MENTAL ILLNESS POLICY ORG.
UNBIASED INFORMATION FOR POLICYMAKERS + MEDIA
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WHY $800 Million THRIVE/NYC IS FAILING

	IT THROWS MONEY HERE[1]			THAT SHOULD BE USED HERE		
Evidence	Mental Health First Aid (MHFA)	Peer Support	Billboards TV Ads (Stigma/Suicide Outreach)	Kendra's Law (Assisted Outpatient Treatment)[2]	Hospitals	Housing
Cuts Homelessness	No	No	No	**Yes**	**Yes**	**Yes**
Cuts Arrest	No	No	No	**Yes**	**Yes**	**Yes**
Cuts Incarceration	No	No	No	**Yes**	**Yes**	**Yes**
Cuts Suicide	No	No	No	**Yes**	**Yes**	**Yes**
Cuts hospitalization	No	No	No	**Yes**	**N/A**	**Yes**

THRIVE/NYC shuns the seriously ill and focuses on "improving mental wellness" in all others.

100% of population can have mental wellness improved; 18% have something in DSM (half is mild); 4% have serious mental illness. It is the seriously ill, not 'worried-well' who become homeless, hospitalized, suicidal and violent without treatment. We should focus the mental health budget on them. ThriveNYC focuses on pop-psychology for the highest functioning, not treatment for the seriously ill.

- Thrive/NYC funds "prevention" but serious mental illness can't be prevented because we don't know what causes it.
- Thrive/NYC funds "early intervention" but we can't predict who will become seriously ill until after the symptoms first appear (late teens/early 20s for schizophrenia and bipolar).
- Thrive/NYC funds "trauma," but trauma is not a mental illness. Everyone loses a loved one, loses a job, experiences accidents, etc. PTSD is mental illness and even that runs from mild to severe.
- Thrive/NYC diverts mental health funds to programs that do not help seriously mentally ill.

Examples: (1) DeBlasio cut $500K from Fountain House budget. They couldn't do outreach to Deborah Danner, a member who was then shot by police. (2) Bratton told Manhattan Institute two biggest problems of his officers are they can't get patients into hospitals or Kendra's Law. (3) ThriveNYC identifies the 73,000 students who report feeling sad or hopeless each month as a priority. Sad and hopeless are not mental illnesses.

[1] MHFA Research at http://mentalillnesspolicy.org/samhsa/mental-health-first-aid-fails.html. Numerous peer support studies show no benefit beyond ordinary care: Cochrane Collaborative, "Consumer-Providers of Care for Adult Clients of Statutory Mental Health Services." PR ineffective at reducing sucides: "Suicide Prevention Strategies" *Journal o American Medical Association* 294, no. 16 http://jama.jamanetwork.com/article.aspx?articleid=201761

[2] AOT (Kendra's Law) Research at http://mentalillnesspolicy.org/national-studies/aotworks.pdf

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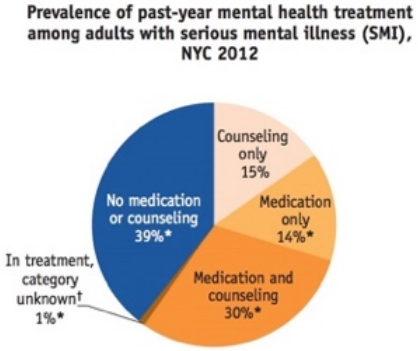
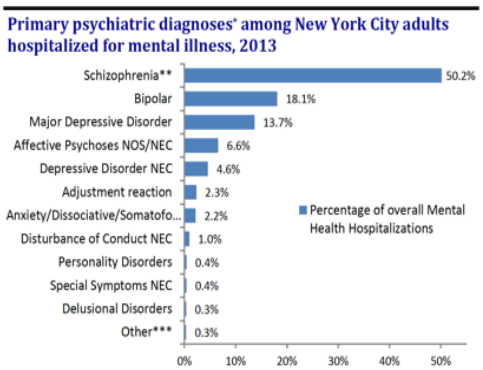
NYC DATA SETS

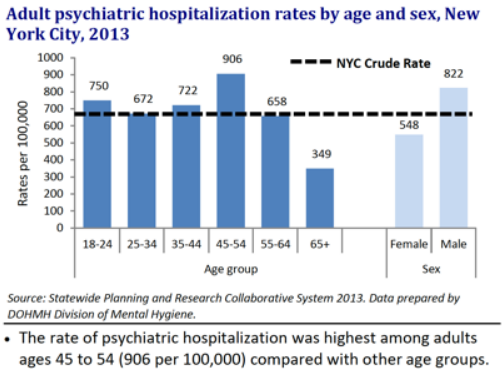
100% of pop. can have mental health improved, 18% have something in DSM, 4% have Serious Mental Illness

Per NYC Vital Signs: Serious Mental Illness Among Adults (2015) and EPI Brief #71 (2016)

- Approximately 239,000 adult New Yorkers (4%) had a serious mental illness (SMI).
- SMI in Whites (5%) and Hispanics (7%) was higher than Blacks (1%) or Asians (1%). Nearly 40% of adult NYers with SMI (95,000) did not receive mental health treatment in past year. Most hospitalizations were Schiz and bipolar, and age 45-54. *(Vital signs: http://www1.nyc.gov/assets/doh/downloads/pdf/survey/survey-2015serious-mental-illness.pdf 2016 EPI Brief https://www1.nyc.gov/assets/doh/downloads/pdf/epi/databrief71.pdf)*

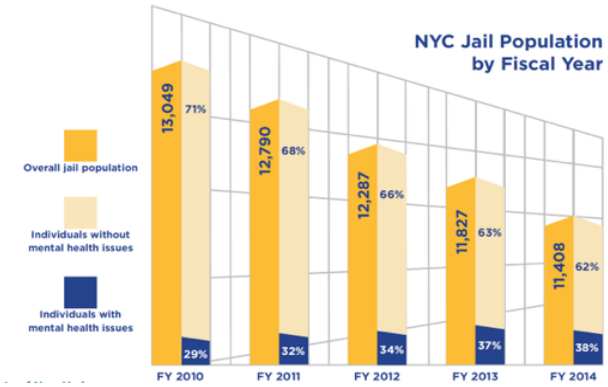






Per Mayor's Task Force on Behavioral Health and Criminal Justice System (2014)

While the number of people incarcerated in city jails has gone down, the percentage with mental illness shot up 30 percent from 2010 to 2014 Of the 400 people jailed more than 18 times in the last five years, 67% have a mental health need; 21% have a serious mental illness. The 400 accounted for over 10,000 jail admissions and 300,000 days in jail. 85% of their charges were misdemeanors or violations. *http://mentalillnesspolicy.org/kendras-law/DeBlasioTaskForceReport.pdf*



Per NYPD Office of Inspector General 2017 Report on Mentally Ill

NYPD calls for Emotionally Disturbed Persons (EDP) are up 10% from 143K in 2014 to 157K in 2016. (*FN 2 http://www1.nyc.gov/assets/oignypd/downloads/pdf/Reports/CIT_Report_01192017.pdf)*

Per 2017 NYC Mayor's Management Report (MMR) and NYS OMH Transformation Report

Readmission: NYC 2017 MMR says 30 day psych readmit rate is 7.3% (pg 159). OMH Transformation Report says NYC hospital psych readmit rates range from 23-34% (pg 22). State avg. is 18%. Why the difference? *(NYC MMR: http://www1.nyc.gov/assets/operations/downloads/pdf/pmmr2017/2017_pmmr.pdf. OMH Transformation: https://www.omh.ny.gov/omhweb/transformation/docs/report-november-2016.pdf*

Kendra's Law (Assisted Outpatient Treatment)

- Guesstimate: 4,000 city residents should be in Kendra's Law (*50% NYS total. http://mentalillnesspolicy.org/national-studies/aotbystatecosts.html)*
- OMH says NYC has 1,448 currently active (2/17), down from 1,460 (11/16). NYC MMR says 1,667. *(http://bi.omh.ny.gov/aot/statistics?p=under-court-order 2058)*
- AOT cut homelessness, arrests, incarceration, and hospitalization about 70% each. It saves taxpayers 50% of the cost of care. *(http://mentalillnesspolicy.org/kendras-law/research/kendras-law-studies.pdf)*

SADNESS ISN'T THE PROBLEM

Bill de Blasio's mental-health plan is too broad to help New York's severely mentally ill.

D. J. Jaffe, December 8, 2015, City Journal

At a recent Manhattan Institute forum, New York City police commissioner William Bratton noted two factors impeding his officers from helping the city's mentally ill homeless population. "Doctors are reluctant to commit . . . someone to a facility where they're going to be retained [involuntarily]," he said. "Secondly, there are so few beds or facilities for these people." Four days later, Bratton's boss—Mayor Bill de Blasio—introduced ThriveNYC, an $850 million package of 58 mental health initiatives. As ambitious as it is, the mayor's agenda fails to solve the two key problems that Bratton identified.

ThriveNYC is a something-for-everyone plan designed to encourage the mental well-being of all New Yorkers, as opposed to delivering treatment to the most seriously mentally ill. It wraps a long list of worthy social-service programs—such as improving parks, creating public art, raising grades, achieving full employment, ending poverty, and fighting discrimination—in a mental-health narrative and diverts scarce mental-health funds to these ancillary programs. De Blasio justifies this lack of focus by claiming that everything from economic adversity to neighborhood violence to divorce are threats to mental health. "Taking a public-health approach to mental illness means examining these root causes," he says. While this laundry list of unfortunate outcomes may in fact make a particular individual feel unhappy, they aren't the root cause of schizophrenia or bipolar disorder, the two mental illnesses frequently found in the homeless, hospitalized, incarcerated, and violent. As the Manhattan Institute's Fred Siegel told senior de Blasio advisor Phil Walzak at the forum, "The problem is not sad people." The audience tittered, but indeed, sadness is one of the issues the de Blasio plan intends to combat.

De Blasio argues his approach delivers "prevention" through "early intervention." It sounds logical, but serious mental illnesses can't be prevented because their causes are not known. And while early intervention can prevent mental illness from becoming more severe and disabling, doing so requires focusing on those who are actually sick, not those who aren't.

The plan's two most touted initiatives—Mental Health First Aid (MHFA) training for 250,000 New Yorkers and a mental-health television campaign—are useless and wasteful. Both are premised on the idea that the mentally ill are so asymptomatic that special training is needed in order to identify and refer them. Identifying the mentally ill has never been a problem for the public or police. Almost all New Yorkers understand that a homeless person walking around shouting "I am the Messiah" has a mental illness. Families beg for treatment for their seriously mentally ill adult children and can't get it. Eighty-four mentally ill people were admitted to New York City jails more than 18 times in 2014. The public doesn't need training to identify them. Police have their names. What's lacking is treatment.

De Blasio pretends that his new referral programs for non-existent treatment programs will solve the problem. It won't. The mayor's heart may be in the right place, but he's been misled by advocates looking to get their hands on the city's mental-health funding stream. De Blasio should listen to Bratton and take a different approach. Focus resources on the 4 percent of New Yorkers with serious mental illness. Ninety-three thousand individuals—41 percent of New York City adults with a serious mental illness—went untreated in the past year. Only 33 percent of those discharged from city psychiatric hospitals were linked to outpatient treatment. De Blasio should get treatment for these people before he turns any mental-health dollars over to New Yorkers dealing with divorce and unemployment.

One solution Bratton and families of the seriously ill strongly support is an expansion of Kendra's Law, which allows judges to require a subset of the seriously ill who have already accumulated multiple episodes of homelessness, arrest, and incarceration to accept violence-preventing treatment so that they can live safely in the community. ThriveNYC—and de Blasio's previously announced, still unimplemented plan, NYC Safe—only paid lip service to Kendra's Law, even though it has reduced homelessness, arrest, and violence significantly. Eighty percent of those retained for treatment under Kendra's Law said that the program helped them "get well and stay well." By reducing incarceration and hospitalization, Kendra's Law halved the cost to taxpayers of caring for these individuals.

Kendra's Law forces mental-health programs to do what they won't do voluntarily: accept the most serious cases. Bratton also calls for creating more hospital beds so that his officers have some place to take the seriously ill—something lacking in the mayor's plan. The 24-hour crisis-stabilization centers de Blasio proposes may help crack and meth addicts, but serious mental illness can't be stabilized in 24 hours.

The mayor's plan thankfully includes two initiatives—new supported housing and the addition of 400 clinicians—that will help if they end up being more than just press releases and are directed to people with serious mental illness. Commissioner Bratton talked of plans to improve NYPD training for handling the mentally ill, but police only step in when the mental-health system fails. Preventing failure would be a better plan. We know who the seriously mentally ill are, where they are, and what they need. ThriveNYC does worse than failing to help them. It pretends they don't exist.

DJ Jaffe is executive director of Mental Illness Policy Org, a non-profit, non-partisan think-tank on serious mental illness.
https://www.manhattan-institute.org/html/treating-serious-mental-illness-nyc.html

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- **Assisted Outpatient Treatment (AOT, Kendra's Law) is the *only* program proven to cut homelessness, arrest, incarceration, hospitalization over 70%**

Overview: *Kendra's Law is NY's most successful program for the most seriously mentally ill. AOT allows judges to order someone who* ***already*** *accumulated* ***multiple*** *episodes of incarceration or needless hospitalization to stay in six months of mandated and monitored treatment while they continue to live free in the community. It is only available to those who* ***already refused*** *to accept voluntary treatment that was made available to them. By replacing expensive incarceration and hospitalization with mandated outpatient treatment, Kendra's Law cuts costs to taxpayers by 50%. Mayor De Blasio should make greater use of this program and provide a way families can alert the city to people who could benefit.*

Kendra's Law comes up for renewal in 2017. State and city should provide mandatory evaluation of all prisoners being discharged who received mental health services while incarcerated to see what they need to keep safe in the community, possibly including enrollment in Kendra's Law. Everyone being discharged from involuntary treatment from city hospitals should be evaluated. These are the two highest risk groups. The state and city should set up and publicize a number for people to call if they want someone evaluated for Kendra's Law.

Kendra's Law Study	Results
New York State Office of Mental Health. Kendra's Law: Final Report on the Status of Assisted Outpatient Treatment. Report to Legislature, Albany: New York State, 2005, 60. http://mentalillnesspolicy.org/kendras-law/research/kendras-law-study-2005.pdf (Accessed 2/8/15).	**Reduces danger and 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% **Improves consumer outcomes** 74% fewer participants experienced homelessness 77% fewer experienced psychiatric hospitalization 56% reduction in length of hospitalization. 83% fewer experienced arrest 87% fewer experienced incarceration 49% fewer abused alcohol 48% fewer abused drugs **Consumer perceptions were positive** 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 meds 87% of participants said they were confident in their case manager's ability 88% said they agreed with case manager on what was important to work on **Has positive 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." *"AOT ensures greater access to services for individuals whom providers have previously been reluctant to serve" "There is now increased collaboration between inpatient and community-based providers."*
Allison Gilbert, Lorna Mower, Richard Van Dorn, Jeffrey Swanson, Christine Wilder, Pamela Clark Robbins, Karli Keator, Henry Steadman, Marvin Swartz. "Reductions in arrest under assisted outpatient treatment in New York." Psychiatric Services 61, no. 10 (2010): 996–999.	**Reduces arrest:** "The odds of arrest for participants currently receiving AOT were nearly two-thirds lower (OR=.39, p<.01) than for individuals who had not yet initiated AOT or signed a voluntary service agreement."

http://dhs.iowa.gov/sites/default/files/GilbertReductionsInArrestUnderAOT_083012.pdf	
Bruce Link, Matthew Epperson, Brian Perron, Dorothy Castille, Lawrence Yang. "Arrest outcomes associated with outpatient commitment in New York State." Psychiatric Services 62, no. 5 (2011): 504–508. http://deepblue.lib.umich.edu/bitstream/handle/2027.42/84915/LinkEpperson_2010.pdf (Accessed 2/8/15).	**Reduces arrest:** "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."
Jo Phelan, Marilyn Sinkewicz, Dorothy Castille, Steven Huz, Bruce Link. "Effectiveness and outcomes of assisted outpatient treatment in New York State." Psychiatric Services 61, no. 2 (2010): 137–143. http://ps.psychiatryonline.org/doi/pdf/10.1176/ps.2010.61.2.137	**Reduces violence: "**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."
Jeffrey Swanson, Richard Van Dorn, Marvin Swartz, Pamela Clark Robbins, Henry Steadman, Thomas McGuire, John Monahan. "The cost of assisted outpatient treatment: can it save states money?" American Journal of Psychiatry 170 (2013): 1423–1432. http://ajp.psychiatryonline.org/doi/pdf/10.1176/appi.ajp.2013.12091152 (Accessed 2/8/15).	**Saves money.** In New York City, net costs declined 50% in the first year after AOT began and an additional 13% in the second year. In non-NYC counties, costs declined 62% in the first year and an additional 27% in the second year. This was in spite of the fact that psychotropic drug costs increased during the first year after initiation of AOT by 40% and 44% in the city and five-county samples, respectively. The increased community-based mental health costs were more than offset by the reduction in inpatient and incarceration costs.
Alisa Busch, Christine Wilder, Richard Van Dorn, Marvin Swartz, Jeffrey Swanson. "Changes in guideline-recommended medication possession after implementing Kendra's Law in New York." Psychiatric Services 61, no. 10 (2010): 1000–1005. http://ps.psychiatryonline.org/doi/full/10.1176/ps.2010.61.10.1000 (Accessed 2/8/15).	**Increases medication compliance:** "In all three regions, for all three groups, the predicted probability of an M(edication) P(ossession) 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).
Marvin Swartz, Christine Wilder, Jeffrey Swanson, Richard Van Dorn, Pamela Clark Robbins, Henry Steadman, Lorna Moser, Allison Gilbert, John Monahan. "Assessing outcomes for consumers in New York's assisted outpatient treatment program." Psychiatric Services 61, no. 10 (2010): 976–981. Available at http://ps.psychiatryonline.org/doi/pdf/10.1176/ps.2010.61.10.976 (Accessed 2/8/15). Marvin Swartz, Jeffrey Swanson, Henry Steadman, Pamela Clark Robbins, John Monahan. "New York State assisted outpatient treatment program evaluation." Duke University School of Medicine, Durham, NC, 2009. https://www.omh.ny.gov/omhweb/resources/publications/aot_program_evaluation/	**Provides equal access to care:** ***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 AOT court order, itself, and its monitoring do appear to offer additional benefits in improving outcomes." *AOT improves the 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." ***AOT 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…current AOT recipients feel neither more positive nor more negative about their treatment experiences than comparable individuals who are not under AOT." **Reduces hospitalization:** The likelihood of psychiatric hospital admission [and days of hospitalization] was significantly reduced by approximately 25% during the initial six-month court order…and by over one-third during a subsequent six-month renewal of the order …. Improvements were also evident in receipt of psychotropic medications and intensive case management services. Analysis of data from case manager reports showed similar reductions in hospital admissions and improved engagement in services."
Richard Van Dorn, Jeffrey Swanson, Marvin Swartz, et. al. "Continuing medication and hospitalization outcomes after assisted outpatient treatment in New York" Psychiatric Services 61, no. 10 (2010): 982–987. http://ps.psychiatryonline.org/doi/full/10.1176/ps.2010.61.10.982	**Beneficial effect continues when AOT ends:** "When the court order was for seven months or more, improved medication possession rates and reduced hospitalization outcomes were sustained even when the former AOT recipients were no longer receiving intensive case coordination services."

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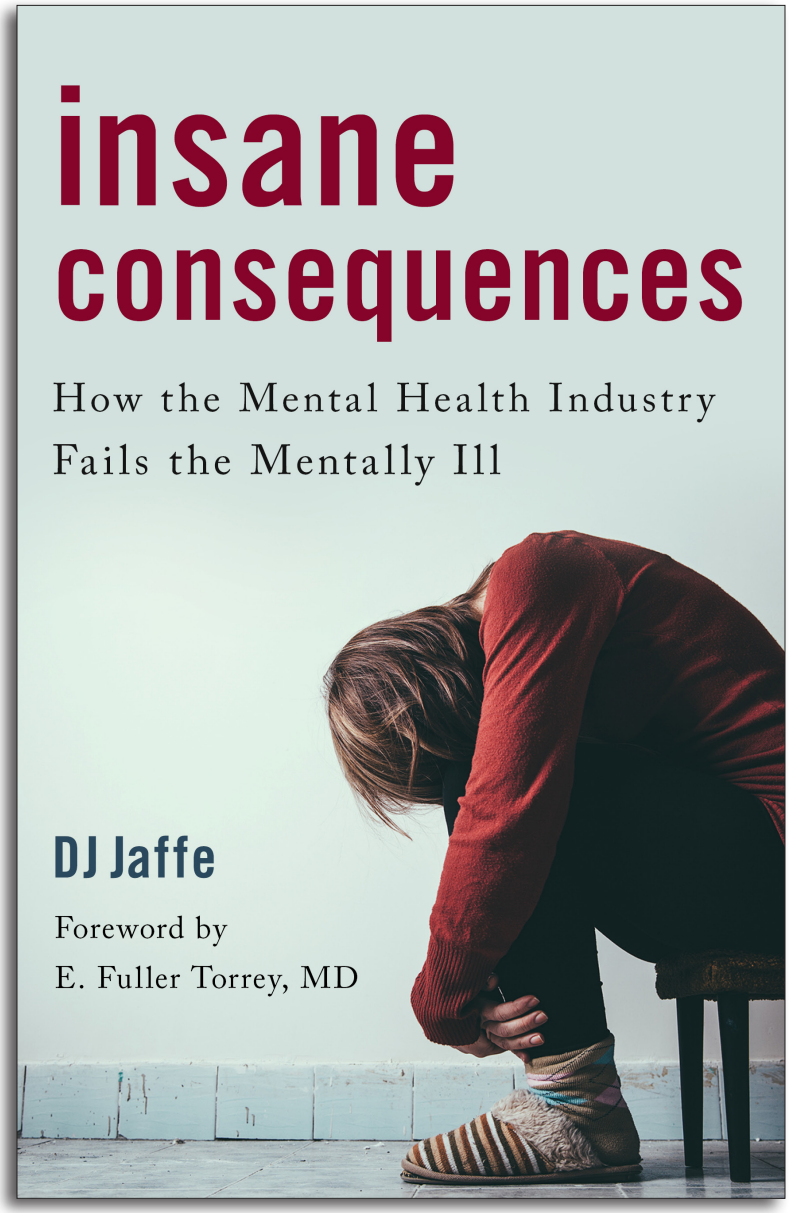

"DJ Jaffe is one of the most important, knowledgeable truth-tellers on the subject of serious mental illness. He has been a tireless advocate for sensible government policies and for compassion and understanding of the real issues at stake for this vulnerable, abused population."

Susan Adams, Senior Editor, Forbes

"Jaffe's a mental health advocate who policymakers depend on when they want to get a better understanding of how badly our mental health system is broken and how to fix it."

Pete Earley, New York Times bestselling author, 2007 Pulitzer Prize finalist for *CRAZY: A Father's Search Through America's Mental Health Madness*

"*Insane Consequences* will likely be one of the most important books on how to reform the system . . . . Because Jaffe has studied the mental illness-mental health field so thoroughly, his ideas for reforming it deserve careful attention."

Dr. E. Fuller Torrey, Researcher and author of multiple studies and books including *Surviving Schizophrenia*

This well-researched and highly critical examination of the state of our mental health system by the industry's most relentless critic presents a new and controversial explanation as to why—in spite of spending $147 billion annually—140,000 seriously mentally ill are homeless, 365,000 are incarcerated, and even educated, tenacious, and caring people can't get treatment for their mentally ill loved ones. DJ Jaffe blames the mental health industry and government for shunning the 10 million adults who are the most seriously mentally ill—mainly those who suffer from schizophrenia and severe bipolar disorder—and, instead, working to improve "mental wellness" in 43 million others, many of whom are barely symptomatic. Using industry and government documents, scientific journals, and anecdotes from his thirty years of advocacy, he documents the consequences of many industry-driven policies.

Insane Consequences proposes smart, compassionate, affordable, and sweeping reforms designed to send the most seriously ill to the head of the line for services rather than to jails, shelters, prisons, and morgues. It lays out a roadmap to replace mission-creep with mission control and return the mental health system to a focus on the most seriously mentally ill. It is not money that is lacking; it's leadership. This book is a must read for anyone who works in the mental health industry or cares about the mentally ill, violence, homelessness, incarceration, or public policy.

DJ Jaffe is executive director of MentalIllnessPolicy.org, a nonpartisan think tank, which creates detailed policy analysis for legislators, the media, and advocates. He regularly appears on television and has written for the *New York Times*, *Washington Post*, *Wall Street Journal*, *National Review*, and *Huffington Post*. He has served with numerous nonprofits including the Treatment Advocacy Center and National Alliance on Mental Illness.

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