴ We construe this regulation as allowing PEI funding for programs for individuals with mental illness and prodromal symptoms of “serious mental illness,” for family and employer outreach programs for people with mental illness that may become “severe,” and for programs addressing “stigma” and “discrimination” pursuant to W.I.C. 5840(b)(1), (3) and (4), see n. 40. To read it more broadly is contrary to statute.⁴⁵ Obviously, state agencies have no power to exempt themselves from the statutes they are supposed to enforce.

Further regulatory abuses stem from 2007 “guidelines” still identified as such on the MHSOAC website,⁴⁶ which were noticed as proposed regulations in 2010.⁴⁷ The proposed regulations were allowed to lapse. (See Government Code Section 11346.4(b) and Attachment B to this memorandum, from the Office of Administrative Law.) However, the lapsed proposed regulations were labeled “regulations,” and therefore appear as “regulations” to people using a Google search. Moreover, they still appear as “proposed regulations” on the DMH website, though they are no longer “proposed” because they have lapsed. Yet these “guidelines”/lapsed proposed “regulations” were still in use as recently as last November,⁴⁸ shuttling PEI money into uses that are contrary to law.⁴⁹ Because of these “guidelines”/lapsed proposed “regulations,” PEI money has never been directed towards relapse prevention programs, *ie*, “programs that have been successful in reducing the duration of untreated severe mental illnesses and assisting people in quickly regaining productive lives” as expressly required by the voters in MHSOAC Section 4.

DMH/MHSOAC not only misled counties and the public with these actions, but also acted contrary to law. “Guidelines” that function as regulations—known as “underground” regulations in this state—are illegal and unenforceable.⁵⁰ So are regulations that are contrary to statute.⁵¹ DMH obviously knew this, or it would not have

⁴³ This regulation suffers from the same procedural irregularities as the regulation discussed earlier at n. 37. Essentially, DMH was issuing emergency MHSOAC regulations even though it had no power to do so after 2005.

⁴⁴ C.C.R. Title 9 Section 3400(b)(1)(A), exempts PEI –funded programs from the general requirement that MHSOAC funds shall “[o]ffer mental health services and/or supports to individuals/clients with serious mental illness and/or serious emotional disturbance, and when appropriate their families.”

⁴⁵ See italicized language at n.41, which repeatedly emphasizes “mental illness” and “severe mental illness.” It is difficult to imagine statutory language more explicit than this.

⁴⁶ Go to MHSOAC Home Page: <http://mhsoac.ca.gov/> then click on PEI (on left hand side of home page) to find this document: <http://mhsoac.ca.gov/Counties/PEI/Prevention-and-Early-Intervention.aspx>.

⁴⁷ See California Regulatory Notice Register 2010 (No. 41-Z ,October 8, 2010) at 1631.

⁴⁸ See http://mhsoac.ca.gov/Meetings/docs/PriorMeetingMinutes/2011/MinutesApproved_Sept2011.pdf p. 2: “In the PEI Guidelines, prevention programs are expected to focus on individuals *prior to diagnosis of a mental illness*. This was a policy the Commission came up with several years ago to try to jump-start prevention in California.” (Emphasis added.)

⁴⁹ For examples of some of the programs for non-mentally ill people that have received PEI funding (which include things like yoga, gardening, homework help programs, horse therapy, drumming , anti-bullying school programs and a “hip hop carwash”) see <http://mentallillnesspolicy.org/states/california/capitalweeklyoped.html> (3 articles).

⁵⁰ . See *Morning Star Co. v. State Bd. of Equalization* (2006) 38 Cal.4th 324 , 42 Cal.Rptr.3d 47; 132 P.3d 249, Government Code Section 11340.5(a)(“ No state agency shall issue, utilize, enforce, or attempt to enforce any guideline, criterion, bulletin, manual, instruction, order, standard of general application, or other rule, which is a regulation as defined in Section 11342.600, unless the guideline, criterion, bulletin, manual, instruction, order, standard of general application, or other rule has been adopted as a regulation and filed with the Secretary of State pursuant to this chapter.”), C.C.R. Title 1, Ch. 2, “Underground Regulations.”

⁵¹ See Government Code Section 11349(a)(2) and (4) (requiring OAH to review proposed regulations for statutory authority and consistency with statutory provisions) and California Government Code Section 11350, which provides, “Any interested person may obtain a judicial declaration as to the validity of any regulation or order of repeal by bringing an action for declaratory relief in the superior court in accordance with the Code of Civil Procedure. . . .(b) In addition to

gone to the trouble of attempting to convert the “guidelines” into regulations. Having abandoned the proposed regulation—for whatever reason--DMH/MHSOAC should not have gone back to enforcing the “guidelines” as if they were law. Yet that is what has happened.

This problem was addressed in AB 100 (2012), which took regulatory and fiscal authority away from DMH and oversight responsibility away from MHSOAC, vesting these powers in “the state.” By separate letter, we are requesting “the state” to remove the lapsed “proposed” regulations and illegal “guidelines” from state websites, and to stop MHSOAC from using them in the future. We are hopeful that future regulations, issued by “the state,” will be consistent with MHSA PEI provisions. In the interim, the statute itself is the only available guidance—and Laura’s Law programs are consistent with the statute. PEI funding is therefore available for Laura’s law programs, because MHSA demands it and there is no contrary legal authority

In sum, PEI monies can and should be used to implement Laura's Law. We do not address arguments made by DRC, because they do not exist. DRC did not address this issue in any correspondence we have seen. This is understandable, because DRC faces an ethical quandary, having received close to \$3,000,000.00 in PEI funding itself. It is therefore doubly unlikely that DRC will file suit if a county uses PEI funds to establish a Laura’s Law program.⁵²

F. MHSA Capital and Innovation Funding Is Available to Fund Laura's Law

The remaining funding streams available for Laura's Law can be dealt with quickly. First, while it is difficult to see how Laura's Law would require a building—much less a locked one—MHSA expressly permits using capital funding even for locked facilities, when patient needs “cannot be met in a less restrictive or more integrated setting.” W.I.C. Section 5847(b)(5). *A fortiori*, capital funding may be used to support Laura's Law programs if they have capital needs, regardless of whether the program is viewed as “involuntary.”

Finally, innovation funding is available for Laura's Law programs, which have already been declared “innovative” by the National Association of Counties⁵³, because they meet all four of its purposes:

any other ground that may exist, a regulation or order of repeal may be declared invalid if either of the following exists: (1)The agency’s determination that the regulation is reasonably necessary to effectuate the purposes of the statute, court decision , or other provision of law that is being implemented, interpreted, or made specific by the regulation is not supported by substantial evidence.”

52 Because DRC has received \$2,917,092.00 in Mental Health Services Act prevention/early intervention funds to address “stigma and discrimination” (CalMHSA Standard Services Agreement dated 8/25/11—improbably labeled “suicide prevention”), it is necessarily embroiled in the present controversy over the use of those funds. DRC at minimum faces an appearance problem if it files a suit in which it has a direct financial interest, particularly since one of its board members, Eduardo Vega, is both a Commissioner of MHSOAC and Executive Director of the Mental Health Association of San Francisco, compare http://www.disabilityrightsca.org/about/board_bios.htm with http://www.mhsoac.ca.gov/About_MHSOAC/Commissioner_Bios.aspx. (The Mental Health Association of San Francisco has also received a large PEI-funded contract for a “Center for Dignity, Social Inclusion and Stigma Elimination” see http://www.bizjournals.com/prnewswire/press_releases/2011/10/24/DC91443). Though a DRC suit would likely not be a breach of ethics if there is client consent, California Code of Professional Conduct, Section 3-310, DRC faces complex issues regarding who the client is, and whether the client can give valid consent. DRC has represented that it is not using MHSA funds or federal mental health funds to pursue its AOT issues (Letter to Mary Palafox dated January 24, 2012). However, using different funding does not resolve the appearance problem or the need for client consent, since it does not eliminate DRC’s substantial financial interest in the controversy.. Moreover, there are contractual and statutory restraints on much of the other funding, including state funding, that DRC receives. This raises question of how DRC will pay for a suit, assuming it really contemplates one. Discovery should be served to determine the funding source, in the unlikely event that suit is filed.

53. Nevada County Achievement Award, 2011. The National Association of Counties found, “The Nevada County Assisted Outpatient Treatment (AOT) Program offered a unique solution that bridged the gap for people that are dangerous and in need of treatment, but do not meet criteria for emergency involuntary hospitalization.” See <http://www.naco.org/programs/recognition/Pages/2011AchievementAwards.aspx> February 20,2012.

- (1) To increase access to underserved groups.
- (2) To increase the quality of services, including better outcomes.
- (3) To promote interagency collaboration.
- (4) To increase access to services. W.I.C. 5830(a).

Laura's Law "increase[s] access" to the most visible "underserved group," the one the voters manifestly intended to help: treatment-refusers. A wealth of statistics, summarized at p.4, show that it "increase[s] the quality of services, including better outcomes." Because state and local government will need to cooperate when mentally ill state prisoners are released pursuant to *Brown v Plata* and bound over to local control, it also "promote [s] interagency cooperation." Finally, it will definitely "increase access to services" for a group that badly needs them: treatment-refusers. Thus, Laura's Law programs qualify for "innovation" funds as well. Again, DRC did not address this issue .

CONCLUSION

Suit against a county by DRC is unlikely and easily winnable, probably on demurrer, in the unlikely event that suit is actually brought. Such a lawsuit would in any event be far less expensive than continuing to deal with treatment-refusers through repeated emergency hospitalizations, jail and prison. Moreover, all counties would benefit from a definitive ruling on this question, regardless of outcome.

Laura's Law implementation should be included in local mental health plans and criminal justice realignment plans, using MHSA Adult System of Care funds, Prevention/Early Intervention Funds, Capital Funds, and/or Innovation funds. Before receiving prisoners from the state pursuant to *Brown v Plata*, counties should ensure that they are screened for Laura's Law eligibility.⁵⁴ Counties and the State should cooperate to ensure a safe transition for Laura's Law-eligible inmates to local control, under a Laura's Law order.

54. MHSA Section 7(f) provides that "[e]ach county plan and annual update pursuant to Section 5847 shall consider ways to provide services similar to those established pursuant to the Mentally Ill Offender Crime Reduction Grant Program. Funds shall not be used to pay for persons incarcerated in state prison or parolees from state prisons." The voters' evident intent was to help persons released from prison, but keep funds under local control. To avoid frustrating voters' intent and reliance on a system that does not work for mentally ill prisoners, mentally ill inmates should not be paroled.