

Mandatory Outpatient Treatment of Persons with Mental Illness: An Overview

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Current Needs

- It should be easier for people in crisis to access intensive services when treatment is needed
- There are problems associated with current statutes that require a person to become a danger to himself or others before gaining access to intensive services
- Virginia needs increased community capacity in both “upstream” mental health services and intensive crisis intervention services

Common Terminology

Involuntary Outpatient Commitment (IOC)

is the same as

Mandatory Outpatient Treatment (MOT)

and

Assisted Outpatient Treatment (AOT)

Three Types of MOT

1. *Conditional Release* – Commitment order begins with hospital care and remains in effect after discharge to outpatient (e.g., NGRI, §19.2-182.7)
2. *Alternative to Hospitalization* – Same criteria (e.g., dangerous or unable to care for self) but two dispositions - inpatient or outpatient (§ 37.2-817)
3. *Need for Treatment* (e.g., Kendra's Law) – There is a lower standard for outpatient commitment order (need for treatment to prevent deterioration) than for inpatient commitment order

Current Virginia Law

- § 37.2-817 - authorizes court to order outpatient treatment in lieu of hospitalization (type 2 from previous slide) when specific conditions are met
- *Used Infrequently* - due to need for intensive services, and practical problems, e.g., treatment planning, hearing procedure, safe transportation, monitoring, etc.
- *Note* - CSB residential crisis stabilization programs are a non-hospital alternative for temporary detention (used for temporary detention but not for commitment to date)

MOT in Other States

(source: M. Swartz)

- Permitted in all but a few states
- Explicitly permitted by 42 states and the District of Columbia
- Despite statutory support, used inconsistently

Points of Disagreement

(source: M. Swartz)

- *The Evidence* - How strong and reliable is the evidence for the benefit of outpatient commitment in practice; what are the important outcomes?
- *The Target Population* - What is the size and nature of the appropriate population to be subjected to outpatient commitment? What are the right criteria?
- *The Reach of Outpatient Commitment* - How long should it last? Provisions and sanctions; safeguards; services to accompany outpatient commitment? Who can petition? What services have to accompany it?

New York's Kendra's Law

- Enacted 1999 with sunset, renewed in 2005 with external evaluation requirement
- State, regional, local “AOT” infrastructure
- \$32 million (FY05-06) for case management and other services, oversight for *Kendra's Law* consumers
- \$125 million for enhanced community services (ACT, Single Point of Access) for all consumers

Kendra's Law – Some Features

- Petition filed alleging person meets AOT criteria, supported by sworn MD statement, exam required
- Criteria (abbreviated): is 18+ YO, has MI, is unlikely to survive safely in community w/o supervision, has history of non-compliance with treatment, is unlikely to volunteer for treatment, is in need of AOT to prevent relapse and deterioration resulting in serious harm, is likely to benefit from AOT
- AOT must be least restrictive option
- Written treatment plan
- Hearing, counsel, other due process protections
- May be hospitalized for failure to comply, pending MD exam

Kendra's Law (cont.)

- Evaluation performed by NY State Office of Mental Health (*Final Report*, March 2005)
- Positive outcomes reported for many (not all) recipients, including:
 - Increased program/treatment participation
 - Reduced hospital admissions
 - Reduced homelessness
 - Reduced arrest and incarceration
 - Sustained improvements in social and community functioning

Kendra's Law - Current Research

(Duke/PRA Independent Study)

(source: M. Swartz)

- Is the court order necessary?
- Would enhanced services alone be enough?
- How do individuals do when they are off AOT?
- Is there a bias in who gets AOT?
 - Racial and economic disparity?
- What is the impact on the service providers?
- Large fiscal obligation – at what cost to the rest of the system?

Operational & Policy Issues related to MOT

- *New Services:* MOT re-prioritizes service delivery. Expansion of MOT without new services would displace voluntary consumers.
- *Administrative Costs:* Resources are needed for developing treatment plans, preparing and filing petitions, conducting hearings, monitoring services, providing transportation, managing revocations, etc.

Operational & Policy Issues

(cont.)

- *Forced Medication:* Biggest issue underlying MOT is medication “non-compliance”. Unwillingness vs. inability to comply - for some people, taking medications poses real problems. Can we “force” compliance in community settings?
- *Training and Support:* Training and support for special justices, law officers and MH providers is needed to ensure consistent practice and quality.

Operational & Policy Issues

(cont.)

- *Virginia's Transformation Initiative:* Current capacity-building is creating more options, more person-centered and recovery-oriented care. This will enhance voluntary engagement in services and lead to better outcomes.
- *Voluntary Treatment Works:* Intensive, accessible voluntary services have positive outcomes similar to those reported for Kendra's Law.

Examples of Voluntary Treatment in Va.

- *PACT*: Outcomes of Assertive Community Treatment Programs (PACT) in Virginia
 - Fewer hospitalizations and hospital days
 - Increased housing stability
 - Reduced involvement with criminal justice system
- *PACT Funds*: \$11 Million in ongoing state funds allocated in FY '07 for 16 PACT teams (1,300 enrollees)
- *Other Crisis Service Investments*: \$8.4 Million allocated in FY '07 for crisis stabilization, crisis response, resolution and referral services

Visible Conditions and Events Spur Debate about MOT

- Family experiences with lack of access to treatment
- Homelessness
- Suicide
- Violent homicide by persons with MI
- Person with MI in Jails and Prisons

Legislative Activity to Date

- Last significant amendment to Virginia's outpatient commitment law was in 1995.
- Several MOT proposals have subsequently been studied and/or introduced.
- Comprehensive *Kendra's Law* – type proposals have included:
 - HB 801 (1998)
 - SB 1079 (2003)
 - SB 18 (2006)
 - SB 808 (2007)

Legislative Activity (cont.)

- Other recent MOT legislation has included:
 - SB 309 (2006)
 - SB 763 (2007)
 - HB 1904 (2007)
- Strongly emotional testimony from both proponents and opponents
- None of these bills were enacted

Related Activity

- *Governor's Transformation Initiative* - increased capacity and improved access to services, including emergency and crisis stabilization services.
- *Commission on Mental Health Law Reform* – comprehensive review and re-design of Virginia's mental health laws, including MOT.
- *Virginia Tech Review Panel*
- *Interagency Civil Admissions Advisory Council (ICAAC)* chaired by Secretary Tavenner, addresses operational issues such as transportation, medical screening, training, alternatives to hospitalization, etc.

Summary

- Today, there is insufficient evidence to say with absolute certainty whether MOT is more effective than voluntary treatment alternatives, if those are available and accessible.
- Nevertheless, some limited and judicious expansion of MOT via a *Kendra's Law* – type statute would probably benefit some people.
- We do know absolutely that mandatory outpatient treatment through a *Kendra's Law* – type initiative is a major investment of time and resources (M.Swartz).

Summary (cont.)

- Policy decisions about MOT must be made in the context of its full impact on the service delivery system in its entirety.
- Any expansion of MOT through a Kendra's law – type initiative must be coupled with expanded community services, and a sufficient administrative infrastructure to support it.
- We must not weaken, deviate from or abandon our explicit commitment to the people we serve to achieve our vision of a recovery-oriented system of care.

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Thank You