SUPPLEMENTAL STATEMENT OF JAN VANTASSEL

INVOLUNTARY OUTPATIENT COMMITMENT

The tragedy in Sandy Hook has given new life to a proposal that has been defeated in this General Assembly on at least four previous occasions, most recently last year. These proposals would authorize Probate Court judges to issue court orders mandating that persons with mental illness comply with treatment plans, including medications. These are usually referred to as Involuntary Outpatient Commitment (IOC) although proponents usually refer to them as Assisted Outpatient Treatment (AOT).

Before I address the merits of these proposals, I want to make it very clear that they have nothing to do with the violence in Newtown. Outpatient commitment orders are not intended to prevent extreme but rare acts of violence. In fact, they have nothing whatsoever to do with preventing violence.

Unfortunately, there is an interest in revisiting this issue because there is an understandable desire for all of us touched by this horrific event to do something to stop it from happening again. It is, as the Hartford Courant characterized the political process in its 1999 editorial opposing New York's Kendra's Law, a "kneejerk reaction." Such actions, the editorial noted, are "often poorly thought out and with little regard for unintended consequences." Laws like Kendra's law "foment unwarranted fear of the mentally ill" the editorial explained and "detract from the most pressing problem" of investing in community services.

While the criteria for applying outpatient commitment differ, their general intent is to address the "revolving door" of persons with psychiatric disabilities who have been in and out of hospitals and jails and unable to remain stable in the community." There are family members distraught from watching relatives deteriorate when they refuse treatment who believe that a court order will change behavior. However, they can already get a court order. They can go to the very same Probate Court and be appointed conservator for the person and the judge can, and often does, tell the person in court that they need to follow the conservator's instructions or they'll be back in court and committed to a hospital. The "black robe" effect is already available, and I do not believe another order is going to make a difference.

What does make a difference is enhanced services and housing, both of which must be part of the enhanced array of services provided to persons under an outpatient commitment order. In fact, many states with outpatient commitment statutes do not implement them because their mental health systems are fragmented and underfunded. Some fear that there may be an incentive created to engage in behaviors that will result in a court order simply to be able to go to the head of the line for housing and services. That may seem far-fetched at first, but if you let it settle in, you'll see there is a logic to this strategy.

There is no doubt that there is data documenting positive outcomes from court orders with enhanced services, but there is no scientific evidence that compares voluntary services with court ordered services, and determines court ordered services are more effective. The Duke study which is often cited for this purpose compared persons under a court order with those who accepted services under the threat of a court order, in other words under duress. Therefore, as one research group that studied the North Carolina experience stated, "although patients who received prolonged involuntary community treatment had reduced hospital admissions and bed days, it was difficult to separate out how much of the improvement was due to compulsory treatment and how much to intensive community case management."

In many respects, outpatient commitment creates a false sense of assurance to families who are desperate for loved ones to engage in services, particularly take medications and get better. However, there is actually no state that forces the person to take medications. In fact, both the Virginia Tech shooter and one of the subway killers in New York were both under outpatient commitment orders. In many states they will hold the person, and petition for inpatient placement if it appears they meet commitment standards. However, that could be done anyway, and that, is what we are trying to avoid.

Connecticut has one of the best mental health systems in the country, and still my program regularly represents clients whose services are denied, reduced or terminated because resources are limited. There will be a rally tomorrow dramatizing the repeated underfunding of community providers that struggle to provide quality services and retain staff. It is well-documented that supportive housing is a cost-effective way to provide a stable living arrangement and access to services, but DMHAS lacks the housing subsidies and services necessary to meet the demand of their clients, forcing them into shelters.

The State must do more to address the needs of persons who are not engaged in services, but we do not need to spend money implementing outpatient commitment to accomplish that goal. In its first year of operations, New York appropriated $32 million to implement Kendra's law in addition to the $125,000 million appropriated for housing and services. As the Hartford Courant concluded in 1999, we are better off investing money directly in services.

I recommend that we adopt the housing first model successfully implemented in New York, which offers housing to people who are not engaged in services. Rather than attempt to influence behavior through a court order with no real effect, we can offer the person who is resistant something tangible that supports their autonomy rather than undermines it. A study of this approach, which requires tenants to meet with Assertive Community Treatment teams regularly and to establish their own goals, found it had an 88% retention rate. Residential treatment programs, in contrast, had only a 47% retention rate.

I would also encourage the state to utilize peers to provide transition support for persons being discharged from hospitals, and to conduct aggressive outreach to persons who are not engaged in services. I have attached a report on the Peer Bridger program, in New

York which has been demonstrated to reduce hospitalizations. Peers might also be incorporated into the Probate Court system to work with people who are making multiple appearances before the court.

I want to make two final points, both of which relate to discrimination. First, a report on the New York program found that a disproportionate number of persons of color were subjected to outpatient commitment. Black people were found to be almost five times more likely as White people to be subjected to this law, which dramatically reduces freedom of choice over their treatment and their lives; Hispanic people are 2.5 times more likely as non-Hispanic White people. Second, the implementation of outpatient commitment singles out persons with mental illness when other persons with chronic diseases fail to follow their treatment and medication regimens without consequence. In fact, 50%-70% of Americans fail to take their prescribed medications properly, and a person with heart disease, diabetes or a history of stroke would be a danger not only to themselves, but to others if they were driving a car and had an attack. We do not force them to comply with treatment

The relationship between voluntary and involuntary outpatient commitment programs
An Assessment of the Scientific Research on OPC Implementation

Jasenn Zaejian, Ph.D.
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Conclusions from Behavioral Science Research, National Disability and Mental Health Organizations

- A review of the studies on outpatient commitment finds benefit from the enhanced services with implementation. Although those studies exhibiting a benefit for involuntary outpatient treatment have been determined, by the Rand Corporation and other researchers, to have faulty research designs such that the conclusions drawn are not supported by the studies. (Rand, 2001. Steadman, et al, 2001, 2009).

- Acceptable scientifically controlled studies illustrated that the same benefits accrue with enhanced voluntary assisted community outpatient treatment services as with OPC. (Steadman, 2001, Cochrane Review, 2011)

- There is no relationship between dangerousness or violence and mental illness.

  "The prevalence of violence among people who have been discharged from a hospital and who do not have symptoms of substance abuse is about the same as the prevalence of violence among other people living in their communities who do not have symptoms of substance abuse." (Steadman, Monahan, et al. (1998) The Macarthur Foundation Community Violence Study)

- While, according to SAMHSA, 20%-25% of the homeless population can be diagnosed as mentally ill, an unpublished randomized study, at NYU, found that a program permitting the tenants of subsidized housing to control whether or not they receive services, compared with a program that linked housing to treatment adherence, reduced homelessness without increasing psychiatric symptoms or substance abuse. (Shinn, M., et al, NYU (2003). *Effects of housing first and continuum of care programs for homeless individuals with a psychiatric diagnosis*)

- **These National organizations strongly oppose implementation of OPC laws: The National Mental Health Association, the Bazelon Center, the California Network on Mental Health Clients (2001), the National Association for Rights Protection and Advocacy ; and the National Council on Disability (2000) have all expressed strong negative opinions regarding OPC laws, as have a few professional associations, such as the International Association of Psychosocial Rehabilitation Services.** *(Geller J. (2006) International Journal of Law and Psychiatry, 29, 234–248.*

Compulsory community and involuntary outpatient treatment for people with severe mental disorders (Cochrane Review)

Kisely S, Campbell LA, Preston N (2005)

"Cochrane Reviews are systematic reviews of primary research in human health care and health policy, and are internationally recognized as the highest standard in evidence-based health care."

- ❑ One research group found that "although patients who received prolonged involuntary community treatment had reduced hospital readmissions and bed days, it was difficult to separate out how much of the improvement was due to compulsory treatment and how much to intensive community management." (North Carolina studies, Swartz 1999)

- ❑ The authors "found little evidence to indicate that compulsory community treatment was effective in any of the main outcome indices..."including readmissions to a hospital or jail, quality of life, social functioning, mental state and homelessness. There may be a decrease in risk of victimization (Risk of the consumer being the victim of a crime), but it is difficult to discern if it is due to the OPC or enhanced services.

- ❑ "In terms of numbers needed to treat, it would take 85 OPC orders to prevent one readmission, 27 to prevent one episode of homelessness and 238 to prevent one arrest."

- ❑ "It appears that compulsory community treatment results in no significant difference in service use, social functioning or quality of life compared with standard care."

- ❑ These internationally recognized reviews argue against the need for Laura's law.