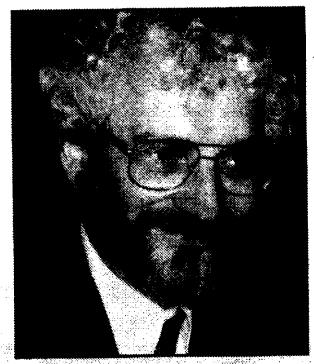
EDITORIAL

Assisted Outpatient Treatment: an idea whose time has come for New Jersey



by William M. Greenberg, M.D.

Recently Adam Lisberg chronicled in *The Record* (July 6) the extraordinary story of "Punchy," a 52-year old man who had been living for many years on the streets in Hackensack. He lived off handouts from friendly strangers, constantly drinking alcohol, consistently resisting help until he was finally taken away in the dead of winter to treat his frostbitten and rotting limbs, which he insisted were fine. "I just need a Band-Aid," he said, while his rescuers were appalled by his decaying, fetid and bloody flesh. Months later, after a protracted process, a judge appointed a medical guardian to override Punchy's refusal to have necessary amputations of his legs. After the surgery, Punchy was able to live in a nursing home, though he still yearned to return to Hackensack. Perhaps not so extraordinary a story, to those of us who have worked in Emergency Departments and inpatient services. This was not just about the ravages of alcoholism, as you might have suspected. Punchy was quieting the disturbing voices in his head, the voices he would sometimes yell and swear at, by drowning them in alcohol, until his mind was too hazy to notice. Yes, Punchy is one of our patients, those we are entrusted to care for, suffering from substance dependence and schizophrenia. Who among us has not seen this man or his brother in the emergency room, on a consultation on a medical/surgical floor, or in one of our psychiatric inpatient units?

Punchy, who only lost his legs, is not our only casualty of 2004. Margaret McHugh listed the known body-count in *The Star-Ledger* (October 26). Gregory Ali, a 34-year Budd Lake man with schizophrenia not taking his medication, stabbed his 72-year old father, who called 911 to have his son taken to a hospital. Gregory attacked the responding police officer with a knife, who then shot and killed him in the struggle. Two other New Jerseyans with mental illness were found dead, two others killed relatives, and another was murdered. An activist attorney with two siblings with schizophrenia, Mary Zdanowicz, Executive Director of the Treatment Advocacy Center (TAC) in Arlington, Virginia maintains records of such cases, culled from newspaper clippings, on the TAC website (www.psych-laws.org) as "preventable tragedies." Ms. Zdanowicz, who interned years ago in Senator Richard Codey's office in Trenton, now hopes to see something useful done in New Jersey to prevent these continuing stories.

What certainly can be done is enacting legislation for "assisted outpatient treatment" (known in some venues as

Continued on page 6

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Assisted Outpatient Treatment *continued from page 2*

"outpatient commitment"). Forty-two of our fifty states now have such laws on their books, providing for selected patients to be constrained by judicial decree to follow a prescribed outpatient treatment regimen, usually for at least six months after a hospital discharge, or face being rehospitalized even if they are not at the time an imminent threat to themselves or others. New Jersey has a very weak law, allowing for some intervention for 90 days after hospital discharge, which is really only being used by Ancora Psychiatric Center.

In 1999, after Kendra Webdale was killed by being pushed in front of a New York City subway train by a man with schizophrenia who had stopped taking his medication and had become acutely psychotic, New York State passed a more typical outpatient commitment law ("Kendra's law," also known as "assisted outpatient treatment, or "AOT"). Although there were fears expressed that 10,000 or more New Yorkers per year would be subjected to such court-mandated treatment (which includes case management services), over the initial years of this program the number is approximately 720 per year, with half of these court orders ending after 6 months. Analyzing the impact of Kendra's law, the New York State Office of Mental Health found that compared with their rates prior to their coming under AOT, outpatient-committed individuals had fewer psychiatric hospitalizations (20% vs. 87%), less homelessness (3% vs. 21%), fewer arrests (5% vs. 30%), fewer incarcerations (3% vs. 21%), less physical harm to self (11% vs. 20%), less damage or destruction of property (20% vs. 35%), less taking property without permission (23% vs. 40%), less alcohol abuse (11% vs. 19%), fewer verbal assaults on others (9% vs. 16%), fewer suicide attempts (27% vs. 32%), among other improvements, all findings statistically significant (January 2003 Interim report available at <www.omh.state.ny.us/omhweb/Kendra_web/interimreport/AOTReport.pdf>; some more recent figures available at <www.omh.state.ny.us/omhweb/Kendra_web/kstatus_rpts/Statewide.htm>).

We have an opportunity to change New Jersey's status, from one of the few remaining states to not have this safety net for those individuals whose psychiatric illness causes them both to not recognize that they have an illness requiring treatment, and repeatedly dangerously decompensate in the community. A New Jersey Senate Bill (S-1640) was introduced, supported by Senators Cardinale and Codey, and, in all, 37 of the 40 NJ Senators, that would create a 6-month AOT law in our state. S-1640 (which also includes "gravely disabled" commitment language), is an elaborated version of S-327, also known as "Gregory's Law," in memory of 11-year old Gregory Kat-snelson, who was murdered near his home by a mentally ill man. His surviving parents, Cathy and Mark, are leading the drive for this legislation, to try to do something that can prevent similar tragic events.

Most recently, NAMI-NJ has indicated that it will seek instead to introduce a far more comprehensive bill to overhaul multiple problem areas in public mental health in New Jersey, including not only outpatient commitment, but also jail diversion programs, expanded rights for family members of the mentally ill, significantly increased access to the Anne Klein Forensic Center, and other provisions. NAMI is opposing S-1640 in favor of its more comprehensive bill arguing that all its areas should be addressed at once. Others have expressed concerns that its complexity and possible significant expenses might delay or entirely derail implementing a simple, separable provision on outpatient commitment. Civil libertarian groups oppose any outpatient commitment provision, unfortunately overlooking that giving individuals autonomy when they seriously lack capacity and will be dangers to themselves or others, is a misguided and misapplied principle, ignoring common sense compassion. Members of the NJPA Council support AOT in principle, without specifying a particular bill (members have not yet been able to review the lengthy NAMI proposal), with the only caveat that its implementation should be fair to all facilities (it may clearly save resources in some organizations, but may cause undue strain for other parts of the mental health system, appearing as another unfunded mandate that interferes with other service delivery expectations).

Families know first-hand the frustration of trying to get help for their impaired relatives, when their relatives reject treatment and are not yet threatening mayhem. We know the frustration, and, disempowered by the current commitment laws, often feel helpless when we discharge someone expecting certain failure, or cannot help someone who is not yet an imminent threat. Police officers and others in the criminal justice system have similar frustrations, being called to see individuals who need help but are not commitable, and who often inappropriately find their way into our jails and prisons for misdemeanors, rather than in psychiatric treatment facilities, where they belong.

Ideally, the backers of S-1640 and NAMI should find common ground, and join their efforts behind one outpatient commitment bill, even if they cannot currently agree on all particulars of jail diversion and other proposals. Senator Codey will be our Governor for at least one year, and is a true believer in reforming the public mental health system: this is a rare opportunity for attention to our patients, who typically suffer from governmental not-so-benign neglect. However, an estimated $4 billion stated budget deficit is also awaiting our public mental health champion. I personally think that outpatient commitment could be separated out and implemented in a timely fashion, and therefore allow other more complex and perhaps more expensive proposals to be addressed independently. I would not know what to say to the family members of the next person who becomes a preventable tragedy, if we delay implementing a responsible outpatient commitment law. ■