



New York Association of Psychiatric Rehabilitation Services, Inc.

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Alameda County Board of Supervisors

Re: AB 1421

Honorable Supervisors,

Thank you for this opportunity to offer the following comments as you consider whether one of the most controversial issues in our field, the use of involuntary outpatient commitment orders for Alameda County residents with psychiatric disabilities.

The issue of AB 1421 and expanding involuntary outpatient commitment laws is one that is deeply important to me, my organization and to our national mental health community.

First, I'd like to provide some background information to help put my comments in some context. I have had over 18 years of direct care experience in a state hospital, an outpatient clinic, local police court and 10 years as director of an Albany based psychiatric rehabilitation program.

I have served over the past 21 years as executive director of the New York Association of Psychiatric Rehabilitation Services or NYAPRS, a unique statewide partnership of tens of thousands of New Yorkers with psychiatric disabilities and community recovery providers that has advanced mental health recovery through grassroots advocacy, empowerment, employment and cultural competence campaigns, provider training programs and the creation of the much replicated peer bridger model of service.

I currently serve on Governor Cuomo's Medicaid Redesign Team and Behavioral Health Subcommittee, on New York's Most Integrated Setting (Olmstead Plan) Coordinating Council, on the Advisory Council for the state's Justice Center for the Protection of People with Special Needs.

Most important, I write to you as someone with over 45 years of hard won recovery from a bipolar disorder and as a family member of daughters who have required psychiatric treatment.

NYAPRS has long been committed to services and policies that best engage and serve people with disabling and serious psychiatric conditions and appreciate the deliberative process you are conducting about how best to help at-risk individuals with these conditions.

We urge you to firmly reject the adoption of Laura's Law costly outpatient commitment initiative and to focus instead on fixing not forcing services onto your neighbors and loved ones. We urge you to reject a return to the policies of the past that over-relied on hospitalization, medication and coercion and to instead invigorate your community systems with innovations that can save both lives and dollars.

Across the country, stalemates around the controversial use of involuntary outpatient treatment orders are amounting to a costly distraction from the strengthening of new policies that are based on fact not fiction.

Since so much of the push for the expansion of outpatient commitment initiatives has centered on the prevention of violence, I'd like to offer the following data:

- **Mental Illnesses and Violence:** numerous studies of the past 15 years¹ have underscored that people with mental illnesses are no more violent than the general public except, like the public, when they use alcohol and drugs. People with mental illnesses are involved in 4% of violent crimes, with one in 70,000 committing murder to strangers.²
- **Mental Illnesses and Victimization:** research demonstrates that people with mental illnesses are 11 times more likely to be victims of general violence and 5 times more likely to be murder victims³
- **Mental Illnesses and Mass Murder:** "No clear relationship between psychiatric diagnosis and mass murder has been established."⁴ "Most of these killers are young men who are not floridly psychotic. They tend to be paranoid loners who hold a grudge and are full of rage."

Despite these findings, between 48-75% of Americans believe that people with mental illnesses are violent and/or make up the majority of mass murderers⁵. These beliefs are often encouraged by defamatory media coverage; for example, 5 of 494 murders in New York City in 2007 were committed by people with mental illnesses⁶ but those incidents were the ones that remained on tabloid front pages for days thereafter.

Before I turn to some analyses of New York's Kendra's Law, I'd like to quote one of its chief researchers Dr. Marvin Swartz of Duke University on the issue of violence: **"People who understand what outpatient commitment is would never say this is a violence prevention strategy. Outpatient commitment isn't going to prevent mass shootings."**⁷

¹ 1998 McArthur Study on "Violence by People Discharged From Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhoods" (Steadman et al); 2009 National Epidemiologic Survey on Alcohol and Related Conditions (Ellenbogen et al);

² 2013 Presentation by Dr. Jeffrey Swanson, Duke University

³ 2005 "Crime Victimization in Adults With Severe Mental Illness" (Teplin et al); 2013 Mental Disorders And Vulnerability To Homicidal Death (Crump et al)

⁴ 2014 'Mass Shootings in America: Moving Beyond Newtown' (Fox and Delateur); 2013 comments by Dr. Michael Stone, professor of clinical psychiatry at Columbia and 'an expert on mass murderers.'

⁵ 2011 Gallup Survey

⁶ <http://www.nydailynews.com/opinion/curbing-madness-article-1.295260>; Wikipedia Timeline of New York City events, crimes and disasters#Murders_by_year

⁷ "AOT Cost-Effectiveness Study Stirs National Debate" Behavioral Healthcare August 22, 2013

I'd like now to turn now to look at other often repeated myths about people with mental illnesses.

Myth: People diagnosed with 'serious and persistent' psychiatric conditions require lifelong supervision.

Fact: Landmark 25-year studies found that even people on backwards with severe disabilities can achieve significant levels of recovery, when they are offered the choice of the right kind and mix of modern services and supports.⁸ But, most people still are not offered or can't get access to the right mix of the right services⁹

Myth: People go off psych meds because of bad brain chemistry (anosognosia).

Fact: Most people who go off psychiatric medications do so because they don't work or because of disturbing side effects.¹⁰

Myth: New York research demonstrates that court mandated outpatient treatment is effective in improving care outcomes.

Fact: In 1999, a legislatively authorized 5 year Involuntary Outpatient Commitment pilot study at Bellevue Hospital provided improved discharge planning and care management to two groups who were deemed at risk for relapse, providing court mandated care to one group in an effort to test whether such mandates provided superior results. "The core finding of the study was that there were no statistically significant differences between the two groups on any outcome measure, including re-hospitalization."¹¹

A Closer Look at New York's Kendra's Law

The Bellevue study is the only study that has provided the most scientific 'head to head' comparison between court mandated and voluntary care, that is, care of the same kind provided to the same types of individuals in the same place.

The 2009 Duke University study was mandated by the NYS legislature, in large part to require such a comparison. While it demonstrates unquestionably positive findings in terms of improved functioning and decreased relapses and incarcerations, the study fails to prove that the court orders are the reason.

There's plenty of research that shows that when people get **priority access to good hospital discharge planning, guaranteed access to scarce case management and community housing and greater provider accountability**, they do a lot better than those who don't.

The Duke study was supposed to compare the outcomes from roughly 8,000 court orders and 7,000 voluntary 'enhanced service packages' but it failed to do so, conceding

⁸ 1997 Maine-Vermont Comparison Study, British Journal of Psychiatry (Harding et al)

⁹ 1998 Patient Outcomes Research Team (PORT) Study, Agency for Health Care Policy and Research (AHCPR); National Institute of Mental Health (NIMH) "Fewer than Half of Schizophrenia Patients Get Proper Treatment" news release

¹⁰ 2005 National Institute of Mental Health 'CATIE' study found high rates (75%) of discontinuation (of atypical antipsychotics were "due to intolerable side effects or failure to adequately control symptoms."

¹¹ 2001 "Assessing the New York City Involuntary Outpatient Commitment Pilot Program" Steadman et al Psychiatric Services

that “available data allow only a limited assessment of whether voluntary agreements are effective alternatives to initiating or continuing AOT” and that **“it is difficult to assess whether the court order was a key ingredient in promoting engagement or whether comparable gains in engagement would have occurred over time with voluntary treatment alone.”**¹²

Finally, just as only 12 of 44 states that have outpatient commitment statutes on their books actually employ this approach,¹³ only a few counties measurably use court orders. New York City and Long Island comprise 82% of the orders, while most other counties have offer voluntary service packages, with 28 upstate counties using 5 or less orders in total since the program’s inception in November of 1999.

The Duke study quoted a psychiatrist from an upstate county: **“We don't do it like downstate...We use the voluntary order first. We don't approach it in an adversarial way.”**

Up until the terrible fallout engendered after the Newton tragedy, efforts to expand or make Kendra’s law permanent had consistently been rejected by the NYS Legislature and advocates

- In 2005, the Legislature refused to make the law permanent and, instead, required an independent study comparing voluntary and involuntary approaches.
- In 2010, the legislature cited the study’s failure to answer the above questions and refused to make it permanent or to expand it.
- In 2011, such proposals died in legislative mental health committees.
- Almost every single leading mental health advocacy group in NY has opposed an expansion or permanent adoption of Kendra’s law including the American Psychiatric Association-NYS, the Association for Community Living, the Center for Disability Rights, the Coalition for the Homeless, the Coalition of Behavioral Health Agencies, the National Association of Social Workers – NYS, the Geriatric Mental Health Alliance, the Greater New York Hospital Association, NYS Rehabilitation Association, NYAPRS, the New York Association on Independent Living, the NYS Conference of Local Mental Hygiene Directors, the Supportive Housing Network of New York and UJA-Federation of New York.

Contrast these efforts with offensive and inaccurate statements meant to promote outpatient commitment like that of D.J. Jaffe: “Assisted Outpatient Treatment is a court order that requires historically violent and non-compliant mentally ill to accept treatment as a condition for living in community.”¹⁴

Outpatient Commitment Programs Have High Costs With Minimal Returns.

Research has shown that, for the cost, there is minimal impact in implementing an outpatient commitment program: it would take 27 court orders to prevent one instance

¹² New York State Assisted Outpatient Treatment Program Evaluation June 30, 2009

¹³ *Assessing Kendra's Law...* Appelbaum Psychiatric Services July 2005; *Torrey's Push for State Laws Sparks Growing Debate over Rights of Patients* Wall Street Journal February 2006

¹⁴ **Save The Hospitals:** Discharging The Mentally Ill From Hospitals Prematurely Endangers Them And Others National Review September 18, 2013.

of homelessness, 85 to prevent one (hospital) readmission, and 238 to prevent one arrest.¹⁵

New York's Kendra's Law program came with a \$32 million startup cost and this didn't include the high cost of needlessly cluttering up our courts and dispatching law enforcement. Further, it came up a \$125 million state investment that enhanced community mobile teams and supported housing.

Investing in the Real Fix

It's not the court order that has allowed Kendra's Law clients to enjoy improved outcomes: it's been the great investment the state has made in expanding critically needed mobile crisis teams, Assertive Community Treatment, family support, peer crisis and support services, supported and supportive housing programs.

These investments cost a good deal of money....but not necessarily new dollars!

For example, New York State is poised to make the single biggest investment in expanded and integrated mental health, addiction and medical treatment services in our lifetime. I want to emphasize that **the vast majority are not new allocations but reinvestment of existing funding from hospital, nursing and adult home settings and the adoption of the most flexible form of federal Medicaid**, the 1915.i Home and Community Based Services Option.

Our ACA-inspired health home provider networks and managed care initiatives are already savings hundreds of millions in reductions from the avoidable use of costly inpatient and emergency services. Our focus is moving the focus and locus of care from the hospital and the office to a 'feet on the street' approach that is already showing great success in helping to engage previously 'hard to serve' at risk individuals.

As an example, NYAPRS was part of an innovative demonstration in Queens between 2008-11 that integrated a NYAPRS peer wellness coach with an Optum nurse and care manager to improve outreach and engagement to 'high cost high needs' individuals.

After 8 repeat visits to his family, our peer wellness coach was finally able to engage a 37 year old man with a long history of severe mental health, addiction and kidney related conditions that had resulted in 7 detox admissions and a total of \$52,000 in Medicaid expenditures. After an intensive effort, our coach was able to help Rohan achieve stability and sobriety and, in the following year, he only had one detox admission and his Medicaid utilization dropped to \$22,000.

As part of our Medicaid Redesign plan, community staff are expected and their agencies will be reimbursed based on their success in engaging and providing successful services to individuals like Rohan.

¹⁵ Compulsory Community and Involuntary Outpatient Treatment for People with Severe Mental Disorders, Kisely, S., Campbell, L., and Preston, N. 2009 *Cochran Database of Systematic Reviews*.

Using reinvestment and HCBS dollars, our state is in the process of rapidly ramping up more responsive approaches that at the same time target the social determinants of illness, making health, housing and economic stability the primary measures of care.

We are currently in the process of expanding our Housing First programs and are developing urgent care walk in centers for individuals and/or families in crisis, employment and educational services, crisis respite houses, transportation and treatment for co-occurring mental health and addiction related conditions.

And there is a mounting emphasis on improving our cultural and linguistic competence to address the injustice that is demonstrated by a disproportionate numbers of people of color in our jails, prisons and on outpatient court orders. Civil commitment should be regarded as a treatment failure and a poor substitute for proper engagement and assistance to these communities!

In recent weeks, I've come to learn a lot more about the innovations that are at play here in Alameda County, including proposals to expand peer crisis respite, housing first, peer bridging and other innovations.

It is my hope, and I understand the hope of hundreds of Alameda County stakeholders, that your county will continue to favor increased use of voluntary outreach, engagement, services and supports initiatives to best help "high needs" individuals, that will keep pace with your extraordinary record of progressive achievement.

Please do not support recommendation number ten, involuntary outreach commitment (AB 1421).

Thank you once again for opportunity to address the Board of Supervisors of Alameda County.

Harvey Rosenthal
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New York Association of Psychiatric Rehabilitation Services