Testimony before the Connecticut General Assembly
Joint Committee on Judiciary

S.B. No. 452 (Raised) An Act Concerning The Care And Treatment Of Persons With Psychiatric Disabilities.

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Senator Coleman, Representative Fox, and members of the Committee:

Thank you for this opportunity to share testimony today before the Judiciary Committee. The issue of how best to serve at risk individuals with psychiatric disabilities is one that is deeply important to me, my organization and state and national community.

I regret that today's hearing falls on the same day we are hosting a large mental health conference in Albany. While I can only submit written comments today, I am eager to come and meet with Committee members later in your session to discuss this issue further.

As background, I'm Harvey Rosenthal and I have served over the past 20 years as executive director of the New York Association of Psychiatric Rehabilitation Services or NYAPRS. NYAPRS is a unique statewide partnership of people with psychiatric disabilities and the providers who support them in over 100 settings across New York.

Since 1981, NYAPRS has worked to improve services, social conditions and public policies for people with psychiatric disabilities by promoting their recovery, rehabilitation, rights and community integration and inclusion. We do so primarily through a well established array of acclaimed grassroots state advocacy, public education and provider training initiatives and through the creation of several innovative, nationally replicated service models. NYAPRS also serves as the state chapter of the United States Psychiatric Rehabilitation Association.

By way of personal background, I currently serve on Governor Cuomo's Medicaid Redesign Team, on New York's Most Integrated Setting Coordinating Council, as a newly appointed member of the CMHS National Advisory Council Subcommittee on Consumer/Survivor Issues and as a longstanding member of the Board of Trustees of the Bazelon Center for Mental Health Law. Like most of my staff and Board, I'm also a person with a psychiatric disability.

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

At the same time, we regard the periodic debates over whether to adopt such initiatives as an increasingly disregarded distraction to the more appropriate, progressive and effective initiatives that are being developed in states around the country, especially in the wake of sweeping changes driven by national and state healthcare reform. I'd like to close my comments with some examples.

Since discussions of this kind are often accompanied by grievously inaccurate depictions of mental illnesses and people with psychiatric conditions and unproven allegations from unscientific 'research,' I'd like to address some of the typical myths that accompany these kinds of discussions.

Myth: People with psychiatric diagnoses pose violent dangers to their communities and require forced treatment.

Fact: Actually, *people with psychiatric disabilities are no more violent than the general public and are far more likely to be victims of violence* except when, like the general public, they abuse alcohol & drugs. (1998 McArthur Study on "Violence by People Discharged From Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhoods" Steadman et al Archives of General Psychiatry 1998).

In fact, we are considerably more likely to be victims of violence (2005 "Crime Victimization in Adults With Severe Mental Illness" study, Teplin et al Archives of General Psychiatry, which found that "more than one quarter of persons with SMI had been victims of a violent crime in the past year, a rate more than 11 times higher than the general population rates."

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 medications* (1997 Maine-Vermont Comparison Study per British Journal of Psychiatry Dr Courtenay Harding et al).

However, **most people still are not offered or can't get access to the right mix of the right services** (1998 Patient Outcomes Research Team (PORT) Study, Agency for Health Care Policy and Research (AHCPR) and the National Institute of Mental Health (NIMH) "Fewer than Half of Schizophrenia Patients Get Proper Treatment").

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

Fact: 75% go off psychiatric medications because they don't work or because of disturbing side effects. Note the 2005 National Institute of Mental Health 'CATIE' 1,400 subject study that found that such medications were....associated with high rates (75%) of discontinuation due to intolerable side effects or failure to adequately control symptoms."

Myth: People with psychiatric diagnoses who are involved in rare violent episodes were noncompliant

Most of the individuals associated with acts of publicly covered violence by or towards them were in fact engaged in community or hospital treatment that failed them. This was true of Andrew Goldstein, who tragically pushed Kendra Webdale to her death (Report Faults Care of Man Who Pushed Woman Onto Tracks, Michael Winerip, New York Times, 11/5/99).

It was also true in the 2007-8 series of tragedies that included 2 fatal police shootings of NYC residents with psychiatric disabilities and a murder by another, David Tarloff. Yet, a NYS/NYC panel that investigated the incidents found the cause to be what NYS OMH Commissioner (and former Connecticut Commissioner) Michael Hogan termed "system failure from top to bottom," sparking a series of recommendations to improve the accountability, monitoring and effectiveness of community treatment rather than any expansions in New York's involuntary outpatient commitment program, Kendra's Law.

Myth: Scientific studies prove that court mandated outpatient mental health treatment is critical to the success of community treatment with at risk individuals.

Fact: What has been consistently proven is that **more active, individualized voluntary engagement and follow up treatment works**, with even individuals with high degrees of impairments.

- 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."* Policy Research Associates, Research Study of the New York City Involuntary Outpatient Commitment Pilot Program, December 1998.
  Nonetheless, following outrageous media depictions about "violent wackos" by NYC tabloids bolstered by "mindless and deadly" depictions by forced treatment proponents from the Treatment Advocacy Center, Kendra's Law was approved in 2000 by the NYS Legislature.
- **A legislatively mandated 2009 Duke University study of Kendra's Law found positive outcomes for those who were given more active and accountable outpatient follow up.....but the *study could not scientifically attribute the results to to the use of court mandates*.** In fact, despite the fact that most counties in NY offered voluntary packages of enhanced care to over 7,000 individuals (compared to over 9,000 court orders), the study did not rigorously compare outcomes

between mandated and voluntary patients and conceded that "available data allow only a limited assessment of whether voluntary agreements are effective alternatives to initiating or continuing AOT."

Kendra's Law is Very Costly

NY's 'AOT' program is budgeted at $32 million a year, which is spent mainly on statewide and county based program coordination, on some jail re-entry services and a medication fund for those not yet on Medicaid.

However, it costs untold millions more in time psychiatrists and clinicians are forced to spend in court, in developing and writing reports...and certainly a great deal more in Medicaid/state aid funds spent by providers who are a part of the mandated service plans.

Involuntary Outpatient Commitment: Rarely Used Across the Nation and in NYS

- While 44 states have such laws on their books, "only a minority actively implement such laws." (*Assessing Kendra's Law: Five Years of Outpatient Commitment in New York* Paul S. Appelbaum, M.D. Columbia University Psychiatric Services July 2005);
- In fact, the nation's greatest proponent for these initiatives conceded that "in only 12 states and the District of Columbia was use of outpatient commitment rated as very common or common." (*A National Survey of the Use of Outpatient Commitment* E. Fuller Torrey, M.D. Robert J. Kaplan, J.D. Psychiatric Services August 1995).
- And in New York, 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."

Efforts to Expand or Make Kendra's Law Permanent Have Consistently Been Rejected by the NYS Legislature and Advocates

- In 2005, concerned about disproportionate use in NYC and LI and with communities of color and no scientific evidence that the court mandate is what drives improved outcomes, the Legislature refused to make the law permanent and, instead, required an independent study.
- 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 once again died in legislative mental health committees in both houses.
- Almost every single leading mental health advocacy group has opposed the law's expansion or permanence 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, Families Together of New York State, the Geriatric Mental Health Alliance, the Greater New York Hospital Association, the Mental Health Association of New York City, the Mental Health Association in New York State, the National Association of Social Workers – NYS, the New York Association of Psychiatric Rehabilitation Services, the New York Association on Independent Living, the New York State Conference of Local Mental Hygiene Directors, the New York State Council for Community Behavioral Healthcare, the New York State Rehabilitation Association, Schuyler Center for Analysis and Advocacy, the Supportive Housing Network of New York and UJA-Federation of New York.

NYC Care Monitoring, Other Service Initiatives Are Providing Better Approaches

Following several tragic deaths involving New York City residents with psychiatric disabilities, a 2008 report conducted by a NYS/NYC Mental Health-Criminal Justice Panel found that, at the heart of these systemic failures, "**poor coordination, fragmented oversight and lack of accountability in the (City's and State's) mental health treatment system" and "inconsistencies in quality of care within the mental health treatment system."** They recommended new tougher standards of care for mental health clinics and the establishment of care monitoring teams for high-need adults, working off of a new database to track the care provided to those individuals.

Alternatives to Court Mandated Commitments

In the wake of state and national healthcare reform initiatives that are calling for more effective and cost effective alternatives to involuntary outpatient commitment.

- This past year, New York State has built on the City initiative and turned to the establishment of Regional Behavioral Health Organizations' charge to improve coordination and post hospital follow up of care to 'high needs' people across the state.
- Most recently, New York is currently rolling out regional "health home" networks of care that are designed to improve the responsiveness, coordination, accountability, effectiveness and cost of innovative community care. As one measure of their effectiveness, Governor Cuomo's NYS Medicaid Redesign Team recommended looking at "reductions in use of court-ordered outpatient treatment for mental health."

- Further, New York is also proud of being the home of several nationally recognized service innovations that have impressive track records of helping to engage and serve 'high needs high cost' individuals on a voluntary basis. These include:

    - **Pathways to Housing's Housing First model**: an innovative 'harm reduction' housing and support program model was able to achieve an 88% service retention rate and general stability among a group of primarily young men of color with psychotic disorders and previous histories of homelessness and non-participation with services...the very same group of those that Kendra's Law proponents would have us believe can only be served via court order.
    - **PEOPLe Inc's Rose House crisis respite house**: replicated in several NYS counties, US states and abroad, this crisis response model run by people with psychiatric histories has a 75% success record in helping divert people from avoidable hospital readmissions in ways that reduce future relapses.
    - **NYAPRS' Peer Bridger/Wellness Coaching initiatives**: have helped 72% of those served to successfully transition from hospitals to recovery supported lives in the community; replicated nationally with similar results.

All of these approaches have successfully engaged the same populations typically given Kendra's Law court orders and helped them to safely advance their own recoveries by emphasizing persistent outreach and engagement, the development of strong treatment relationships.

In closing, in my recent work at the national level with the federal Center for Mental Health Services, it is clear that Connecticut is highly regarded as having one of the best and most progressive model mental health systems in the country.

It is our hope, and we understand the hope of thousands of Connecticut stakeholders, that your state will continue to favor increased use of voluntary outreach, engagement, service and support initiatives to best help "high needs" individuals, matching that extraordinary record of progressive achievement.

Thank you once again for the opportunity to address the committee.