Treatment Advocacy Center Briefing Paper

Modernizing Maine's civil commitment law

Maine needs assisted outpatient treatment

Assisted outpatient treatment (AOT), also known as involuntary outpatient commitment (IOC), refers to a court order mandating that a person with a severe mental illness adhere to a prescribed community treatment plan, using the possibility of hospitalization for treatment noncompliance as leverage. The main goal of AOT is to enable more consistent adherence to treatment for people whose severe mental illnesses impair their ability to seek and voluntarily comply with treatment.[1] AOT has also been shown to:

- *Reduce Hospital Readmissions* - Medication nonadherence is a significant factor in hospital readmissions.[2] Maine does not have sufficient state psychiatric hospital bed capacity.[3] AOT has been shown to reduce hospital readmission and is necessary to reduce Maine's current hospital crowding.
- *Reduce Violence* - Noncompliance with treatment, specifically nonadherence to medication, is strongly associated with violence[4] among people with severe mental illnesses. Since 2000, there have been at least seven preventable deaths in Maine resulting from nontreatment.[5]
- *Reduce Arrests* – Nonadherence with medication is strongly associated with the risk of incarceration.[6] Managing individuals with mental illness in jails is a risky proposition – in 2003, one inmate at the state prison in Warren, Maine, tried to commit suicide four times while being bounced between jail and mental hospitals.[7] AOT reduces the risk of arrest and incarceration.

New York has seen dramatic success in its first five years using AOT

On March 1, 2005, New York's Office of Mental Health issued a report detailing the results of the first five years of AOT under Kendra's Law.[8] Among individuals in the program, far fewer experienced hospitalizations (77 percent), episodes of homelessness (74 percent), arrests (83 percent), and incarceration (87 percent) and significantly more individuals had improved medication compliance (103 percent) and participation in substance abuse treatment (67 percent). There were marked reductions in harmful behavior; individuals who were in AOT for longer periods had greater reductions in violent behavior. Hospital days were reduced dramatically from an average of 50 days over a six-month period before starting AOT, to an average of 22 days during the six months of AOT, to an average of only 13 days in the six-month period after AOT. That is a full 74 percent reduction in hospital days six months after termination of the court order when compared with the six months prior to AOT.

People with severe mental illnesses report improved quality of life with AOT

More than 75 face-to-face interviews have been conducted with participants in New York's AOT program to assess their opinions about AOT including their perceptions of coercion or stigma associated with the court order and their quality of life as a result of AOT. Contrary to what AOT opponents speculate, the interviews of AOT recipients showed that when asked about the impact of the pressures and other measures that people took to get them to stay in treatment:

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

A randomized control study of AOT showed similar results. Researchers assessed the impact of AOT on quality of life of people with severe mental illnesses, covering a range of areas including social relationships, daily activities, finances, residential living situation, and global life satisfaction. They found evidence that subjects who underwent sustained periods of AOT had measurably greater subjective quality of life at the end of the study

year. The researchers concluded that AOT exerts its effect largely by improving treatment adherence and decreasing symptomatology.[9]

Consumers believe the benefits of AOT outweigh the potential disadvantage of perceived coercion

In a survey of people with schizophrenia concerning preferences related to AOT, "being free to participate in treatment or not" was the least important outcome. When asked to rank their preferences, consumers responded that reducing symptoms, avoiding interpersonal conflict, and avoiding rehospitalization outranked avoidance of outpatient commitment.[10] Studies show that a majority of people with severe mental illnesses who received mandatory treatment later agreed with the decision.[11] An informal survey of consumers of services for people with severe mental illnesses by a fellow consumer revealed that a majority supported outpatient commitment.[12] A formal survey published in July 2004 found that a majority of consumers regard mandated treatment as effective and fair.[13] One prominent consumer advocate who has schizophrenia explained that those "who have been primarily interested in consumer rights and liberties … focus … on opposing the use of forced treatment. … On the other hand, consumer advocates who place a high value on the need for psychiatrically disabled persons to receive treatment tend to support [AOT]."[14]

Maine is one of only eight states without AOT

Maine is one of only eight states that does not yet provide AOT as an alternative to involuntary hospitalization for people with severe mental illnesses. The practical result of Maine's current law is that community mental health services are only available to people who are able to accept services voluntarily. The rest are left untreated until their condition deteriorates to the point where they "pose a likelihood of serious harm."[15] Maine essentially forces people who lack insight into their illness to hit rock bottom before they can be helped.

In the last six years, 16 states have adopted more progressive civil commitment laws: Wyoming (1999), Nevada (1999), New York (1999), South Dakota (2000), Washington (2001), Montana (2001), West Virginia (2001), Minnesota (2001), Wisconsin (2001), California (2001, 2002), Idaho (2002), Utah (2003), Maryland (2003), Illinois (2003), Florida (2004), and Michigan (2004).

Studies in other states also demonstrate that AOT works

- In Washington, D.C., hospital admissions decreased from 1.81 per year to 0.95 per year before and after outpatient commitment.[16]
- In Ohio, the number of hospital admissions decreased from 1.5 to 0.4 per year. Outpatient commitment increased patients' compliance with outpatient psychiatric appointments from 5.7 to 13.0 per year and with attendance at day treatment sessions from 23 to 60 per year.[17]
- In Iowa, the number of hospital admission reduced from 1.3 to 0.3, total number of hospital days reduced from 33.3 to 4.6, and length of stay from 26.7 to 18.6.[18]
- In North Carolina, admissions for patients on outpatient commitment decreased from 3.7 to 0.7 per 1,000 days.[19]
- In North Carolina, only 30 percent of patients on outpatient commitment refused medication during a six-month period compared to 66 percent of patients not on outpatient commitment.[20]
- In Arizona, among patients who had been outpatient committed "71 percent of the patients voluntarily maintained treatment contacts six months after their orders expired" compared to "almost no patients" who had not been put on outpatient commitment.[21]

AOT addresses the most common reason for refusing treatment - lack of insight (anosognosia)

Extensive research since the early 1990s has revealed that some people with schizophrenia and bipolar disorder experience a neurological deficit called "anosognosia," a condition also commonly found in people suffering other brain disorders such as Alzheimer's or stroke.[22] Anosognosia impairs a person's ability to recognize that his or her symptoms are caused by a brain disorder.[23] A leading researcher detailed the severe consequences of this condition:

> [P]oor insight in schizophrenia is associated with poorer medication compliance, poorer psychosocial functioning, poorer prognosis, increased relapses and hospitalization and poorer treatment outcomes.[24]

The most common reason that people with severe mental illnesses are not being treated is that they do not believe that they need treatment for a mental illness.[25] A severe lack of insight into illness, whether caused by schizophrenia or other impairment, can "seriously interfere with [a patient's] ability to weigh meaningfully the consequences of various treatment options."[26]

A randomized control study further proved that AOT reduces the consequences of nontreatment

The most comprehensive, randomized control study of AOT, referred to as the Duke Study, involved people who "generally did not view themselves as mentally ill or in need of treatment."[27] The study compared people who were offered community mental health services with people who were offered the same services *combined* with a court order requiring participation in those services (i.e., the difference was the court order). The Duke Study showed that combining a court order with services for a long term (at least six months) reduced hospitalization (up to 74 percent), reduced arrests (74 percent), reduced violence (up to 50 percent), reduced victimization (43 percent), and improved treatment compliance (58 percent).

Maine cannot afford *not* to have assisted outpatient treatment

Maine does not have sufficient state psychiatric hospital bed capacity.[28] Medication nonadherence is a significant factor in hospital readmissions. A recently published study of Medicaid recipients with schizophrenia in California revealed that "individuals who were [medication] nonadherent were two and one-half times more likely to be hospitalized than those who were adherent."[29] The same study found that those who are nonadherent incur 43 percent more in service costs than those who adhere to medication. AOT can help reduce such costs by improving medication compliance.

Maine has made a substantial investment in community mental health services in recent years.[30] Between 1994 and 2002, the funding for community services tripled. Assertive Community Treatment (ACT) teams are available for "consumers who historically are underserved by traditional services," that is, people who are treatment resistant and experience frequent rehospitalization. Unfortunately, the effectiveness of ACT services is compromised because Maine does not have assisted outpatient treatment. The ACT Model recognizes that sometimes a court order may be required to ensure that clients benefit from these services.[31] In 1989 in Dane County, Wisconsin, where ACT originated, nearly 25 percent of the chronically mentally ill population had community medication court orders.[32]

ENDNOTES

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[1] Swanson, J.W., Swartz, M.S., Elbogen. E.B., Wagner, H.R., Burns, B.J. (2003). Effects of involuntary outpatient commitment on subjective quality of life in persons with severe mental illness. *Behavioral Science and the Law*, 21, 473-91.

[2] Weiden, P.J., Kozma, C., Grogg, A., Locklear, J. (2004). Partial compliance and risk of hospitalization among California Medicaid patients with schizophrenia. *Psychiatric Services*, 55, 886-91. Medication gaps as small as one to ten continuous days in a one-year period were associated with a two-fold increase in hospitalization risk.

[3] (2004, June 10) Some say new $31 million Maine psychiatric hospital is too small. *Portland Press Herald*.

[4] Swartz, M.S., Swanson, J.W., Hiday, V.A., Borum, R., Wagner, H.R., Burns, B.J. (1998). Violence and severe mental illness: The effects of substance abuse and nonadherence to medication. *American Journal of Psychiatry*, 155, 226-31. Substance abuse, medication non-compliance and low insight into illness operate together to increase violence risk.

[5] Preventable Tragedies in Maine, Examples from 2000-2005

[6] Munetz, M.R., Grande, T.P., Chambers, M.R. (2001). The incarceration of individuals with severe mental disorders. *Community Mental Health*, 34, 361-71. Nearly 90 percent of a sample of individuals with severe mental illness in a local jail were partially or completely non-complaint with medication in the year before they were incarcerated.

[7] (2004, April 10). Out of Jail Space. *Bangor Daily News*.

[8] New York State Office of Mental Health. (2005, March). *Kendra's Law: Final report on the status of assisted outpatient treatment*.

[9] Swanson, J.W., Swartz, M.S., Elbogen. E.B., Wagner, H.R., Burns, B.J. (2003). Effects of involuntary outpatient commitment on subjective quality of life in persons with severe mental illness. Behavioral Science and the *Law*, 21, 473-91.

[10] Swartz, M.S., Swanson, J.W., Wagner, H.R., Hannon, M.J., Burns, B.J., Shumway, M. (2003). Assessment of four stakeholder groups' preferences concerning outpatient commitment for persons with schizophrenia. *American Journal of Psychiatry*. 160, 1139-46.

[11] Treatment Advocacy Center. *What happens when an individual is ordered to accept hospitalization or medication?* Retrieved February 21, 2005 from *http://www.psychlaws.org/BriefingPapers/BP12.htm*.

[12] Kull, N.J. *What do consumers really think about assisted outpatient treatment?* Retrieved February 21, 2004 from *http://www.psychlaws.org/GeneralResources/pa16.htm*

[13] Swartz, M.S., Wagner, H.R., Swanson, J.W., Elbogen. E.B. (2004). Consumers' perceptions of the fairness and effectiveness of mandated community treatment and related pressure. *Psychiatric Services* 55, 780-5.

[14] Munetz, M.R., Galon, P.A., Frese, F.J. (2003) The ethics of mandatory community treatment. *Journal of Amer. Acad. of Psychiatry and the Law*, 31, 173-83.

[15] ME. REV. STAT. ANN. tit. 34-B, § 3864(6)(A).
[16] Zanni, G, deVeau, L. (1986) Inpatient stays before and after outpatient commitment. *Hospital and Community Psychiatry* 37, 941–942.
[17] Munetz, M.R., Grande, T, Kleist, J, Peterson G.A. (1996). The effectiveness of outpatient civil commitment. *Psychiatric Services* 47, 1251–1253.
[18] Rohland. B.M., Rohrer, J.E., Richards, C.R. (2000). The long-term effect of outpatient commitment on service use. *Administration and Policy in Mental Health*, 27, 383-393.
[19] Fernandez, G.A., Nygard S. (1990). Impact of involuntary outpatient commitment on the revolving-door syndrome in North Carolina. *Hospital and Community Psychiatry* 41, 1001–1004.
[20] Hiday, V.A., Scheid-Cook, T.L. (1987). The North Carolina experience with outpatient commitment: a critical appraisal. *International Journal of Law and Psychiatry* 10, 215–232.
[21] Van Putten, R.A., Santiago, J.M., Berren, M.R. (1988). Involuntary outpatient commitment in Arizona: a retrospective study. *Hospital and Community Psychiatry*, 39, 953–958.
[22] Treatment Advocacy Center (2003, Oct.) Impaired awareness of illness (anosognosia): A major problem for individuals with schizophrenia and bipolar disorder. Retrieved February 21, 2005, from http://www.psychlaws.org/BriefingPapers/BP14.htm; McGlynn, S.M., & Schacter, D.L. (1997). The neuropsychology of insight: Impaired awareness of deficits in a psychiatric context. *Psychiatric Annals* 27, 806-11; Amador, X. (2000). *I Am Not Sick, I Don't Need Help* (1st ed.) New York: Vida Press.
[23] Amador, X.F., Flaum, M., Andreason, N.C., Strauss, D.H., Yale, S.A., Clark, S.C., et al. (1994). Awareness of illness in schizophrenia and schizoaffective and mood disorders, *Archives Gen. Psychiatry*, 51, 826-36; Fennig, S., Everett, E., Bromet, E.J., Jandorf, L., Fenning, S.R., Tanenberg-Karant, et al., (1996). Insight in first-admission psychotic patients. *Schizophrenia Research*, 22, 257-63.
[24] Schwartz, R.C. (1998). The relationship between insight, illness, and treatment outcome in schizophrenia. *Psychiatric Quarterly*, Spring, 19-22.
[25] Kessler, R.C., Berglund, P.A., Bruce, M.L., Koch, J.R., Laska, E.M., Leaf, P.J., et al. (2001). The prevalence and correlates of untreated serious mental illness. *Health Services Research*, 36, 987-1007; Treatment Advocacy Center. *What percentage of individuals with severe mental illnesses are untreated and why*. Retrieved February 21, 2005 from *http://www.psychlaws.org/BriefingPapers/BP13.pdf*.
[26] Grisso, T., & Appelbaum, P.S. (1998). *Assessing competence to consent to treatment: A guide for physicians and other health professionals.* New York: Oxford University Press.
[27] A randomized controlled trial of outpatient commitment in North Carolina. *Psychiatric Services*, 52, 325-9.; Swartz, M.S., Swanson, J.W., Wagner, H.R., Burns, B.J., Hiday, V.A., Borum, R. (1999). Can involuntary outpatient commitment reduce hospital recidivism? *American Journal of Psychiatry*, 156, 1968-75; Swanson, J.W., Borum, R., Swartz, M.S., Hiday, V.A., Wagner, H.R., Burns, B.J. (2001). Can involuntary outpatient commitment reduce arrests among persons with severe mental illness? (2001). *Criminal Justice and Behavior*, 28, 156-89.; Swanson, J.W., Borum, R., Swartz, M.S., Hiday, V.A., Wagner, H.R., Burns, B.J. (2000). Involuntary outpatient commitment and reduction of violent behaviour in persons with severe mental illness. *Brit. J. Psychiatry*, 176, 324-31; Hiday, V.A., Swartz, M.S., Swanson, J.W., Borum, R.,Wagner, H.R. (2002). Impact of outpatient commitment on victimization of people with severe mental illness. *American Journal of Psychiatry*, 159, 1403-11; Swartz, M.S., Swanson, J.W., Wagner, H.R., Burns, B.J., Hiday, V.A. (2001). Effects of involuntary outpatient commitment and depot antipsychotics on treatment adherence in persons with severe mental illness. *J. Nerv. and Mental Diseases*, 189, 583-92.
[28] Some say new $31 million Maine psychiatric hospital is too small, *Portland Press Herald*, June 10, 2004.
[29] Gilmer, T.P., Dolder, C.R., Lacro, J.P. Folsom, D.P., Garcia, P., et al. (2004). Adherence to treatment with antipsychotic medication and health care costs among Medicaid beneficiaries with schizophrenia. *American Journal of Psychiatry*, 161, 692-9.
[30] State of Maine Department of Behavioral and Developmental Services. (2002, July). *Adult Mental Health Services – Quality Systems of Care Support Good Mental Health*.
[31] The ACT Manual recognizes that:

> some clients who enter PACT treatment voluntarily later refuse treatment and may become candidates for involuntary services if they relapse… In this case the PACT team first tries to stay involved with the client who declines treatment … If the client's behavior … meets the commitment law criteria, the PACT team participates in the commitment process.

Allness, D., Knoedler, W.H. (2003, June). *A manual for ACT start-up: Based on the PACT model for community-based treatment for persons with severe and persistent mental illnesses* (2003 ed.). Virginia: NAMI
[32] Isaac, R.J, Armat, V.C. (1990). Madness in the streets: How psychiatry and the law abandoned the mentally ill. Treatment Advocacy Center: Arlington. See pg. 299-300, 312.