STATE OF WISCONSIN

IN SUPREME COURT

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Case No. 01-0374

IN RE THE COMMITMENT
OF DENNIS H.,

STATE OF WISCONSIN,

Petitioner-Respondent,

v.

DENNIS H.,

Respondent-Appellant.

CERTIFICATION BY THE COURT OF APPEALS,
DISTRICT 1, OF AN APPEAL FROM AN ORDER OF
THE CIRCUIT COURT FOR MILWAUKEE COUNTY,
VICTOR MANIAN, JUDGE

BRIEF OF *AMICUS CURIAE* TREATMENT ADVOCACY CENTER

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STATEMENT OF INTEREST

The Treatment Advocacy Center is a nonprofit judicial advocacy organization working to eliminate barriers to treatment of severe mental illness. The Center is regarded as a national authority in the analysis and utilization of treatment mechanisms, such as the one being considered by the Court in this appeal.

ARGUMENT

IN ENACTING THE FIFTH STANDARD, THE LEGISLATURE RESPONDED TO EXTRAORDINARILY INCREASED KNOWLEDGE OF THE NATURE, EFFECTS, AND MOST EFFICACIOUS TREATMENTS OF SEVERE MENTAL ILLNESS AS WELL AS THE CATACLYSMIC RESULTS OF LEAVING THESE ILLNESSES UNTREATED.

A. The Fifth Standard Is An Effective Response To The Inability Of Some Individuals To Make Rational Treatment Decisions Because Of A Severe Mental Illness.

Perhaps the discovery most relevant to the need for Wisconsin Statute § 51.20(1)(a)2e (hereinafter "Fifth Standard") is science's growing comprehension of the prevalence and ramifications of impaired insight in untreated schizophrenia and manic depression.[1]

On reviewing the applicable literature, one researcher concluded that:

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

Robert C. Schwartz, *The Relationship Between Insight, Illness, and Treatment Outcome in Schizophrenia*, Psychiatric Q., Spring 1998 at 19.

[1] As late as 1990, only 19 empirical studies had been published on insight in psychotic patients. More than 70 were available, only five years later, when the Fifth Standard was enacted. *See* Xavier F. Amador, *I Am Not Sick I Don't Need Help* 174-175 (2000).

The three kinds of insight that are most vulnerable to severe mental illnesses, as well as most pertinent to the use of the Fifth Standard, are the awareness: (1) that a person is suffering from a mental disorder; (2) of the effects of medication; and (3) of the social consequences of having a mental disorder. *See* Xavier F. Amador et al., *Assessment of Insight in Psychosis*, 150 Am. J. Psychiatry 873, 874 (1993).

Lack of insight results from a neurological deficit called anosognosia, which impairs a person's ability to be fully aware of his or her condition. *See* Susan McGlynn & Daniel L. Schacter, *The Neuropsychology of Insight: Impaired Awareness of Deficits in a Psychiatric Context*, 27 Psychiatric Annals 806 (1997). Approximately half of all those with schizophrenia and manic depression have moderate to severe anosognosia. *See* Xavier Amador et al., *Awareness of Illness in Schizophrenia*, 17 Schizophrenia Bull., 113 (1991); S. Nassir Ghaemi et al., *Insight and Psychiatric Disorders: A Review of the Literature, With a Focus on its Clinical Relevance for Bipolar Disorder*, 27 Psychiatric Annals 782 (1997).

Empirical studies verify that, for individuals with severe mental illnesses, lack of awareness of illness is significantly associated with both medication non-compliance and re-hospitalization. *See* Joseph P. McEvoy, *The Relationship Between Insight in Psychosis and Compliance With Medications, in Insight & Psychosis* at 299 (Xavier F. Amador & Anthony S. David eds., 1998). Fifteen percent of individuals with severe mental illnesses who refuse to take medication voluntarily under any circumstances may require some form of coercion to remain compliant because of anosognosia. Id. at 293.

One study of voluntary and involuntary inpatients confirmed that committed patients require coercive treatment because they fail to recognize their need for care. *See* Joseph P. McEvoy et al., *Why Must Some Schizophrenic Patients be Involuntarily Committed? The Role of Insight*, 30 Comprehensive Psychiatry 13, 16 (1989). Predictably, the patients committed to the hospital had significantly lower measures of insight than the voluntary patients.

Anosognosia is also intimately related to other cognitive dysfunctions that may impair the capacity to continuously participate in treatment. *See* Paul Lysaker et al., *Insight and Psychosocial Treatment Compliance in*

Schizophrenia, 57 Psychiatry 311 (1994). Other research has suggested that attitudes toward treatment can improve after involuntary treatment and that previously committed patients tend to later seek voluntarily treatment. John M. Kane et al., *Attitudinal Changes of Involuntarily Committed Patients Following Treatment*, 40 Arch. Gen. Psychiatry 374 (1983).

Through its focus on the understanding of the advantages and disadvantages of treatment and, alternatively, the capability of making an informed decision concerning psychiatric care, the Fifth Standard is a measured design by the Legislature to permit the state to aid individuals with impaired awareness.

B. The Fifth Standard Allows The Use Of New And Superior Treatments For Severe Mental Illnesses.

As recently as 1987, psychotropic medications were widely considered to be ineffective and prone to cause debilitating side effects. *See Jones v. Gerhardstein*, 141 Wis. 2d 710, 727, 416 N.W.2d 883, 890 (1987) ("It is undisputed that some of these drugs cause numerous side effects that are more prevalent than with any other drug used in medicine."). In the years since, psychotropic medications have so advanced that a leading researcher in the area of mental illness could pronounce, "antipsychotic drugs, as a group, are one of the safest groups in common use and are the greatest advance in treatment of schizophrenia that has occurred to date." E. Fuller Torrey, *Surviving Schizophrenia* 220 (2001).

The scientific community overwhelmingly holds antipsychotic drugs to be the most beneficial treatment option available for those with schizophrenia. *See* Nat'l Institute of Mental Health, *Schizophrenia: How is it treated?* http://www.nimh.nih.gov/publicat/schizoph.htm#schiz3 (visited Feb. 13, 2002) ("Antipsychotic drugs are the best treatment now available . . . ."). Antipsychotics diminish or eliminate symptoms, shorten hospital stays, and dramatically reduce rehospitalizations. Torrey, *supra*, at 213. The success rate for treatment of schizophrenia with antipsychotic medications is now sixty percent, higher than that of heart disease. Nat'l Alliance for the Mentally Ill, *Schizophrenia Fact Sheet*, at http://www.nami.org/helpline/schizo.htm (visited Feb. 9, 2002).

The advent of new-line atypical antipsychotics has radically cut the incidence of the most debilitating side effects.[2] Moreover, "The role of new antipsychotic drugs in inducing positive subjective responses and improving patients' quality of life represents a significant advance in the treatment of schizophrenia." Voruganti et al., *supra* note 2, at 142.

Most notable is that atypical antipsychotics have a particularly low rate of the Parkinsonian side effects[3] that were a major concern of this Court in *Gerhardstein*. 141 Wis. 2d at 727, 416 N.W.2d at 890. As one expert noted, "[t]he one property that is clearly apparent in most studies is reduced propensity to produce neurological adverse effects." Kane, *supra* note 2, at 1397.

Appellant ignores these data, instead contending that these medications are extremely harmful, even going so far as to accuse these drugs of cutting ten to fifteen years off of one's life. (Br. for Resp't-Appellant at 6.) To support the latter declaration, the Appellant points to a legal article offering no citation, medical or otherwise, for this claim. *See* Ralph Slovenko, *Civil Commitment Laws: An Analysis and Critique*, 17 T.M. Cooley L. Rev. 25, 47 (2000). As the clear majority of evidence[4] holds that this statistic is untrue, its origin and underlying scientific basis is, at best, suspect.

While it is true that the death rate for those with schizophrenia is increased, suicide and accidental death account for forty percent of the excess mortality. Steve Brown, *Excess Mortality of Schizophrenia*, 171 Brit. J.

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[2] *See, e.g.*, U.S. Dept. of Health & Human Serv., *Mental Health: A Report of the Surgeon General* 281-282 (1999); M. Campbell et al., *The Use of Atypicals in the Management of Schizophrenia*, 47 Brit. J. Clinical Pharmacology 13, 21 (1999); John M. Kane, *Pharmalogic Treatment of Schizophrenia*, 46 Soc'y of Biological Psychiatry 1396, 1397(1999); Voruganti et al., *Comparative Evaluation of Conventional and Novel Antipsychotic Drugs with Reference to Their Subjective Tolerability, Side-effect Profile and Impact on Quality of Life*, 43 Schizophrenia Res. 135, 136 (2000).

[3] *See, e.g.*, U.S. Dept. of Health & Human Serv., *supra* note 2, at 281-282; Peter F. Buckley, *Broad Therapeutic Uses of Atypical Medications*, 50 Biological Psychiatry 912, 912 (2001) ("[A]typical antipsychotics have a low incidence of extrapyramidial side effects (EPS), have improved tardive dyskinesia profiles, and have a broad range of therapeutic efficacy."); M. Campbell et al., *supra* note 2, at 13, 20-21.

[4] Evidence supporting Appellant's contentions tends to rely on clinical research conducted at least fifteen years ago.

Psychiatry 502, 505-506 (1997). Considering that these occur more frequently in untreated patients, medication may actually decrease the mortality rate.

Although medication side effects have not been completely eliminated, they have now been shown to play only a small role in the perceived quality of life of persons with severe mental illness. One recent study noted, "adverse events of antipsychotic drugs influence subjective quality of life . . . to a significantly lesser degree than other clinical and psychosocial factors." Michael Ritsner, *The Impact of Side Effects of Antipsychotic Agents on Life Satisfaction of Schizophrenia Patients: A Naturalistic Study*, 12 Eur. Neuropsychopharmacology 31, 36 (2002).

Courts throughout the country have begun to recognize the advances that science has made in the field of antipsychotic medication.[5] No doubt the availability of these medicines was an impetus for the Legislature's creation of the Fifth Standard.

C. The Fifth Standard Is A Crucial Response To The Ravages Of Untreated Severe Mental Illnesses.

The state has an interest in protecting its citizens from the predictable consequences of non-treatment. Failing to secure timely treatment for people with severe mental illnesses rendered incapable of making rational treatment decisions often results in tragedy: violence, incarceration, victimization, homelessness, increased mortality, and more uncertain and severe clinical outcomes.

Severe and persistent mental illness is a factor in ten to fifteen percent of violent acts. Lewin Group, Nat'l Inst. of Mental Health, *The Economic Costs of Mental Illness, 1992*, 5-1 (July 2000). One of three primary predictors of violent behavior is a severe mental illness combined with a failure to take medication. E. Fuller Torrey, *Violent Behavior by*

[5] At times, the acclaim of courts for these medications has even been unmitigated. *See U.S. v. Weston*, 134 F. Supp. 2d 115, 124 (D.D.C. 2001) ("[T]here is a world of difference between antipsychotic medications described in the judicial opinions of the early 1990's and the current … medications now available."); *In re Mausner*, 694 N.Y.2d 165, 166 (N.Y. App. Div. 1999) ("[T]his . . . would allow him to take newer antipsychotic medications which have no side effects.").

Individuals With Serious Mental Illness, 45 Hosp. & Community Psychiatry 653-662 (1994).

Many individuals with severe mental illnesses are incarcerated for "nuisance crimes" such as disorderly conduct and trespassing due to untreated symptoms. E. Fuller Torrey et al., Nat'l Alliance for the Mentally Ill & Pub. Citizen Health Research Group, *Criminalizing the Seriously Mentally Ill* 43-55 (1992). Sixteen percent of those in state and federal correctional facilities suffer from a mental illness. Paula Ditton, U.S. Dep't of Justice, *Mental Health and Treatment of Inmates and Probationers* at 1 (1999).

Individuals with a severe mental illness often become prey. They are two and a half times more likely to be attacked, raped or mugged than the general population. Virginia A. Hiday et al., *Criminal Victimization of Persons with Severe Mental Illness*, 50 Psychiatric Services 62-68 (1999).

Not surprisingly, given the effects of untreated symptoms, an estimated one-third of the homeless population suffers from a severe mental illness. Richard C. Tessler & Deborah L. Dennis, Nat'l Inst. of Mental Health, *A Synthesis of NIMH-Funded Research Concerning Persons Who Are Homeless and Mentally Ill* (1989).

Seventy-two percent of people who commit suicide have a severe and persistent mental illness. Lewin Group, *supra*, at 4. And, of course, suicide is most likely among those with severe mental illnesses when there is inadequate treatment or no treatment at all.[6]

The adverse effects of delaying treatment for severe mental illnesses also include increased treatment resistance, Jane Edwards et al., *Prolonged Recovery in First-Episode Psychosis*, 172 Brit. J. Psychiatry 107 (Supp. 1998), worsening severity of symptoms, Jeffrey A. Lieberman et al., *Factors Influencing Treatment Response and Outcome of*

[6] Hannele Heilä et al., *Suicide and Schizophrenia: A Nationwide Psychological Autopsy Study on Age- and Sex-Specific Clinical Characteristics of 92 Suicide Victims With Schizophrenia*, 154 Am. J. Psychiatry 1235 (1997); E. Nieto et al., *Suicide Attempts of High Medical Seriousness in Schizophrenic Patients*, 33 Comprehensive Psychiatry 384 (1992); Wayne S. Fenton et al., *Symptoms, Subtype, and Suicidality in Patients with Schizophrenia Spectrum Disorders*, 154 Am. J. Psychiatry 199 (1997); Alec. Roy, *Risk Factors for Suicide in Psychiatric Patients*, 39 Archives Gen. Psychiatry 1089 (1982).

First Episode Schizophrenia: Implications for Understanding the Pathophysiology of Schizophrenia, 57 J. Clinical Psychiatry 5 (1996), increased hospitalizations, P. Power et al., *Analysis of the Initial Treatment Phase in First-Episode Psychosis*, 172 Brit. J. Psychiatry 71 (1998), and delayed remission of symptoms, Durk Wiersma et al., *Natural Course of Schizophrenic Disorders: a 15-year Follow-up of a Dutch Incidence Cohort*, 24 Schizophrenia Bull. 75 (1998).

D. The Fifth Standard Facilitates The Use Of Outpatient Commitment, An Effective And Less Restrictive Form Of Mandatory Treatment.

Laggardly following the mass emigration from psychiatric hospitals were new mechanisms for non-volitional care. Crucial among these is outpatient commitment, which is court-ordered care for people whose conditions acutely deteriorate but who can safely recover in supervised outpatient treatment.[7] Outpatient commitment is available in Wisconsin. Wis. Stat. § 51.20(13)(a)3.

An essential predicate to the use of outpatient commitment is that the individual can live safely in the community. Rarely would a court make such a determination contemporaneously with finding that the person presents an immediate danger because of an unstabilized mental illness. Thus the Fifth Standard greatly facilitates the use of outpatient commitment in Wisconsin.

"Use of mandatory outpatient treatment is strongly and consistently associated with reduced rates of rehospitalization, longer stays in the community, and increased treatment compliance among patients with severe and persistent mental illness." Subcomm. on Mandatory Outpatient Treatment, Am. Psychiatric Ass'n, *Mandatory Outpatient Treatment* 22 (1999).

In the pre-eminent study of outpatient commitment it was found that the treatment modality reduced hospital admissions by fifty-seven percent and cut the incidence of violence in half when used for at least six months and

[7] While the precise number depends on the criteria adopted to define it, over 40 states have statutory provisions for outpatient commitment. *See* Kenneth J. Kress, *An Argument for Assisted Outpatient Treatment for Persons with Serious Mental Illness Illustrated with Reference to a Proposed Statute for Iowa*, 85 Iowa L. Rev. 1269, 1290 (2000).

combined with routine mental health services. Marvin S. Swartz et al., *Can Involuntary Outpatient Commitment Reduce Hospital Recidivism?,* 156 Am. J. Psychiatry 1968, 1973 (1999); Jeffrey W. Swanson et al., *Involuntary Out-Patient Commitment and Reduction of Violent Behaviour in Persons With Severe Mental Illness,* 176 Brit. J. Psychiatry 224, 228-29 (2000).

Among those with a history of multiple hospitalizations and arrests or violence, the median re-arrest rate of those under orders was approximately one-quarter (12% versus 47%) that of those who were not. Jeffrey W. Swanson et al., *Can Involuntary Outpatient Commitment Reduce Arrests Among Persons with Severe Mental Illness?*, 28 Crim. Just. & Behav. 156, 182-83 (2001). Other clinical examinations have born out the efficacy of outpatient commitment.[8]

Most telling is outcome data of New York's new law for outpatient commitment. N.Y. Mental Hyg Law § 9.60. The New York State Office of Mental Health reports that the first 141 individuals under orders experienced 129% greater medication compliance, 194% increased use of case management, 26% less harmful behavior, and the elimination of homelessness. *Progress Report on New York State's Mental Health System* (Jan. 2001), 16-18.

In fashioning the Fifth Standard, the Legislature created a treatment standard matched to the use of outpatient commitment, and to secure such vital components of recovery both for Wisconsin and, most especially, for her citizens overwhelmed by mental illness.

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[8] Gustavo A. Fernandez & Sylvia Nygard, *Impact of Involuntary Outpatient Commitment on the Revolving-Door Syndrome in North Carolina*, 41 Hosp. and Community Psychiatry 1001, 1003 (1990) (median readmissions decrease from 3.7 to 0.7 per 1,000 days); Virginia A. Hiday & Teresa L. Scheid-Cook, *The North Carolina Experience with Outpatient Commitment: A Critical Appraisal*, 10 Int'l J Law & Psychiatry 215, 229 (1987) (over six months, 30% medication refusal versus 66% absent orders); Robert A. Van Putten et al., *Involuntary Outpatient Commitment in Arizona: A Retrospective Study*, 39 Hosp. & Community Psychiatry 953, 957 (1988) ("almost no patients" without orders voluntarily maintain treatment in mental health system versus 71 % who do in group with orders); Guido Zanni & Leslie deVeau, *Inpatient Stays Before and After Outpatient Commitment,* 37 Hospital & Community Psychiatry 941, 942 (1986). (readmissions decrease from 1.81 to 0.95 per year).

E. The Fifth Standard Is A Considered Reaction By The Legislature To The Heightened Need Of The State To Secure Care For And The Lessened Interest In Avoiding Treatment Of People With Severe Mental Illness.

Even if absolute, neither probable catastrophic effects of an illness or beneficence of the treatment for it is, alone, sufficient basis to mandate care for a specific afflicted individual. The likelihood and severity of an illness' consequences as well as the nature and effectiveness of treatment does, nonetheless, impact the balance of interests when the state seeks such a mandatory placement.

Understanding how untreated mental illness leads to incarceration, homelessness, suicide, victimization, and violence intensifies the state's interest in obtaining treatment. As does proof that many with these illnesses are rendered unable to recognize their own sickness by the effects of the sickness itself.

Improved treatments and a superior likelihood of clinical success also heightens the state's interest in exercising its police power to help those who could become a danger to others.

Better and less restrictive treatment mechanisms like outpatient commitment mitigate the interest of an individual in avoiding their imposition.

Most resoundingly, the effectiveness of treatment and modalities for it fortifies the "legitimate interest" of the state "under its *parens patriae* powers in providing care to its citizens who are unable because of emotional disorders to care for themselves." *Addington v. Texas*, 441 U.S. 418, 426 (1978).

CONCLUSION

It is therefore respectfully submitted that the order of the circuit court should be affirmed, and that the Fifth Standard should found to be constitutional.

Dated this 21st day of February 2002.

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CERTIFICATION

I certify that his brief conforms to the rules contained in s. 801.19 (8) (b) and (c) for a brief and appendix produced with a proportional serif font. The length of this brief is 2,983 words.

Respectfully submitted,

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