MENTAL ILLNESS POLICY ORG.

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October 21, 2011

Mr. Bill Campbell
Chair
Orange County Board of Supervisors
Hall of Administration
333 W. Santa Ana Blvd.
Santa Ana, CA 92701

Dear Chairman Campbell:

Innacuracies in report on Laura's Law Implementation you received from OC Health Care Agency

Mental Illness Policy Org. is a think-tank dedicated to providing unbiased information to policymakers and media. In our September 9th letter to you and the other supervisors, we indicated that you could anticipate resistance from the Orange County Health Care Agency towards implementing Laura's Law:

> *Some providers of mental health services and peer-support services do not like losing the ability to cherry-pick the easiest to treat for admission to their programs. So they oppose (Laura's Law). Likewise, some mental health officials object to a law that requires them to focus on the most severely disabled.*

The report you received dated October 13, 2011, from Health Care Agency Deputy Director, Mark Refowitz bears out that prediction. While it does a good job of analyzing some difficulties in implementing Laura's Law, it failed to inform the supervisors about the advantages; overstated disadvantages; inflated costs; failed to offset the costs with savings, relied on outdated research, and misled the supervisors about the multiple funding streams already available.

In order to be of further assistance, we have analyzed his report and submit our analysis to you for your consideration.

To help people with severe mental illness, and mitigate the effects of the pending release of mentally ill parolees to Orange County as a result of Brown v. Plata, we recommend Orange County move forward with plans to implement Laura's Law. Our analysis indicates programs like this have reduced violence, incarceration, hospitalization and improved barometers of wellness in other localities. Our review shows that there is no other program in Orange County that allows the provision of services to mentally ill people with a past history of dangerous behavior *who refuse treatment*. Our review shows there are multiple existing funding that can be used for this program.

Please let us know how we can help. Thank you for your efforts on behalf of people with serious mental illness.

Sincerely,

DJ Jaffe
Executive Director

Cc: Mr. John Moorlach
Ms. Janet Nguyen
Mr. Shawn Nelson
Ms. Patricia Bates

Att. *Analysis of Orange County Health Care Agency Response to Board of Suprevisors Request for Plan To Implement Laura's Law*

Analysis of
Orange County Health Care Agency
Response to Board of Supervisors
Request for a Plan to Implement Laura's Law.

October 25, 2011

Prepared by
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Analysis of Health Care Agency response to Board of Supervisor's request for a plan to implement Laura's Law.

Prepared by Mental Illness Policy Org (http://mentalillnesspolicy.org)

Executive Summary

In light of the increasing incidence of homelessness, arrest, incarceration, suicide and dangerous behavior by (and to) people with untreated serious mental illness who *refuse voluntary treatment*, and the impending release of incarcerated mentally ill to Orange County as a result of Brown v. Plata, the Orange County Board of Supervisors asked the Health Care Agency (HCA) to submit a "recommendation to implement" Laura's Law (also known as "Assisted Outpatient Treatment" or "AOT") as a way to keep patients and public safer.[1]

On October 13, 2011, Health Care Agency Deputy Director, Mark Refowitz submitted a report with three options to the supervisors:

1. Provide $5.7-$6.1 million to implement Laura's Law
2. Don't implement Laura's Law
3. Implement more voluntary programs

Mental Illness Policy Org (MIPO) is a think-tank dedicated to providing unbiased information to policy makers about difficult issues surrounding serious mental illness. We examined the report submitted by Mr. Refowitz. We find it does a good job of outlining the difficulties implementing Laura's Law. But we were disturbed by the lack of balance.[2] Option one is the only option that meets the supervisor's goal of delivering services to seriously mentally ill people who have a past history of violence, incarceration, dangerous behavior or multiple rehospitalizations who *refuse voluntary treatment.* It is also the only one likely to be of benefit to mentally ill inmates released to Orange County as a result of Brown v. Plata who *refuse voluntary treatment*.. While option one ostensibly presents a path to implementation, Mr. Refowitz failed to inform the supervisors about the advantages of that plan; overstated alleged disadvantages; grossly inflated the costs; failed to offset the costs with the savings and misled the supervisors about the multiple funding streams available to implement the program including over $75 million in Mental Health Services Act (MHSA) funds which Orange County Health Care Agency (HCA) accepted for FY 11-12 and $556 million since MHSA inception [3]. This MHSA funding could fund complete implementation of Laura's Law without any incremental funds being needed. Options two and three fail to deliver services to seriously mentally ill individuals *who refuse voluntary treatment* and therefore fail to meet the goals of the supervisors.[4]

Background

Current HCA policy is to not provide services to mentally ill people who refuse them until *after* they become 'danger to self or others" or 'gravely disabled'. *After* that, HCA will offer inpatient commitment when requested by police. Laura's Law provides a less restrictive, less expensive alternative to these LPS/5150 inpatient commitments.

Findings

We find Mr. Refowitz's report

1. is biased against AOT
2. ignored the scientific peer reviewed literature on AOT
3. ignored research from Arizona, Florida, New York, North Carolina, Los Angeles, Nevada County and multiple other locations that would have given the supervisors a clearer picture of the advantages of Assisted Outpatient Treatment
4. relied on outdated research and disproved hearsay arguments to present alleged disadvantages.

Recommendation

1. Based on a review of Mr. Refowitz's report, regulations issued by the California Department of Mental Health, AOT literature in peer-reviewed publications; plus actual implementation in New York, Nevada County, Los Angeles and elsewhere, Mental Illness Policy Org suggests the board of supervisors implement Laura's Law.
2. We suggest funding Laura's Law in Orange County by using Mental Health Services Act funds and requiring HCA to make narrowly-defined serious mental "illness" rather than "all other" their top priority.
3. Because Health Care Agency leadership is critical to implementing a successful Laura's Law program (one that keeps patients and public safer), we recommend the supervisors consider replacing Mr. Refowitz with a Behavioral Health Services Director who will work with the board to implement and champion the program.

Att:

(1) Analysis of funding options (2) Recent research on AOT in NY (4) Myths about AOT (5) Detailed Analysis of 10/13/11HCA report to OC Board of Supervisors on implementation of AB1421; (6) Anosognosia Fact Sheet (7) Uncivil Liberties.

[1] The Board of Supervisors first expressed interest in implementing Laura's Law in 2004. http://bos.ocgov.com/legacy3/newsletters/vol2issue11.htm

[2] See September 9, 2011 letter from MIPO to OC Board of Supervisors suggesting HCA will resist any action that requires them to focus greater efforts on serving the most seriously ill.

[3] See "In California's system of care for the mentally ill, leadership is lacking" Jaffe, DJ and Bernard, M. Capital Weekly 8/25/11

[4] The OC Health Care Agency offered to fund option three with existing funds, but would not use those funds for option one.

How to fund Laura's Law using MHSA, Medi-Cal, Medicare, private insurance and patient fees

Prepared by Mental Illness Policy Org

Summary

The October 13, 2011 plan submitted by Mr. Refowitz to the Board of Supervisors did not include a plan on how to fund Laura's Law implementation or mention the several available funding streams in addition to MHSA (Medicaid, Medicare, private insurance, and patient fees) which allow Nevada County to carry on it's program and could do the same for OC. Mr. Refowitz's report indicated that implementing Laura's Law in OC would cost $5.7 million to $6.1 million annually, no MHSA funding can be used and the only BHS programs that can be cut to pay for it are programs serving involuntarily committed patients. None of these statements is true. MHSA funds can be used. The non-MHSA costs of implementing Laura's Law would not exceed $676,000. Involuntary programs would not have to be cut.

OC can fully implement Laura's Law with $476,000-$676,000 and that would be offset by decreased arrest, trial, incarceration and parole.

In "Option 3" HCA states it could "Implement a pilot program of voluntary outpatient services program that has some AB 1421 aspects and is funded by Proposition 63." Mr. Refowitz is correct. The California Department of Mental Health has stated that counties may make existing services available to people regardless of their status as a voluntary or involuntary patients. Put another way, the services currently serving voluntary patients may be used to serve involuntary patients. If that were done, the only missing funding (non-MHSA) would be that required to fund the court order itself. The court order is the core component (and only *incremental* component) required to ensure that these services become available to severely mentally ill individuals *who refuse to voluntarily comply with treatment.* Mr. Refowitz estimated those costs to be $476,000 to $676,000[1]. That expenditure would be offset by significant savings in arrest, incarceration, parole, and other costs that occur when individuals with severe mental illness and a history of dangerousness are put under court order to accept treatment rather than allowed to go untreated.

The $676,000 can be funded without cutting programs that serve involuntary patients.

Mr Refowitz indicated that BHS can only fund AB1421 by cutting services to those who already receive involuntary inpatient services. That is not accurate. Legal restrictions on use of MHSA funds were specific: such programs must be effective in "preventing mental illnesses from becoming severe" or "successful in reducing the duration of untreated severe mental illness." OC has been allocated total of $556,272 million in MHSA revenue ($75 million FY 11-12) but gives much of it programs that do not focus on "severe mental illness". OC HCA could fund the incremental $676,000 in court costs associated with Laura's Law by cutting programs that get MHSA funding but do not meet the criteria of focusing on "severe mental illness". This strategy--sending people with severe mental illness to the front of the line for HCA services rather than the rear—would dramatically improve the quality of care received by people with severe mental illness and keep the patients and public safer. It would reduce the use of 5150s, 911, hospitals jails, courts, police and prisons to serve severely mentally ill individuals refused treatment by HCA. It would allow OC to implement Laura's Law within existing budgets and avoid the kind of incidents that led the OC supervisors to request an implementation plan.

HCA accepted MHSA funding. Not the requirement to spend it on the "severely" mentally ill.

In preparation for receipt of MHSA funding, HCA leaders used a focus-group technique to identify priority populations by age, victimization status, service status, etc.. There was no HCA prioritization on the basis of diagnosis of "severe mental illness". For example, few individuals with "severe mental illness" have access to MHSA PEI funded services in OC while those with mental health issues do. According to the OC "Prevention and Early Intervention Plan":

(T)he wide variety of services and resources to be offered through the Early Intervention Services Project and associated programs will help the County address many of the community mental ***health*** *issues that survey respondents rated as a priority, such as the number of undetected mental* ***health*** *problems, school failure or dropout rates, arrests and incarcerations, removal of children from their homes/families, problems facing military veterans and their families, and unemployment".*

People with severe mental illness are not mentioned. Elsewhere in the plan, priority populations are defined as "(O)lder adults, foster/adopted youth and their families, women at risk for post-partum depression, military veterans and families, homeless individuals, and victims of violence or other trauma." Again: people with severe mental illness as a primary diagnosis are not included. In other documents HCA reveals it is using MHSA funding for programs specifically limited to those "who have achieved a high level of recovery" and programs that intentionally "focus on the person rather than the disease." People with severe mental illness are specifically excluded.

Conclusion:

By allowing court ordered patients access to existing MHSA-funded programs currently limited to voluntary patients, reducing the number of individuals without severe mental illness ("mission-creep") being served by HCA, limiting use of MHSA funds to programs "successful in reducing the duration of untreated severe mental illness" the Orange County Board of Supervisors can fully fund Laura's Law within existing budgeted amounts.

[1] Perhaps less. We used Mr. Refowitz's data to compile the estimate, but as noted elsewhere, the numbers are inflated, for example, by calculating court orders for one year, when they are legislatively limited to six months.

Detailed Analysis of Orange County Health Care Agency Report to the Orange County Board of Supervisors on Implementation of Laura's Law

What the Report Said	What Research Shows	Source
The preliminary cost estimate of an AB 1421 program for Orange County is approximately $5.7 million to $6.1 million annually for the Health Care Agency, Public Defender, and County Counsel.	(1) Mr. Refowitz's report does a good job of noting that the costs of implementation cross various disciplines and departments. (2) The report grossly (and one has to believe, intentionally) overstates the cost of Laura's Law by calculating court orders will last one year, when they are legislatively limited to six months, adding in all treatment costs (not just the incremental costs associated with getting the court order) and failing to offset the real costs with savings from reduced hospitalizations, decreased length of hospitalizations, reduced arrests, trials, and incarcerations. When Nevada County implemented Laura's Law, the found it resulted in a net savings of $500,000 or $2.52 for every $1.00 invested.	Nevada County Cost Savings: California State Association of Counties 2010 Challenge Awards.
	"The (Orange County) Health Care Agency…report found that the law would cost up to $6.1 million annually and would apply to roughly 120 people a year. …San Diego County, meanwhile, has estimated Laura's Law's cost at $2.2 million a year to serve 540 people."	San Diego City Beat, October 19, 2011
There are significant … civil liberty issues	"(I)t is now well settled that (New York's version of Laura's Law) Kendra's Law is in all respects a constitutional exercise of the states police power, and its parens patria power. Further, the removal provisions of the law have withstood constitutional scrutiny."	"New York State Assisted Outpatient Treatment Program Evaluation " Swartz, June 2009 Duke University (Appendix)
There are significant …questions of effectiveness.	When New York when it implemented it's version of Laura's Law (Kendra's Law) research showed • 74% fewer participants experienced homelessness • 77% fewer experienced psychiatric hospitalization • 83% fewer experienced arrest • 87% fewer experienced incarceration. • Individuals in Kendra's Law were also more likely to regularly participate in services and take prescribed medication. • On average, AOT recipients' length of hospitalization was reduced 56% from pre-AOT levels. • 55% fewer recipients engaged in suicide attempts or physical harm to self • 49% fewer abused alcohol • 48% fewer abused drugs • The number of individuals exhibiting good adherence to medication increased by 51%. • The number of individuals exhibiting good service engagement increased by 103%.	March 2005 "Kendra's Law: Final Report on the Status of Assisted Outpatient Treatment." N.Y. State Office of Mental Health and others.
	"Patients given mandatory outpatient treatment - who were more violent to begin with - were nevertheless four times less likely than members of the control group to perpetrate serious violence after undergoing treatment."	February 2010 Columbia University. "Effectiveness and Outcomes of Assisted Outpatient Treatment in New York State" Phelan, Sinkewicz, etc. Psychiatric Services, Vol 61. No 2
(F)unds for the program would very likely have to come from a general fund budget augmentation.	HCA is currently spending Mental Health Services Act Funds on programs that do not focus on severe mental illness. HCA can use these funds to fund Laura's Law within their existing budget.	See funding analysis (att.)
(M)any family members and other advocates have sought to have the program implemented	In addition, the program has support from ACLU Members for LPS Reform Alliance on Mental Illness Orange County American Psychiatric Association Task Force on Outpatient Commitment American Psychiatric Nurses Association California Association of Marriage and Family Therapists California Medical Association California Peace Officers' Association California Psychiatric Association California State Sheriffs' Association	California Treatment Advocacy Coalition and Mental Illness Policy Org

	Mental Illness Policy Org National Commission on Crime Prevention National Sheriff's Association	
(T)he program…has met with opposition from …service providers	Laura's Law, to some extent gives courts the discretion of requiring HCA and HCA-funded providers to allow the most seriously ill admission to their programs. Some providers do not like losing the ability to cherry-pick the easiest to treat for admission to their programs.	September 9, 2011 letter from MIPO to OC Supervisors anticipating why HCA and providers will likely oppose the law (file)
(T)he program…has met with opposition from… disability rights attorneys.	"The opposition to involuntary committal and treatment betrays profound misunderstanding of the principle of civil liberties. Medication can free victims from their illness -- free them from the Bastille of their psychosis -- and restore their dignity, their free will and the meaningful exercise of their liberties."	Uncivil Liberties, Herschel Hardin, Toronto Sun.
A broad range of intensive voluntary services have been implemented in Orange County....($45 million).	Voluntary programs and AB1421 serve two mutually exclusive populations. Voluntary programs serve those who 'voluntarily' accept services. AOT, by definition is for those won't.	AB 1421
Other than the pre-evaluation hold of up to 72 hours and court oversight, AB 1421 does not offer any additional statutory framework for involuntary treatment that is not already in place and available (under the current Lanterman-Petris-Short (LPS) system).	LPS only provides for inpatient commitment. Laura's Law provides for outpatient commitment. Outpatient commitment is less expensive, less restrictive, more humane than inpatient. The pre-evaluation hold procedures under Laura's Law may be instituted *before* a person is already "danger to self or others" or "gravely disabled". Under LPS procedures may only begin *after* someone meets those criteria. Laura's Law prevents dangerousness. LPS requires it.	AB 1421 and LPS
	The court-order which potentially allows for a pre-evaluation hold is what keeps most patients compliant: "The increased services available under AOT clearly improve recipient outcomes, however, the AOT court order, itself, and its monitoring do appear to offer additional benefits in improving outcomes." …"AOT Improves likelihood that providers will serve seriously mentally ill: It is also important to recognize that the AOT order exerts a critical effect on service providers stimulating their efforts to prioritize care for AOT recipients."	June 2009 D Swartz, MS, Swanson, JW, Steadman, HJ, Robbins, PC and Monahan J. New York State Assisted Outpatient Treatment Program Evaluation. Duke University School of Medicine, Durham, NC, June, 2009
AOT has no specific provision for involuntary medication. This limitation is significant because proponents of AOT often cite mandatory medication compliance as a critical element for effective treatment.	True. Existing rules for involuntarily administering medication are not changed by AB1421. However, AOT works even without involuntary medication provisions. Colloquially this is often referred to as "The Black Robe Effect." The process of going in front of a judge is enough to ensure ongoing compliance. "(T)he predicted probability of an Medication Possession Ratio ≥80% improved over time (AOT improved by 31–40 percentage points, followed by enhanced services)"	Changes in Guideline-Recommended Medication Possession After Implementing Kendra's Law in New York Psychiatric Services, Busch, A. , October 2010
	Mr. Refowitz used the lack of an involuntary medication provision as an example of supporters misstating the benefits. Opponents of the law (some funded by HCA) are much more prone pose "forced medication' as a drawback (horror if you will) of Laura's Law.	"Myths surrounding AOT" (attached)
AB 1421 does not allow for any specific release from HIPPA privacy rules regarding access to medical records. As a result, family members may be disappointed to learn that, absent a waiver, AB 1421 does not authorize family participation in AOT treatment.	True. AB1421 was designed to protect consumer rights and be HIPPA-compliant. It allows consumers to sign a waiver so families can receive information about treatment of a loved one. However, absent a waiver, nothing in HIPPA precludes HCA from *receiving* information from families. For example, the family of Kelly Thomas informed HCA of Kelly's need for treatment. Absent Laura's Law, HCA can simply ignore that information. With Laura's Law, HCA would have to take action or document their inaction.	HIPPA/Various media reports on Kelly Thomas featuring quotes from Ron Thomas
MHSA funding may only be used for voluntary programs and that funding of involuntary treatment … personnel is prohibited.	Not true. Nevada and Los Angeles County both use MHSA funds. "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 status"	5/22/07 letter from Steve Mayburg, Director of California Department of Mental Health to Michael Heggarty, Director Nevada County Behavioral Health Services (on file)
Existing HCA voluntary programs cannot be reduced	Misleading. HCA does not need is not to 'cut' voluntary programs like ACT, visits to doctors, rehabiliation, etc., it needs to let court-ordered patients get access to those	5/22/07 letter from Steve Mayburg, Director of

to fund an AB 1421 program because AB 1421 requires that "...no voluntary mental health program serving adults and no children's mental health program may be reduced as a result of the implementation."	programs by implementing AB1421. "The (California) Department (of Mental Health) 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 status"	California Department of Mental Health to Michael Heggarty, Director Nevada County Behavioral Health Services (on file)
(I)t is very likely that AOT programs can be financed only …(by) funding shifts from involuntary mental health programs.	Not true. (1) Programs other than involuntary programs can be cut (see attached). (2) Neither Mr. Refowitz nor the supervisors have the authority to cut a 5150 as they are court mandated.	See funding analysis (att)
	A large body of research shows implementing AOT in itself, reduces the need for expensive involuntary inpatient commitment. "(O)verall (after AOT was introduced) service capacity was increased, and the focus on enhanced services for AOT participants appears to have led to greater access to enhanced services for both voluntary and involuntary recipients.	"Robbing Peter to Pay Paul: Did New York State's Outpatient Commitment Program Crowd Out Voluntary Service Recipients?" Swanson, J. et al. Psychiatric Services, October 2010.
Orange County's current involuntary programs are primarily inpatient and residential treatment programs used for evaluation and treatment of persons already placed on conservatorship.	True. Involuntary inpatient commitment is the most restrictive and expensive form of commitment and the least humane. Laura's Law would offer a less restrictive, less expensive, more humane alternative.	
There are legitimate reasons why a person may want to opt out of treatment, including the fact that side effects of psychiatric medications can be severely uncomfortable and can involve health risks.	True. And AB1421 anticipates that. (1) Medication is not a mandated service. If other treatments are effective, medication does not have to be prescribed. (2) The consumer is given an attorney and a right to participate in developing their own treatment plan. (3) The practice of balancing the benefits of medication with the side-effects are not superceded by Laura's Law. (4) There is no provision in Laura's Law for involuntary medication over objection.	AB1421
	Mr. Rifowitz failed to mention that the number one reason why people with severe mental illness do not comply with treatment, is not 'side-effects', it is anosognosia (unawareness of illness). Individuals with anosognosia often do not recognize they are ill. (Ex. They don't "think" the FBI planted a transmitter in their brain, they "know" it). Because these individuals don't recognize they are ill they see no need to comply with treatment.	See Anosognosia Fact Sheet (att.)
Negative experiences with involuntary treatment may make people more hesitant to access any form of treatment at a later point in time.	Not true. **"**Despite being under a court order to participate in treatment, current AOT recipients feel neither more positive nor more negative about their treatment experiences than comparable individuals who are not under AOT."	New York State Assisted Outpatient Treatment Program Evaluation. Duke University School of Medicine, Durham, NC, June, 2009
	"(L)egal status (voluntary vs. involuntary hospitalization) often does not correlate with patients' actual perception of coercion".	The MacArthur coercion studies: A Wisconsin perspective. Treffert, D.A. (1999). Marquette Law Review, 82, 759-85.
Many clients are opposed to AB 1421 because of civil liberty concerns, as are some client and patients' rights organizations	In Orange County, client "opposition" necessarily comes from 'clients' who have not experienced Laura's Law since it has not been offered. In NY, there was also opposition to prior to implementation by those who hadn't experienced it. After implementation research found that of those enrolled: • 87% of participants interviewed said they were confident in their case manager's ability to help them • 88% said they and their case manager agreed on what is important for them. • 75% reported that AOT helped them gain control over their lives, • 81% said AOT helped them get and stay well • 90% said AOT made them more likely to keep appointments and take medication.	N.Y. State Office of Mental Health "Kendra's Law: Final Report on the Status of Assisted Outpatient Treatment."March 2005
The types of treatment services offered under AB 1421 program are comparable to the new MHSA programs	Not true. Orange County has no services for people with serious mental illness who refuse treatment.	

that have been implemented		
The effectiveness of voluntary outpatient care vs. involuntary outpatient care is an open issue	Not true. Mr. Refowitz presented a 2001 study in support of this claim. Over 25 studies in the last 10 years published in peer-reviewed scientific publications have shown benefits that include reduced crime, reduced arrest, reduced hospital admissions, reduced length of hospitalization, increased medication compliance, improvements to mental health system, increasing mental health system capacity, increased consumer satisfaction, reduced costs, greater public safety, better patient safety and other benefits. **Small sample of more recent studies:** *Reductions in Arrest under Assisted Outpatient Treatment in NY*, Gilbert, A., Psychiatric Services, October, 2010; *Assesing Outcomes for Consumers in NY's Assisted Outpatient Treatment Program*, Swatz, M., Psychiatric Services, 2010; *Changes in Guideline-Recommended Medication Possession after Implementing Kendra's Law*; Psychiatric Services, 2010; *Robbing Peter to Pay Paul: Did NYS Outpatient Commitment Program Crowd out Voluntary Service Recipients*; Swanson, J. Psychiatric Services, October 2010, *Continuing Medication and Hospitalization Outcomes after Assisted Outpatient Treatment*, Van Dorn, Richard. Psychiatric Services, October 2010; *Regional Differences in New York's Assisted Outpatient Treatment Program*, Robbins, P. Psychiatric Services October 2010. Columbia University. Phelan, Sinkewicz, Castille and Link. *Effectiveness and Outcomes of Assisted Outpatient Treatment in NYS* Psychiatric Services, February 2010 Vol 61. No 2 *NYS Assisted Outpatient Treatment Program Evaluation*. Duke University School of Medicine, June, 2009 *"Kendra's Law: Final Report on the Status of Assisted Outpatient Treatment*. NYS Office of Mental Health 3/2005	NY studies (att.). Studies from other states, are available at mentalillnesspolicy.org
Orange County's direct treatment cost for patients similar to those covered by AB 1421 is $23,648 per client annually. approximate contracted direct treatment costs for 120 clients would thus be 120 times $23,648, or $2,837,760.	Erroneous. (1) This calculation assumes OC will not provide services to these individuals even if they were voluntary patients, ie, it includes all costs, rather than just the incremental cost of the court orders. As Mr. Refowitz points out elsewhere, individuals are already entitled to these medical and rehabilitation services and HCA already makes them available. (In fact, his third option, "expand voluntary services" contemplates serving these 120 individuals with no additional funds.) The only cost Laura's Law adds, are the court associated costs. (2) Assumes full year of service, when under Laura's Law may not exceed 180 days.	
$1,883,073 in *other* HCA costs would be incurred (for)…Clinical Psychologists…Licensed masters level clinicians…Bachelor's level and/or paraprofessional staff…A supervisor and support staff… comprehensive education and training …County services and supplies…	(1) While difficult to validate these costs without additional information, it is likely that these also contemplate serving each consumer for a full year even though court orders expire after six months. (2) This calculation includes all costs, rather than just the incremental cost of the court orders. The medication services are due to the person having a severe mental illness and are not an incremental cost of implementing Laura's Law. (3) These costs should be offset by HCA savings from reductions in hospitalizations, length of hospitalizations, involuntary commitments, emergency room visits, etc.	For cost savings see studies previously referred to in this document.
$476,000 and $676,000 annually *Public Defender and County Counsel Costs*	These costs seem high prima facie. In addition, Mr. Refowitz should have shown the offsetting savings from reductions in 911 calls, arrests, prosecutions, incarcerations, parole, involuntary commitments, and other legal services.	For cost savings see studies previously referred to in this document.
HCA would require 6 to 12 months	New York ramped up the program *statewide* in six months	NY 9.60
It might be prudent to postpone implementation until it is determined whether AB 1421 will be extended or made permanent	Sunset provisions were built into AB1421 to force the legislature to periodically review the law to see if there are ways it can be improved. For example, instead of letting Laura's Law sunset on 1/1/2013, the legislature will likely review it to see if it needs improvement to better accommodate the impact of Brown v. Plata which could release many incarcerated mentally ill into OC. There is little likelihood that the legislature would let AB1421 expire because that would allow those under court order to go off treatment with potentially dangerous consequences	

Research from the recent studies conducted on NYS Assisted Outpatient Treatment (Kendra's Law)[1]

Study	Findings
May 2011 Arrest Outcomes Associated With Outpatient Commitment in New York State Bruce G. Link, et al. Ph.D. Psychiatric Services	"For those who received AOT, the odds of any arrest were 2.66 times greater ($p<.01$) and the odds of arrest for a violent offense 8.61 times greater ($p<.05$) before AOT than they were in the period during and shortly after AOT. The group never receiving AOT had nearly double the odds (1.91, $p<.05$) of arrest compared with the AOT group in the period during and shortly after assignment."
March 2005 N.Y. State Office of Mental Health "Kendra's Law: Final Report on the Status of Assisted Outpatient Treatment. "	**Danger/Violence** • 55% fewer recipients engaged in suicide attempts or physical harm to self • 47% fewer physically harmed others • 46% fewer damaged or destroyed property • 43% fewer threatened physical harm to others. • Overall, the average decrease in harmful behaviors was 44%. **Consumer Outcomes** • 74% fewer participants experienced homelessness • 77% fewer experienced psychiatric hospitalization • On average, AOT recipients' length of hospitalization was reduced 56% from pre-AOT levels. • 83% fewer experienced arrest • 87% fewer experienced incarceration. • 49% fewer abused alcohol • 48% fewer abused drugs • Individuals in Kendra's Law were also more likely to regularly participate in services and take prescribed medication. • The number of individuals exhibiting good adherence to medication increased by 51%. • The number of individuals exhibiting good service engagement increased by 103%. **Consumer Perceptions** • 75% reported that AOT helped them gain control over their lives • 81% said AOT helped them get and stay well • 90% said AOT made them more likely to keep appointments and take medication. • 87% of participants interviewed said they were confident in their case manager's ability to help them • 88% said they and their case manager agreed on what is important for them to work on. **Effect on mental illness system** • **Improved Access to Services.** AOT has been instrumental in increasing accountability at all system levels regarding delivery of services to high need individuals. Community awareness of AOT has resulted in increased outreach to individuals who had previously presented engagement challenges to mental health service providers. • **Improved Treatment Plan Development, Discharge Planning, and Coordination of Service Planning.** Processes and structures developed for AOT have resulted in improvements to treatment plans that more appropriately match the needs of individuals who have had difficulties using mental health services in the past. • **Improved Collaboration between Mental Health and Court Systems.** As AOT processes have matured, professionals from the two systems have improved their working relationships, resulting in greater efficiencies, and ultimately, the conservation of judicial, clinical, and administrative resources. o There is now an organized process to prioritize and monitor individuals with the greatest need; o AOT ensures greater access to services for individuals whom providers have previously been reluctant to serve; o Increased collaboration between inpatient and community-based mental health providers.
October 2010: Assessing Outcomes for Consumers in New York's Assisted Outpatient Treatment Program Marvin S. Swartz, M.D., Psychiatric	Consumers who received court orders for AOT appeared to experience a number of improved outcomes: reduced hospitalization and length of stay, increased receipt of psychotropic medication and intensive case management services, and greater engagement in outpatient services.

[1] There have been many studies on AOT programs in multiple states that all show the same positive outcomes as NY. But because NY is the most studied program, and NY has large urban and sparsely populated rural areas, only NY studies are shown in this paper.

Services	
October 2010: Changes in Guideline-Recommended Medication Possession After Implementing Kendra's Law in New York, Alisa B. Busch, M.D Psychiatric Services	In all three regions, for all three groups, the predicted probability of an M(edication) P(ossesion) R(atio) ≥80% improved over time (AOT improved by 31–40 percentage points, followed by enhanced services, which improved by 15–22 points, and "neither treatment," improving 8–19 points). Some regional differences in MPR trajectories were observed.
October 2010 Robbing Peter to Pay Paul: Did New York State's Outpatient Commitment Program Crowd Out Voluntary Service Recipients? Jeffrey Swanson, et al. Psychiatric Services	*In tandem with New York's AOT program, enhanced services increased among involuntary recipients, whereas no corresponding increase was initially seen for voluntary recipients. In the long run, however, overall service capacity was increased, and the focus on enhanced services for AOT participants appears to have led to greater access to enhanced services for both voluntary and involuntary recipients.*
February 2010 Columbia University. Phelan, Sinkewicz, Castille and Link. Effectiveness and Outcomes of Assisted Outpatient Treatment in New York State Psychiatric Services, Vol 61. No 2	Kendra's Law has lowered risk of violent behaviors, reduced thoughts about suicide and enhanced capacity to function despite problems with mental illness. *Patients given mandatory outpatient treatment - who were more violent to begin with - were nevertheless four times less likely than members of the control group to perpetrate serious violence* after undergoing treatment. Patients who underwent mandatory treatment reported higher social functioning and *slightly less stigma*, rebutting claims that mandatory outpatient care is a threat to self-esteem.
June 2009 D Swartz, MS, Swanson, JW, Steadman, HJ, Robbins, PC and Monahan J. New York State Assisted Outpatient Treatment Program Evaluation. Duke University School of Medicine, Durham, NC, June, 2009	We find that New York State's AOT Program improves a range of important outcomes for its recipients, apparently *without feared negative consequences* to recipients. • **Racial neutrality:** We find no evidence that the AOT Program is disproportionately selecting African Americans for court orders, nor is there evidence of a disproportionate effect on other minority populations. Our interviews with key stakeholders across the state corroborate these findings. • **Court orders add value:** The increased services available under AOT clearly improve recipient outcomes, however, the AOT court order, itself, and its monitoring do appear to offer *additional benefits* in improving outcomes. • **Improves likelihood that providers will serve seriously mentally ill**: It is also important to recognize that the AOT order exerts a critical effect on service providers stimulating their efforts to prioritize care for AOT recipients. • **Improves service engagement:** After 12 months or more on AOT, service engagement increased such that AOT recipients were judged to be more engaged than voluntary patients. This suggests that after 12 months or more, when combined with intensive services, AOT increases service engagement compared to voluntary treatment alone. • **Consumers Approve:** Despite being under a court order to participate in treatment, current AOT recipients feel neither more positive nor more negative about their treatment experiences than comparable individuals who are not under AOT.
1999 NYC Dept. of Mental Health, Mental Retardation and Alcoholism Services. H. Telson, R. Glickstein, M. Trujillo, Report of the Bellevue Hospital Center Outpatient Commitment Pilot	• Outpatient commitment orders often assist patients in complying with outpatient treatment. • Outpatient commitment orders are clinically helpful in addressing a number of manifestations of serious and persistent mental illness. • Approximately 20% of patients do, upon initial screening, express hesitation and opposition regarding the prospect of a court order. After discharge with a court order, the majority of patients express no reservations or complaints about the orders. • Providers of both transitional and permanent housing generally report that outpatient commitment help clients abide by the rules of the residence. More importantly, they often indicate that the court order helps clients to take medication and accept psychiatric services. • Housing providers state that they value the leverage provided by the order and the access to the hospital it offers.
1998 Policy Research Associates, Inc. Research study of the New York City involuntary outpatient commitment pilot program.	• Individuals who received court ordered treatment in addition to enhanced community services spent 57 percent less time in psychiatric hospitals than individuals who received only enhanced services. • Individuals who had both court ordered treatment and enhanced services spent only six weeks in the hospital, compared to 14 weeks for those who did not receive court orders.

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MYTHS ABOUT ASSISTED OUTPATIENT TREATMENT

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MYTH: AOT doesn't work.

REALITY: Multiple studies over 10 years proved Kendra's Law

- ✓ Helps the mentally ill by reducing homelessness (74%); suicide attempts (55%); and substance abuse (48%)
- ✓ Keeps the public safer by reducing physical harm to others (47%) and property destruction (43%)
- ✓ Saves money by reducing hospitalization (77%); arrests (83%); and incarceration (87%).

MYTH: AOT will lead to a roundup of mentally ill individuals who will be forced into treatment.

REALITY: AOT's narrowly-focused eligibility criteria, stringent multi-layer administrative requirements, independent judicial review and strong due process protections protect against misuse. Of the 650,000 individuals served by NYS OMH, only 2,300 (.003%) have been allowed into Kendra's Law.

MYTH: If there were more voluntary services, AOT would not be needed.

REALITY: Voluntary programs and AOT serve two mutually exclusive populations. Voluntary programs serve those who 'voluntarily' accept services. AOT, by definition is for those won't accept voluntary services. The existence of AOT does not preclude anyone from accepting voluntary services.

MYTH: Court orders do not confer any benefits beyond those gained from increased services.

REALITY: The 2009 NYS study researched this issue and found

> "The increased services available under AOT clearly improve recipient outcomes, however, the AOT court order, itself, and its monitoring do appear to offer *additional benefits* in improving outcomes."

- ✓ The likelihood of a hospital admission over six months was "highly statistically significant" and lower among AOT recipients than among voluntary recipients.
- ✓ AOT patients were less likely to be arrested than their voluntary counterparts
- ✓ Persons receiving AOT for 12 months or more had a substantially higher level of personal engagement in treatment than those receiving services voluntarily.
- ✓

MYTH: AOT is unconstitutional and infringes on civil liberties.

REALITY: AOT has survived constitutional challenges in multiple states. A 2009 NYS study found:

> "(I)t is now well settled that Kendra's Law is in all respects a constitutional exercise of the states police power, and its parens *patriae* power. Further, the removal provisions of the law have withstood constitutional scrutiny.

The head of a civil liberties union wrote:

> The opposition to involuntary committal and treatment betrays profound misunderstanding of the principle of civil liberties. Medication can free individuals from their illness-- from them from the Bastille of their psychosis, and restore their dignity, their free will, and the meaningful exercicse of their liberties.

AOT also cuts the need for incarceration, restraints, and involuntary inpatient commitment, allowing individuals to retain more liberties.

MYTH: Assisted Outpatient Treatment is not racially neutral.

REALITY: A 2009 NYS study researched this issue and found:

> "(N)o evidence that the AOT Program is disproportionately selecting African Americans for court orders, nor is there evidence of a disproportionate effect on other minority populations. Our interviews with key stakeholders across the state corroborate these findings."

MYTH: Consumers oppose AOT and it frightens consumers from seeking voluntary services

REALITY: A study in *Psychiatric News* of involutarily treated discharged psychiatric patients found that 60 percent retrospectively favored having been treated against their will. A 2005 NYS study of consumers found:

- ✓ 75% reported that AOT helped them gain control over their lives;
- ✓ 81% said that AOT helped them to get and stay well;
- ✓ 90% said AOT made them more likely to keep appointments and take medication.

The 2009 independent study found:

> "On the whole, AOT recipients and non-AOT recipients report remarkably similar attitudes and treatment experiences. That is, despite being under a court order to participate in treatment, current AOT recipients feel neither more positive nor more negative about their mental health treatment experiences than comparable individuals who are not under AOT."

MYTH: Assisted Treatment forces people to take medications.

REALITY: A court may order someone to take medication, but may not enforce the order. In most cases, that is enough to ensure compliance. But if not, medication over objection may only be made after a de novo competency hearing. AOT does not supercede the need for a competency hearing. Involuntarily administered medication can only happen in a licensed setting, eg hospital, and then except in dire emergency can only occur after a due process hearing.

MYTH: AOT requires individuals to take dangerous medicines.

REALITY: Overdosing on anti-psychotics is very difficult. However, all medicines, including those used to treat neurobiological disorders have different efficacy and side effect profiles. Assisted Treatment Legislation does not supercede the practice of balancing the side effects of the medicines with the likely benefits. Consumers are given specific rights to decide what medications they do and don't want.

MYTH: There is wide opposition to AOT

REALITY: AOT has wide support from constituencies as diverse as the National Alliance on Mental Illness, National Sheriff's Association, American Psychiatric Association, and National Crime Prevention Council. It is supported by consumers in AOT. Opposition is limited to those who do not believe mental illness exists and Scientologists. Other opposition comes from trade associations representing providers of non-medical voluntary services (peer and non-peer) and some mental health officials. They oppose the possibility of being forced to accept more symptomatic patients for admission to their programs. Currently the most symptomatic are often moved to and treated in the criminal justice system. AOT could keep them in the mental health system.

MYTH: Mental Health Commissioners embrace AOT because it forces patients into care

REALITY: Most (not all) mental health commissioners oppose AOT because it allows courts to require them to provide services to individuals can be highly symptomatic. Many mental health commissioners and providers prefer to serve the largest number of people ("mission-creep) or easiest to treat, as opposed to the most seriously disabled.

Anosognosia (lack of awareness of illness) affects up to 50% of individuals with schizophrenia and 40% with bipolar.

Anosognosia is a major reason some people with severe mental illness refuse medications and why voluntary programs don't serve their needs.

Summary: Impaired awareness of illness (anosognosia), not side-effects, is the single largest reason why individuals with schizophrenia and bipolar disorder do not take their medications. Anosognosia is caused by damage to specific parts of the brain, especially the right hemisphere. It affects approximately 50 percent of individuals with schizophrenia and 40 percent of individuals with bipolar disorder. Impaired awareness of illness is very difficult for other people to comprehend. To other people, a person's psychiatric symptoms seem so obvious that it's hard to believe the person is not aware he/she is ill. But a person with mental illness and anosognosia may not 'think' the FBI planted a transmitter in their head, they "know" it. Only treatment can restore their reasoning ability, **but the failure to believe they are ill causes them to reject the treatment.** These individuals often can not be reached by voluntary services and need assisted forms of treatment.

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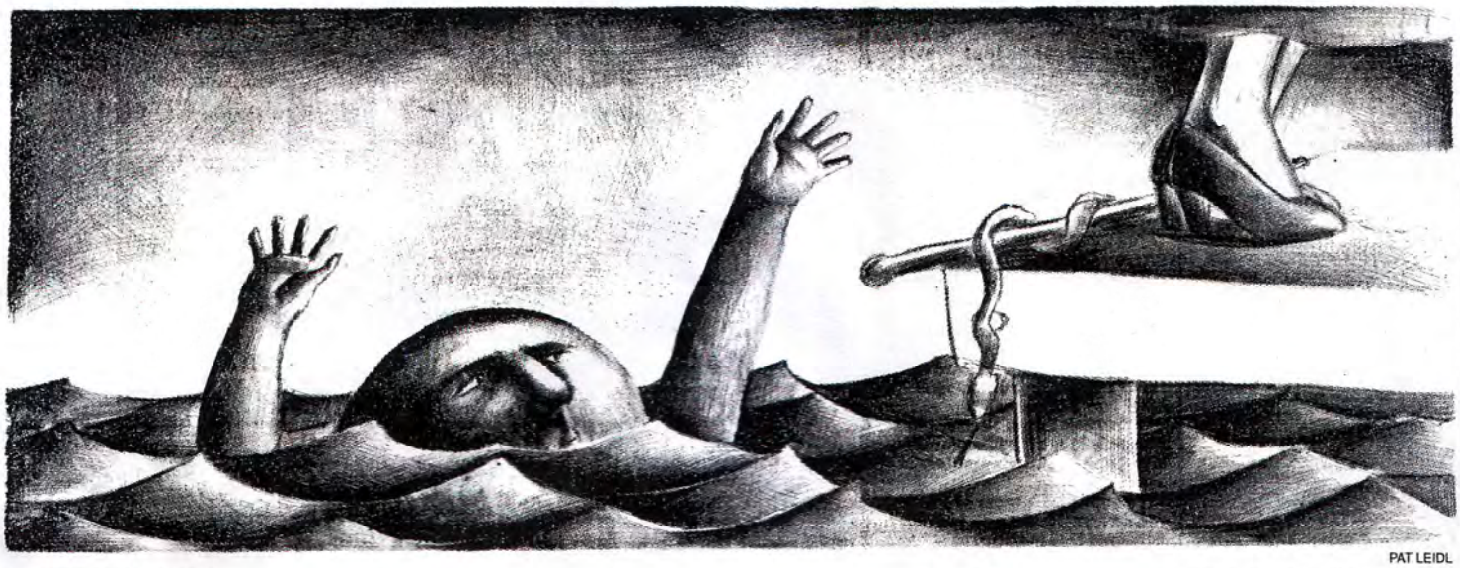

PAT LEIDL

Uncivil liberties

Far from respecting civil liberties, legal obstacles to treating the mentally ill limit or destroy the liberty of the person

by HERSCHEL HARDIN
... a West Vancouver author and consultant. He was a director of the B.C. Civil Liberties Association from 1965 to 1974, and has been involved in defence of liberty and free speech through his work with Amnesty International. One of his children has schizophrenia.

THE PUBLIC is growing increasingly confused by how we treat the mentally ill.

More and more, the mentally ill are showing up in the streets, badly in need of help. Incidents of illness-driven violence are reported regularly — incidents which common sense tells us could easily have been avoided. And this is just the visible tip of the greater tragedy — of many more sufferers deteriorating in the shadows and, often, committing suicide.

People ask in perplexed astonishment: "Why don't we provide help and treatment, when the need is so obvious?" Yet every such cry of anguish is met with the rejoinder that unrequested intervention is an infringement of civil liberties.

This stops everything. Civil liberties, after all, are a fundamental part of our democratic society.

The rhetoric and lobbying results in legislative obstacles to timely and adequate treatment, and the psychiatric community is cowed by the anti-treatment climate produced.

Here is the Kafkaesque irony: Far from respecting civil liberties, legal obstacles to treatment limit or destroy the liberty of the person.

The best example concerns schizophrenia. The most chronic and disabling of the major mental illnesses, schizophrenia involves a chemical imbalance in the brain, alleviated in most cases by medication. Symptoms can include confusion; inability to concentrate, to think abstractly, or to plan; thought disorder to the point of raving babble; delusions and hallucinations; and variations such as paranoia.

Untreated, the disease is ravaging. Its victims cannot work or care for themselves. They may think they are other people — usually historical or cultural characters such as Jesus Christ or John Lennon — or otherwise lose their sense of identity. They find it hard or impossible to live with others, and they may become hostile and threatening. They can end up living in the most degraded, shocking circumstances, voiding in their own clothes, living in rooms overrun by rodents — or in the streets. They often deteriorate physically, losing weight and suffering corresponding malnutrition, rotting teeth and skin sores. They become particularly vulnerable to injury and abuse.

TORMENTED by voices, or in the grip of paranoia, they may commit suicide or violence upon others. (The case of a Coquitlam boy who killed most of his family is only one well-publicized incident of such delusion-driven violence.) Becoming suddenly threatening or bearing a weapon, say a knife — because of a delusionally perceived need for self-protection — the innocent schizophrenic may be shot down by police.

Depression from the illness, without adequate stability — often as the result of premature release — is also a factor in suicides.

Such victims are prisoners of their illness. Their personalities are subsumed by their distorted thoughts. They cannot think for themselves and cannot exercise any meaningful liberty.

The remedy is treatment — most essentially, medication. In most cases, this means involuntary treatment because people in the throes of their illness have little or no insight into their own condition. If you think you are Jesus Christ or an avenging angel, you are not likely to agree that you need to go to hospital.

Anti-treatment advocates insist that involuntary committal should be limited to cases of imminent physical danger — instances where a person is going to do serious bodily harm to himself or somebody else.

But the establishment of such "dangerousness" usually comes too late — a psychotic break or loss of control, leading to violence, happens suddenly. And all the while, the victim suffers the ravages of the illness itself, the degradation of life, the tragic loss of individual potential.

The anti-treatment advocates say: "If that's how people want to live (babbling on a street corner, in rags), or if they wish to take their own lives, they should be allowed to exercise their free will. To interfere — with involuntary committal — is to deny them their civil liberties." As for the tragedy that follows from this dictum, well, "That's the price that has to be paid if society is to maintain its civil liberties."

Whether or not anti-treatment advocates actually voice such opinions, they seem content to sacrifice a few lives here and there to uphold an abstract doctrine. Their intent, if noble, has a chilly, Stalinist justification — the odd tragedy along the way is warranted to ensure the greater good.

THE NOTION that this doctrine is misapplied escapes them. They merely deny the nature of the illness.

Health Minister Elizabeth Cull appears to have fallen into the trap of this juxtaposition. She has talked about balancing the need for treatment and civil liberties, as if they were opposites. It is with such a misconceptualization that anti-treatment lobbyists promote legislation loaded with administrative and judicial obstacles to involuntary committal.

The result, inadvertently for Cull, Attorney-General Colin Gabelmann (as regards guardianship legislation) and the government, will be a certain number of illness-caused suicides every year, just as surely as if those people were lined up annually in front of a firing squad. Add to that the broader ravages of the illness, and keep in mind the manic-depressives who also have a high suicide rate.

A doubly ironic downstream effect: the inappropriate use of criminal prosecutions against the mentally ill, and the attendant cruelty of committal to jails and prisons rather than hospitals. B.C. Corrections once estimated that almost one-third of adult offenders and close to one-half of young offenders in the provincial corrections system have a diagnosable mental disorder.

Clinical evidence has now indicated that allowing schizophrenia to progress to a psychotic break lowers the possible level of future recovery, and subsequent psychotic breaks lower that level further — in other words, the cost of withholding treatment is permanent damage.

Meanwhile, bureaucratic roadblocks, such as time-consuming judicial hearings, are passed off under the cloak of "due process" — as if the illness were a crime with which one is being charged and hospitalization for treatment is a punishment. Such cumbersome restraints ignore the existing adequate safeguards — the requirement for two independent assessments and a review panel to check against overlong stays.

How can so much degradation and death — so much inhumanity — be justified in the name of civil liberties? It cannot.

The opposition to involuntary committal and treatment betrays a profound misunderstanding of the principle of civil liberties. Medication can free victims from their illness — free them from the Bastille of their psychoses — and restore their dignity, their free will and the meaningful exercise of their liberties. ❑