

The Untapped Power of Virginia's Mandatory Outpatient Treatment Law

**Continuum of Care Workgroup
Joint Subcommittee to Study Mental
Health Services in the Commonwealth
in the 21st Century
Suffolk, VA
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Why MOT?

Two underlying premises, confirmed by research:

1: Non-adherence to mental health treatment has severe consequences

2: The leading cause of treatment non-adherence is ANOSOGNOSIA (Lack of insight)

The Consequences of Non-Adherence: Violence and Crime

- People with SMI receiving treatment (the great majority) are NOT more dangerous than general pop.
- UNTREATED people with SMI *ARE* more dangerous than general pop.
- Untreated SMI estimated to be a factor in 10% of US homicides.
- More commonly, untreated SMI leads to assaults, property and drug crimes

The Consequences of Non-Adherence: Frequent Hospitalization

- People with SMI can only be kept in a hospital until stabilized
- Non-adherence with outpatient treatment makes re-hospitalization inevitable. A vicious cycle.
- Each successive psychotic break puts recovery further out of reach.

The Consequences of Non-Adherence: Budgetary Impact

- Law enforcement, incarceration, and hospitalization are enormously expensive.
- Patients caught in the revolving door are stressing the CJ & MH systems beyond the breaking point.

**The leading cause
of non-adherence:**

**a symptom of brain
dysfunction known as ...**

ANOSOGNOSIA



Anosognosia

- Lack of insight into one's own illness. (inability to recognize illness in self)
- NOT denial
- Brain-based. Out of the individual's control
- Makes non-adherence *logical*

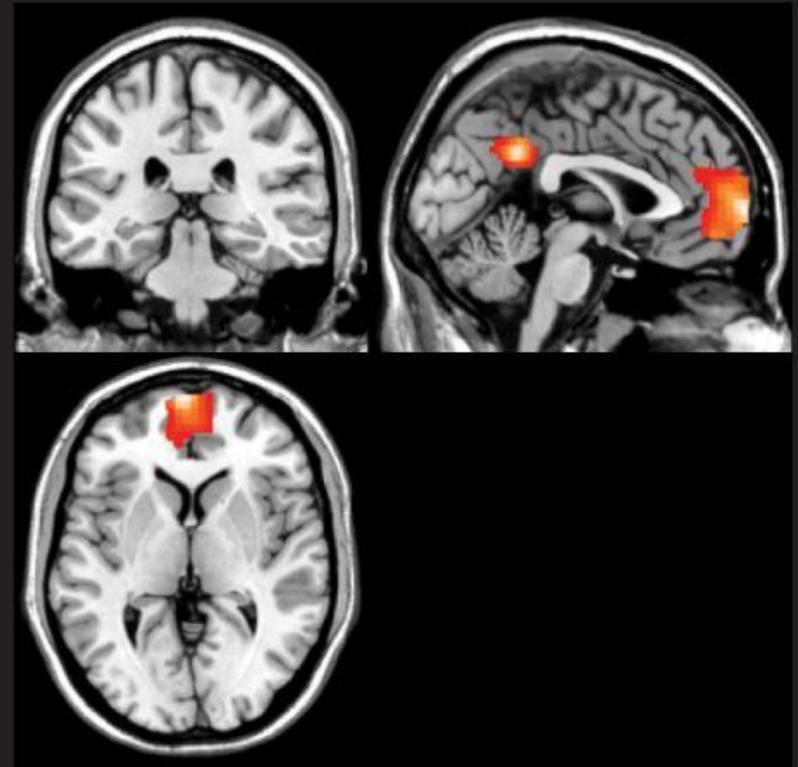
A**Low self-reflection****B****High self-reflection**

Figure 2. Brain activation of selected individuals is displayed (the patterns of activation are consistent with the group-level differences). Differences in brain activation in the left and right vMPFC during a self reflection task between two patients with schizophrenia, one patient with impaired insight and one patient with good insight. (A) a patient with a low score (7) on the subscale self reflectiveness of the Beck Cognitive Insight Scale (BCIS) and (B) a patient with a high score (27) on the subscale self-reflectiveness.

Linking Anosognosia and Non-Adherence

Psych. Services 2/06:

- Of 300 patients with non-adherence tracked, 32% found to lack insight.
- Those 32% had significantly longer non-adherent episodes, more likely to completely cease meds, have severe symptoms, be hospitalized

Bottom Line on Anosognosia

- If you build it ...



... **SOME** still won't come!

MOT is ...

- **A strategy to address non-adherence**
- **Intended for the small subset caught in the revolving door**



MOT, broadly defined

Petition to court, identifying individual as:

- Mentally ill
- In need of treatment to survive safely in the community
- Unlikely to comply with treatment voluntarily

Submission of treatment plan to the court, specifically tailored and backed up by medical testimony

Outpatient commitment (cont.)

- Court hearing, with patient represented by counsel
- Court order directing BOTH
 - Patient to comply with treatment plan
 - MH system to ensure delivery of treatment plan

It's Not About the Teeth!



Purpose #1: “The Black Robe Effect”



Purpose #2: Light a Fire Under Providers



Purpose #3: Rapid Response to Non-Compliance



Lessons from the Field

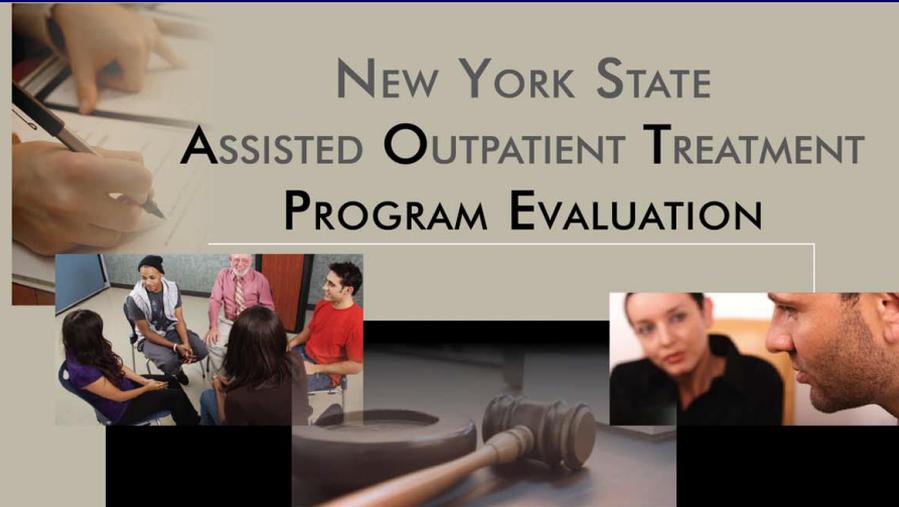
Kendra's LAW

Final Report on the Status of

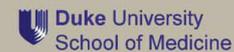
Assisted Outpatient Treatment

New York State
George E. Pataki,
Governor

Office of Mental Health
Sharon E. Carpinello, R.N., Ph.D.,
Commissioner
March 2005



Submitted under Contract with the New York State Office of Mental Health



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June 30, 2009

MOT Works: Harmful Behaviors Plummet

2005 NYS-OMH study compared 1st 6 mos. under AOT to 6 mos. prior:

- 55% fewer recipients engaged in suicide attempts or physical harm to self;
- 49% fewer abused alcohol;
- 48% fewer abused drugs;
- 47% fewer physically harmed others;
- 46% fewer damaged or destroyed property; and
- 43% fewer threatened physical harm to others.

MOT Works: Reconfirmed in 2009

2009 NY study results (Duke et. al.):

- Likelihood of arrest over 1-month period cut in half (3.7% to 1.9%)
- AOT group 4x less likely to commit serious violence than non-eligible control group, despite more violent histories
- Likelihood of hospital admission over 6-month period cut in half (74% to 36%)
- “Substantial reductions” in hosp days

Fears of MOT are Unfounded

- MOT recipients no more likely to feel coerced by mental health system
- MOT recipients report no greater sense of stigma
- Impact on quality of voluntary services was **POSITIVE**

The Court Order Matters

Comparison of MOT patients to MOT-eligible “voluntaries,” with equal quality of services, found:

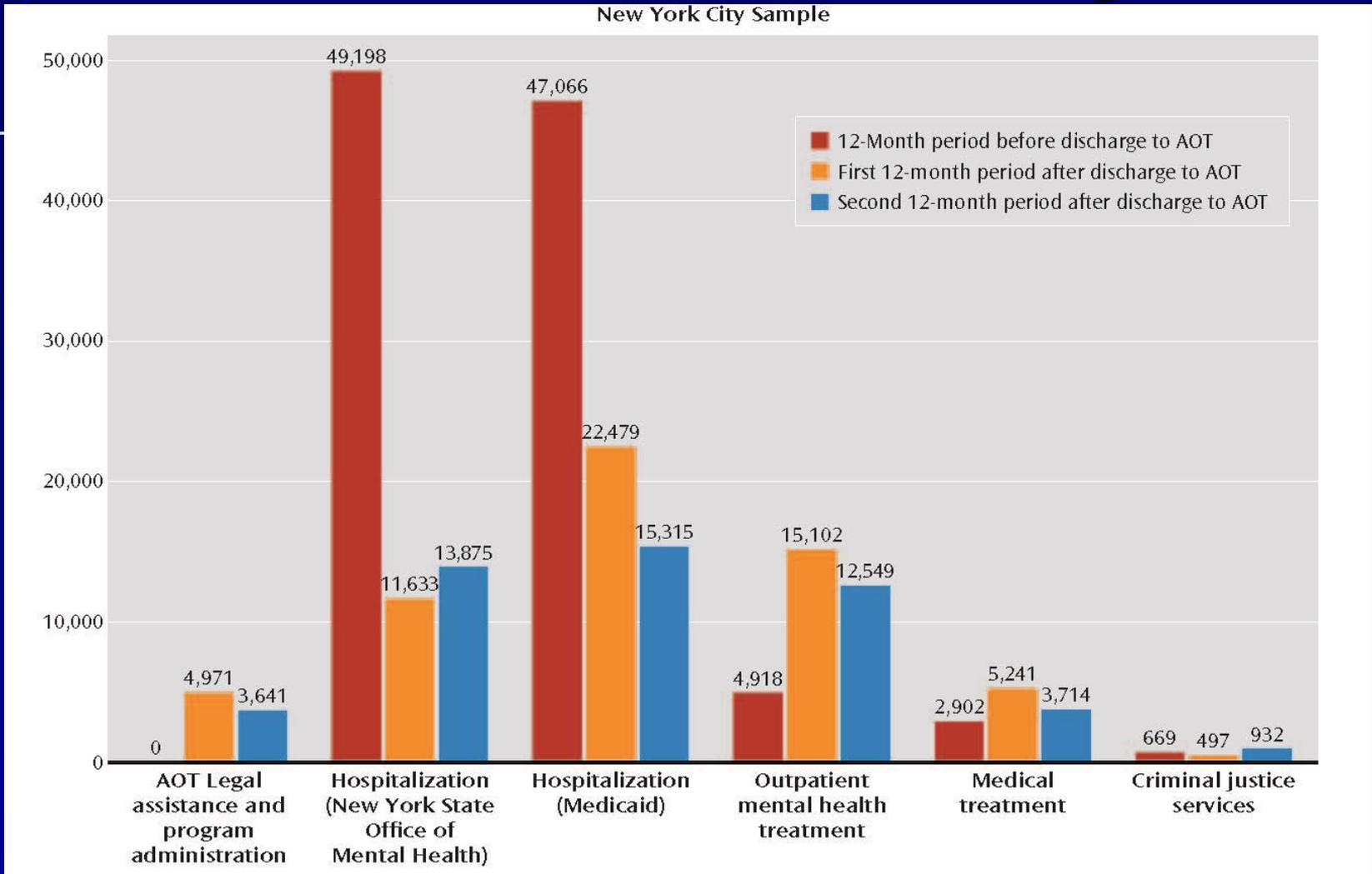
- “Highly statistically significant” difference in the likelihood of a hospital admission over six months (36% vs. 58%).
- MOT patients less likely to be arrested than “voluntaries” (1.9% per month vs. 2.8%)
- MOT patients had substantially higher level of personal engagement in their treatment (55% “good” or “excellent” vs. 43%).

The Court Order Matters

NY research conclusion:

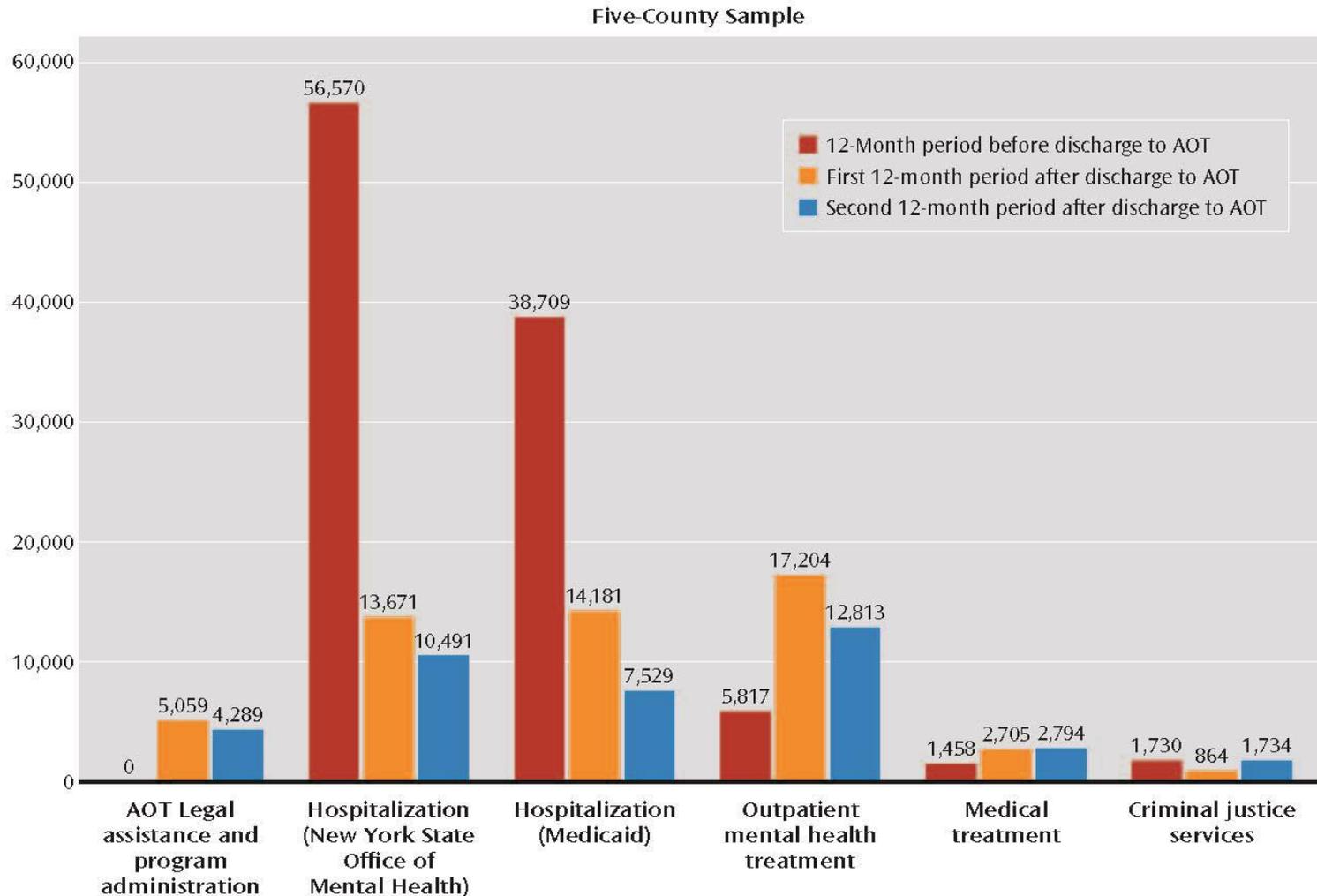
- “The increased services available under [MOT] clearly improve recipient outcomes. However, the [MOT] court order, itself, and its monitoring do appear to offer additional benefits in improving outcomes.”

MOT Saves Money!



In NYC, net treatment costs declined 43% Y1, another 13% in Y2.

MOT Saves Money!



In 5 other counties, net treatment costs declined 49% Y1, another 27% in Y2.



Assisted Outpatient Treatment (AOT)

Assisted outpatient treatment (AOT) is the practice of delivering outpatient treatment under court order to adults with severe mental illness who are found by a judge, in consideration of prior history, to be unlikely to adhere to prescribed treatment on a voluntary basis. AOT is a form of civil commitment intended for those who suffer from anosognosia (lack of insight) in addition to severe mental illness, and have been repeatedly hospitalized or arrested as a consequence of treatment nonadherence. Through the ritual of a court hearing and the symbolic weight of a judge's order, AOT seeks to leverage a "black robe effect," motivating the individual to regard treatment adherence as a legal obligation and impressing upon treatment providers that the individual requires close monitoring and comprehensive services.

Forty-five states and the District of Columbia currently have laws authorizing AOT and dictating the specific legal process. Although the requirements for implementing AOT on the local level will vary with the specifics of each state law, implementation generally requires collaboration among local mental health authorities, treatment providers, and the court with jurisdiction over civil commitments.

Descriptive Information

Areas of Interest	Mental health treatment
Outcomes	Review Date: February 2015 1: Assault or threat of violent behavior 2: Hospitalization 3: Quality of life 4: Suicide risk

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Program Profile

Assisted Outpatient Treatment (AOT)

Evidence Rating: [Effective - More than one study](#) 

Program Description

Program Goals

Assisted outpatient treatment (AOT), also known as outpatient commitment (OPC), is a civil legal procedure whereby a judge can order an individual with a serious mental illness to follow a court-ordered treatment plan in the community. AOT is intended for adults diagnosed with a serious mental illness who are unlikely to live safely in the community without supervision and treatment, and who also are unlikely to voluntarily participate in treatment. The goal of AOT is to improve access and adherence to intensive behavioral health services in order to avert relapse, repeated hospitalizations, arrest, incarceration, suicide, property destruction, and violent behavior.

Forty-four states have statutes permitting some form of OPC or AOT (Robbins et al. 2010). One example is New York State's "Kendra's Law." The law, passed in 1999, which was proposed by the New York State Attorney General, was named for a young woman who was killed after being pushed in front of a New York City subway by a man with a history of serious mental illness and hospitalizations. The intent of the law was not only to authorize court-ordered community treatment but also to require mental health authorities to provide resources and oversight necessary so that high-risk individuals with serious mental illness may experience fewer incidents and can live in a less restrictive alternative to incarceration or involuntary hospitalization.

Program Snapshot

Age: 18 - 50

Gender: Both

Race/Ethnicity: Black, Asian/Pacific Islander, White, Other

Geography: Rural, Suburban, Urban

Setting (Delivery): Inpatient/Outpatient

Program Type: Cognitive Behavioral Treatment, Group Therapy, Individual Therapy, Wraparound/Case Management, Violence Prevention

Targeted Population: Mentally Ill Offenders

Current Program Status: Active

MOT in Virginia



44 other states have **ONE AOT law *each!!***

- 2 camps:
 - 27 states have **a unified commitment standard**. Person found to be dangerous to self/others can be ordered to inpatient or outpatient, depending on which is the least restrictive appropriate alternative.
 - 17 states have **separate commitment standards**: inpatient requires current dangerousness; outpatient requires elevated risk of future dangerousness.

Virginia refuses to choose! (a foot in each camp)

- Option 1: “Direct MOT”
 - VA Code § 37.2-817(D)
 - Judge finds person is dangerous, BUT, MOT is the LRAA
 - Patient “agrees to abide”
 - Treatment will be delivered by the CSB or designated provider

Virginia refuses to choose! (a foot in each camp)

- Option 2: “New Hearing Step-Down MOT”
 - VA Code § 37.2-817(C)
 - While person is inpatient, a physician, fam member, personal representative of the person, or CSB may petition for MOT to commence at discharge (potentially post-danger)
 - Must have two involuntary admissions, or two voluntary admissions following TDOs, or one of each, in the prior 36 months

Virginia throws in a 3rd (illogical) hybrid option!

- “Pre-authorized step-down” MOT
 - VA Code § 37.2-817(C)
 - Discharge to MOT can be pre-authorized within an order of inpatient commitment. Doctors can use it later, if MOT becomes the LRAA (which may mean patient is still dangerous)
 - 4 additional findings that don’t apply to Direct MOT (listed on next slide):

Pre-auth step-down MOT: 4 additional findings

- 2 invol admissions in 36 mos **caused by non-compliance;**
- Needs MOT to prevent a relapse or deterioration likely to result in person again meeting the criteria for involuntary admission;
- Unlikely to voluntarily participate in outpatient treatment after completing inpatient treatment; and
- Is likely to benefit from MOT.

Good News: MOT Usage on the rise!

Figure 12. Annual Frequency of MOT Orders (All Types), FY10-FY14 (CMS)

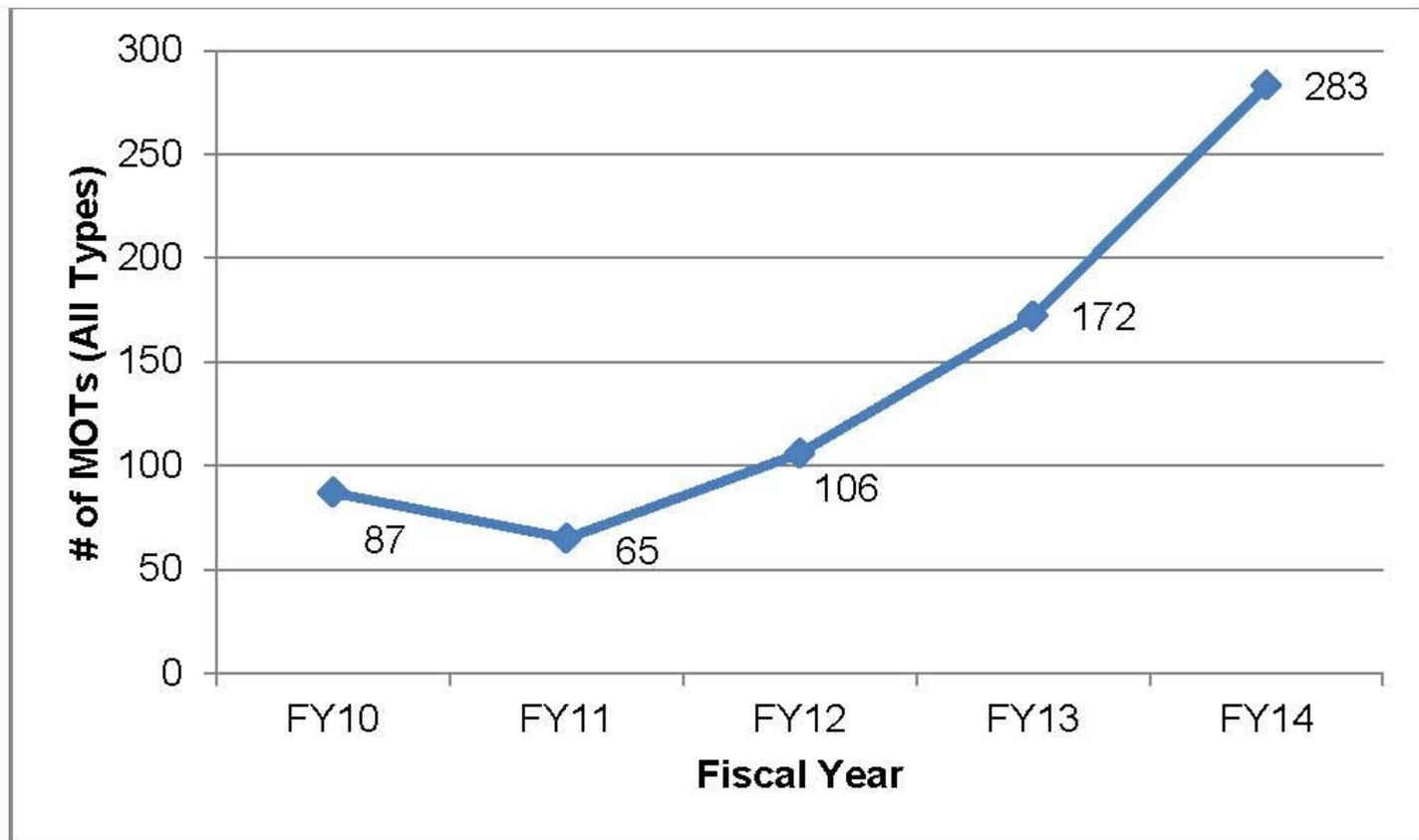


Table 8. Fiscal Year MOT Counts by Type (CMS)

	MOT TYPE				Total
	Direct	"Step-Down"			
		New Hearing	Discharge		
			Initial	Recommitment	
FY 2009	44	6	0	0	50
FY 2010	86	1	0	0	87
FY 2011	24	5	6	30	65
FY 2012	51	5	6	44	106
FY 2013	103	26	10	33	172
FY 2014	195	33	19	36	283
TOTAL	503	76	41	143	763

Fixes to consider

- Eliminate the hybrid: Why should pre-authorized step-down MOT require anything more than a finding that the person's condition has improved such that MOT has become the LRAA?
 - Current law means a “dangerous but improved” patient who no longer needs the hospital must stay there anyway.

Fixes to consider

- Requirement of “patient agreement” filters out many who could most stand to benefit from MOT
- 90-days of MOT is rarely enough

Thus always to tyrants!
(untreated psychosis **IS** a tyrant)

