

John Snook
Treatment Advocacy Center
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What too many families are going through in Pennsylvania. Imagine you're the mother or father of a young man with schizophrenia. He's been hospitalized multiple times, has a substance abuse problem from self-medicating, and refuses to take his medication. He's deteriorating, and believes his family is part of a CIA plot to murder him. You call emergency services, but they say he hasn't done anything violent **yet**, so there's nothing they can do. They recommend you put him out into the street, because if he's homeless there's more of a chance that he'll get care.

But you know that even if he was hospitalized, he'll likely be there only long enough to be stabilized, and then he'll be released with no means of ensuring that he'll stay on it. And that means he's likely to deteriorate again, and be at risk for rehospitalization, or something worse: homelessness, incarceration or death.

These consequences all stem from the fact that Pennsylvania's treatment standard fails to reflect the advances that science has made in our understanding of severe mental illness. I'm going to concentrate quickly here at the beginning on one vitally important aspect that our current commitment standard fails to take into account – that is the phenomena of anosognosia. The illness is affecting his brain in such a way that he physically cannot understand that he's sick. This is much more than denial, he simply is unable, because of how his brain is being affected by his illness, to attribute his symptoms to the illness and not a CIA plot. This condition is also commonly seen in stroke victims and people with Alzheimer's. And what this means for this young man and his treatment – all of the voluntary programs and offers in the world will not be enough for him. His recovery depends on his being treated until he can recover the ability to understand that he needs care.

Unfortunately, Pennsylvania's treatment system does not account for this type of situation. Pennsylvania invests significant funds for mental health care. According to the National Association of State Mental Health Program Directors, Pennsylvania is ranked second nationally in per capita mental health spending. But Pennsylvania's policy has been to focus services solely on voluntary care; individuals who fail to participate are too often dropped from the rolls until they pop up again in an emergency room or after being 302'd.

Pennsylvania has worked hard to transform its system to focus on recovery and self-direction. It is a wonderful testament to the people of Pennsylvania that it has become a national model for recovery-based care. **But recovery should be for everyone.** Individuals who are too sick to know they need care should not be abandoned simply because they cannot participate voluntarily. They shouldn't have to deteriorate until they become so sick that they pose a "*clear and present danger*" before their families can help get them the care they need. And the option to help them stay in treatment when necessary should be available.

And that's what I've here to discuss today – how utilizing AOT **effectively can begin to address some of these problems, and help Pennsylvania save resources while helping those most in need.** 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. AOT allows a court to order an individual to participate in treatment and order a facility to provide that treatment. These laws are carefully crafted to affect only the most severely ill – that small portion that cycles in and out of jails, hospitals, and the streets because they cannot voluntarily maintain their treatment in the community. Providing care to this group benefits the system as a whole, as they are taking up the lion's share of Pennsylvania's mental health resources, without receiving a concurrent benefit.

And we truly are speaking about a small group of individuals. In New York, where the program is robustly utilized, an average of 62 individuals per month, or approximately 750 individuals per year, is ordered to maintain treatment under the program. Comparing populations, **Pennsylvania could reasonably expect to see less than five hundred people per year in its program** – and that is only if it were to be as robustly utilized as in New York.

But not treating this small group has a huge effect on the entirety of the system. Relapse is about 3 times more likely for patients with poor medication compliance. A large study of Medicaid recipients with schizophrenia revealed that "individuals who were [medication] nonadherent were two and one-half times more likely to be hospitalized than those who were adherent." Psychiatric hospitalization is the single most expensive aspect of mental health treatment.

Patients who were nonadherent are more than twice as likely to be arrested – regardless of prior arrest history. Nonadherent patients with schizophrenia are also nearly twice as likely to be victims of violent crime. Nonadherence is a significant factor in housing instability. One psychiatrist explained that clients who had histories of treatment nonadherence typically "burned their bridges" with housing providers. A recent study of treatment outcomes for individuals with schizophrenia cautioned,

“[The results] signal alarm for the nonadherent group, who are high risk of psychiatric hospitalizations, arrests, and victimizations. This relatively small group of patients, about 20% of the current sample, appears to consume a disproportionate amount of resources in the mental health system as well as the criminal justice system...”

Studies have documented that AOT is effective in increasing treatment compliance during the course of the court order and promoting long-term voluntary treatment compliance.

Increased treatment adherence, reduces the risks associated with nontreatment. Several studies have demonstrated reductions in hospitalization, arrests, homelessness, victimization and violence. Its role in reducing substance abuse was demonstrated in New York where individuals who received a court order under Kendra’s Law were 58 percent more likely to have a co-occurring substance abuse problem compared with a similar population of mental health service recipients. The incidence of substance abuse at six months in AOT as compared to a similar period of time prior to the court order decreased substantially: 49 percent fewer abused alcohol and 48 percent fewer abused drugs.

There has also been a great deal published internationally regarding AOT. For example, AOT has been utilized extensively in Australia and New Zealand with great success. A series of studies focused on New Zealand’s “well embedded and widely used” AOT program. There, researchers examining the views of participants concluded that, “the usefulness of community treatment orders is accepted by most patients under them in NZ, as well as by most physicians.” Another study found that “families considered the orders relief for them and a supportive structure for their relative’s care.” Mental health professionals felt the orders were “useful for engaging services users in a continued therapeutic relationship and for promoting treatment adherence.”

This reinforces much of what has been learned in the United States. For example, a study in North Carolina found that AOT significantly reduced caregiver stress – a critical point for overwhelmed families.

An extensive study of all AOT orders over nine years in Victoria, Australia found that individuals receiving extended outpatient commitment experienced 65% decreases in hospitalization days (from an average 56.3 days per year before extended AOT to only 19.6 days per year after) and a third more service utilization than in the period before AOT. This is similar to reductions in hospitalization reported in the United States. In Washington, D.C., inpatient admissions decreased from 1.81 per year to 0.95 per year before and after. In Ohio, the decrease was from 1.5 to 0.4, and in Iowa, from 1.3 to 0.3.

Another significant finding in the Victoria study was that neither the order nor community services accounted for the reduction in inpatient bed use – in fact, either one without the other was actually associated with increased inpatient utilization. The researchers’ analysis demonstrated that “it is the combination of community services enabled by outpatient commitment that facilitates the reduction in hospital utilization.”

That was also the finding of an extensive study of AOT in North Carolina. I’m going to talk about the North Carolina study in more detail, as it is probably the best study we have on the use AOT. Similar to the Victoria Study, the North Carolina researchers looked at **whether enhanced services were enough** for this population, or if their care required enhanced services plus something more, namely the outpatient order.

Who participants were: Coming out of hospital, 60% had substance abuse, 75% medication noncompliant, most did not view themselves as needed mental health care, inpatient admissions were common in the previous year, 40% had been hospitalized more than 2x in the previous year.

Study design: ½ were immunized from the outpatient order, ½ were placed on if decided they needed it by a judge, with judge also determining renewals. Enhanced services = 3x or more services a month; mean of 7.

What they found: Reductions in hospitalizations (up to 72% for psychotic disorders); increases in treatment adherence; increases in QOL for participants, reductions in victimization (mediated by reduced substance abuse + increased treatment adherence); violence(*even after controlling for substance abuse*); and arrests (74%).

And interestingly, they found that these benefits were not replicated for participants who had enhanced services alone – it was the services plus a long term court order that provided these types of benefits. The researchers found that “**Receiving frequent services in the absence of AOT was not associated with improved treatment adherence.**” In fact, enhanced services w/o AOT actually caused greater stress for caregivers, because they had appts to fight about, but no way to ensure treatment adherence.

Very similar results were found in **New York's Kendra's Law** – the most extensive study of AOT in practice we have. There they've found:

- 74 percent fewer experienced homelessness;
- 77 percent fewer experienced psychiatric hospitalization;
- 83 percent fewer experienced arrest;
- 87 percent fewer experienced incarceration;
- 49 percent fewer abused alcohol; 48 percent fewer abused drugs;
- Good adherence to medication increased by 103 percent; and
- Good service engagement increased by 51 percent.

A common argument you will hear is that Pennsylvania simply doesn't have enough services, and we must wait until there's a "perfect system."

There's a real danger in waiting for a perfect system, namely that people continue to die while we wait on a day that may never come. Especially as we are talking about individuals **already in the system** – but who are being seen, as one newspaper put it, only in "crisis mode." Mental illness is like any other illness, the longer you wait to treat it, the more difficult and more expensive it is. Now services are coming from our **emergency rooms and jails**, not our mental health systems, and we need to ask why are they allowing their responsibilities to be shouldered by someone else?

There are things that you can do to ensure that you **aren't unnecessarily stressing the system or ordering people into unavailable services**. SB226 specifies that there has to be a certain minimum level of service – namely case management or PACT teams for anyone who received a court order. Florida went with a case-by-case approach, namely that there had to be testimony that whatever level of service was deemed clinically appropriate had to be available for this individual, and services aren't available the state is notified and a count is being kept, bringing accountability to the system.

You will also hear that SB 226 is going to cause people to avoid treatment / too coercive

AOT does affect people's liberty, no one disputes that. And because that is such a big issue, the issue of **coercion and outpatient commitment** has been carefully studied. In the Duke Studies, researchers looked at the role of coercion and its affect on people's quality of life and what they found was that the benefits they received from AOT outweighed any coercion they felt.

Procedural Justice – it's not the legal status of a person that determines coercion; it's whether or not they felt treated fairly by the system. Were they allowed to speak, were their concerns listened to by the judge and their treatment team? And that is why due process is so important throughout any state action on a person.

In NY, researchers conducted face-to-face interviews with recipients (76):

- Did say AOT made about half of recipients feel angry or embarrassed, **BUT**
 - 75 percent reported that AOT helped them gain control over their lives;
 - 81 percent said that AOT helped them to get and stay well; and
 - 90 percent said AOT made them more likely to keep appointments and take medication.
 - 87 percent said they were confident in their case manager's ability to help them – and 88 percent said that they and their case manager agreed on what is important for them to work on.
 - **Rather than a forcing people away from treatment, AOT had a positive effect on the therapeutic alliance.**