RESPONSE TO THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE'S REPORT ON THE OUTPATIENT SERVICES PROGRAMS WORKGROUP

Submitted by:
Maryland Disability Law Center
Mental Health Association of Maryland
On Our Own of Maryland, Inc.

December 2014

Maryland Disability Law Center (MDLC) is the federally funded, non-profit legal services organization officially designated by the Governor of the State of Maryland as the Protection and Advocacy System for individuals with disabilities. Founded in 1977, MDLC's mission is to work with and for people with disabilities in defense of their legal and human rights. MDLC has been extensively involved with litigation, legislative, and policy work related to mandated community treatment in both the civil and criminal contexts; the statutory and constitutional limits on the involuntary administration of psychotropic medication; and the rights of individuals with mental disabilities to be free from coercion and to be fully integrated into the community.

Mental Health Association of Maryland (MHAMD) is a voluntary, nonprofit citizens' organization that brings together consumers, families, professionals, advocates and concerned citizens for unified action in all aspects of mental health and mental illness. Since 1915, MHAMD has been dedicated to promoting mental health, preventing mental disorders, and achieving victory over mental illness through advocacy, education, research, and service. MHAMD is an affiliate of Mental Health America and the National Council for Behavioral Health. MHAMD envisions a just, humane and healthy society in which all people are accorded respect, dignity and the opportunity to achieve their full potential free from stigma and prejudice. MHAMD supports person-centered recovery in the least restrictive environment, and opposes unnecessary restrictions on liberty, independence, choice and self-determination.

On Our Own of Maryland, Inc. is a statewide mental health consumer education and advocacy organization that promotes equality in all aspects of society for people who receive mental health services, and develops alternative, recovery-based mental health initiatives. The organization's goals are to support and to provide technical assistance to its affiliated organizations and their members; to encourage improvements and alternatives to the current mental health system; to promote self-help programs; and to advocate for the least restrictive setting for those undergoing treatment and provide the maximum degree of personal freedom. One of On Our Own of Maryland's many programs includes the Olmstead Peer Support Project. This project prepares consumers in the state's psychiatric facilities to leave these facilities by advocating their options in less restrictive settings, such as community placements.

TABLE OF CONTENTS

EXECUTIVE SUMMARY

During the 2014 legislative session, two legislative approaches were put forward to address the longstanding need for better engagement of a discrete population of individuals with serious mental illness. An outpatient civil commitment bill was introduced, accompanied by a substantial amount of misinformation put forward by a national lobbying group. House Bill 1267/Senate Bill 882 was also introduced to establish a voluntary program designed to engage individuals at risk for disruptions in continuity of care – the same population targeted by supporters of outpatient civil commitment. While there was no opposition to House Bill 1267/Senate Bill 882, proponents of outpatient civil commitment argued that involuntary treatment was still needed. In an effort to resolve disputed claims about the necessity and potential effectiveness of each approach, the Legislature amended House Bill 1267/Senate Bill 882, to direct the Department to engage stakeholders in an evidence-based examination of a broad range of potential programs, voluntary and involuntary, and to address potential critical disparities in implementation.

Consumers, family members, advocates and providers alike are in complete agreement that a solution is needed to improve continuity of care. The interim study offered an opportunity to build consensus around a proposal that could be supported by all. Rather than leading an unbiased examination and allowing stakeholders to potentially choose a voluntary program of services as the best model to reach at-risk individuals – and as an *alternative* to involuntary treatment – the Department pre-determined that involuntary treatment would be proposed to the Legislature in the required Final Report.

While we were distressed by the Department's unilateral decision, we are stunned by the inadequacy of the final proposal for outpatient civil commitment. The Department makes broad assumptions about the target population and asserts that outpatient commitment would "improve continuity of care," yet provides no evidence-base to support its assumptions or conclusion. Because outpatient civil commitment deprives individuals of the constitutional right to make their own treatment decisions, however, the Department must demonstrate that involuntary treatment is necessary because it produces sufficiently superior outcomes to voluntary services to justify the infringement of rights. The Department could not make this showing, because the weight of the research evidence is against the effectiveness of outpatient civil commitment.

Moreover, the Department fails to adequately address potential racial, economic and geographic disparities, and instead merely states that having a single petitioning entity will resolve these issues. The Legislature, the mental health community, the general public, and most certainly the individuals who would be targeted for expanded coercion, deserve a full analysis on these critical

points. We offer this response to provide the Legislature with the required evidence-based examination of outpatient civil commitment and to offer our proposal for an alternative voluntary program.

Summary of the key findings:

•Six independent systematic reviews of the body of outpatient civil commitment research concluded that there is **little or no evidence** that people court ordered to community treatment have better outcomes than those receiving voluntary services. Conducted by teams of independent researchers with expertise in the topic area, a systematic review is regarded as the highest level of research evidence, as all qualified studies are identified, collected and analyzed. The six independent systematic reviews of outpatient civil commitment research included two meta-analysis studies, in which primary data from existing randomized, controlled trials is pooled and analyzed. As compared to any single study, this pooling of data increases statistical power and reduces potential bias. A quality meta-analysis thus provides the most accurate analysis of existing randomized controlled research trials.

Consultants, hired by the Department to review only three selected studies, came to a different conclusion on only one domain, finding *moderate* evidence that people on court orders have fewer hospital admissions. The Department's consultants rated the strength of evidence on all other claims as "weak" or unconfirmed.

•According to Maryland data, 503 individuals were identified as having high emergency department or inpatient care utilization rates in fiscal year 2012. In the following fiscal year, 89% of that population was receiving voluntary services. It is unknown whether the remaining 53 individuals were offered enhanced and coordinated services and refused, or if they were simply discharged with no follow-up. In addition, 50% of the at-risk population no longer met the high utilization criteria the following year, demonstrating the effectiveness, to some unknown extent, of voluntary services in reducing hospital and emergency department admissions. Nearly three-quarters of the high-risk population were diagnosed with substance use disorder, indicating that substance use, not mental illness, may be the primary cause of high inpatient admissions.

While this data is incomplete, it calls into question the Department's hypothesis that "many individuals" having frequent contact with a psychiatric facility will refuse voluntary services and that coercion is necessary to reduce hospital admissions. More information is required before a reasonable conclusion can be made about the nature and cause of disengagement from community services – in other words, whether it results from a fragmented system, poor quality of care

experienced by the individuals, the impact of substance use, or the symptoms of a severe mental illness.

•Studies on outpatient civil commitment conducted in North Carolina and New York revealed that people of color and those living in poverty are disproportionately impacted by involuntary community treatment orders. In North Carolina, two-thirds of individuals court-ordered to community treatment were African American, despite only representing approximately 22% of the total state population. In New York, African Americans were subjected to court orders **five times** more frequently than whites, while Latinos were **two and a half times** more likely than whites to be under a court order. The study authors observed that states targeting the "revolving door" population – those involuntarily hospitalized and concentrated in the public mental health system – will "inevitably select a greater proportion of African Americans than their share in the general population, because that is the racial distribution of the target population, for historical reasons."

•Although it is frequently reported that forty-five states have civil outpatient commitment, only ten states have the type of "preventive commitment" law proposed by the Department. Preventive commitment targets people who do not meet the state's inpatient commitment criteria; in other words, they are not presently dangerous or gravely disabled. Thus, the Department's proposal is a radical departure from the well-established concept that people who have the capacity to make treatment decisions are free to do so absent a clinical prediction of reasonably imminent harm to self or others.

Regardless of the specific type of outpatient civil commitment law, few states use it widely and it appears that only New York has developed a comprehensive program to implement its law. Undoubtedly, cost is a major factor in the decision by most mental health authorities not to use outpatient civil commitment. New York spends approximately **one hundred and fifty-eight million dollars annually** to support its outpatient civil commitment program. Despite this massive influx of additional annual funding, intensive voluntary services were dramatically reduced during the initial three-year implementation period. Accessibility to voluntary services remains vulnerable due to flat funding.

Without significant additional funding attached annually to any outpatient civil commitment program proposed for Maryland, it will either be rarely used or it will result in "queue jumping," in which people court-ordered to treatment will be prioritized for intensive services, shutting out those who voluntarily seek such services. Given the lack of empirical research support for the proposition that a court order offers any benefit above and beyond voluntary services, passing a

civil commitment law does nothing more than promote stigma against persons with a serious mental illness while effectively punishing those seeking help.

•In contrast to the lack of evidence supporting the need for mandated community treatment, there is clear evidence supporting the efficacy of intensive community services in significantly improving outcomes for people at risk for disruptions in continuity of care. For example, Assertive Community Treatment (ACT) is one of the most extensively researched models of community care for people diagnosed with severe mental illness who have been disengaged from mental health treatment. Systematic reviews of over fifty-five studies, including twenty-five randomized controlled trials of ACT, conclude that it is highly successful in engaging clients in treatment, substantially reduces psychiatric hospital use, lowers rates of substance use, increases housing stability and moderately improves psychiatric symptoms and subjective quality of life. Enhancements to the traditional ACT model have been used in pilot programs in Maryland, resulting in significant reductions in hospital admissions and improvements in other outcomes for the same population that would be targeted under a civil outpatient commitment program. Moreover, New York's experience with mandated community treatment demonstrates that creating a single point of entry to a coordinated system of care and having provider and administrative oversight are the key elements to improving outcomes for people with histories of disengagement from traditional services.

A court order is simply **not** necessary to create a well-designed program to engage people in treatment and significantly improve outcomes for the at-risk population. Moreover, a voluntary program avoids the significant problems attendant to outpatient civil commitment – discrimination and deprivation of civil liberties, racial/economic/geographic disparities, and unnecessary legal, court and enforcement costs.

Recommendation

As introduced, House Bill 1267/Senate Bill 882 provided for a voluntary program to engage individuals at risk for disruptions in continuity of care and as an alternative to outpatient civil commitment. The legislation was developed with input from representatives from Maryland's advocacy and provider community, current and former Maryland mental health system administrators, and a former New York mental health administration official with experience implementing and overseeing an outpatient civil commitment program. The proposed program included Assertive Community Treatment as the service delivery model with enhancements such as peer support, unlimited outreach efforts, and financial incentives for providers. The program also

incorporated elements of the New York program, such as a single point of entry and service provider and systems accountability for outcomes.

In light of the lack of current evidence that a court-order offers any benefit above and beyond voluntary services, we believe that a reasoned approach to this divisive issue would be to establish a five-year pilot to design and implement a voluntary program in selected jurisdictions based on the elements found in the 2014 legislation. Such a pilot would afford Maryland the opportunity to accurately assess the effectiveness of a well-designed targeted voluntary program without the significant additional funding necessary to implement a comprehensive program throughout the state. It would also provide an opportunity to collect the data and other information needed to determine whether some people would still remain disengaged from services and, if so, whether there are any common characteristics of that population so further enhancements to the program could be strategically developed and implemented.

SECTION I. Outpatient Civil Commitment

A. Few States Have The Type of "Preventive Outpatient Commitment" Law That The Department Is Proposing

Legally mandated treatment in the community is known by a variety of titles that are frequently used interchangeably, including "Assisted Outpatient Treatment," "Outpatient Civil Commitment," "Involuntary Outpatient Treatment," "Preventive Outpatient Commitment" and "Compulsory Treatment Orders." The Department has chosen to use "Outpatient Civil Commitment." Titles, however, do not convey the criteria or requirements of the particular laws[1] that have been enacted outside of Maryland, which fall under one of three[i] categories:

(1) Less Restrictive Alternative to Inpatient Admission. Thirty-three states permit a court or administrative hearing officer to order an individual to adhere to community treatment in lieu of involuntary inpatient admission. Thus, this type of Outpatient Civil Commitment is restricted to situations in which it has already been proven by clear and convincing evidence that the individual meets the inpatient commitment criteria, i.e., is a current danger to self or others, or currently gravely disabled.

(2) Conditional Release From Inpatient Hospital. Forty states permit mandated community treatment as a condition of discharge for persons who have been involuntarily admitted on an inpatient basis.

(3) Preventive Outpatient Commitment. Ten states[2] permit mandated community treatment for individuals who do not currently meet the inpatient commitment criteria, but are believed to need mental health treatment to prevent "likely" future hospitalizations.

In their repeated assertion that Maryland is sorely out of step with the rest of the nation because 45 states have Outpatient Civil Commitment ("OCC") laws, proponents fail to disclose that the "Preventive Outpatient Commitment" model is squarely in the minority. The vast majority of states currently only authorize OCC for individuals who already meet the inpatient commitment criteria, and thus it is truly a "less restrictive alternative" to inpatient hospital care. The Department, however, is urging the Legislature to instead strip civil liberties from persons who are not dangerous (or gravely disabled), based on the belief that at some undetermined point in the future, they *may* meet the inpatient commitment criteria. This is, in fact, a quite radical proposal that

[1] Several states have passed more than one type of outpatient civil commitment law.
[2] Current as of October 2013.

contravenes long-standing legal and policy principles of individual liberty and self-determination in the absence of an objective prediction of a reasonably imminent threat of harm to self or others.

Proponents often characterize preventive OCC as a benign tool that merely "assists" individuals to reach their maximum potential, and argue that there is little impact on civil liberties because individuals may still live "freely" in the community. We strongly disagree. The Department proposes that treatment orders may mandate that a person live in supervised housing, take prescribed medications, submit to blood tests and urinalysis, attend day programs, group therapies, specified educational or vocational activities, and accept any and all other services that may be contemplated in the future.[ii] In sum, individuals will have no independent choice in where they live, their personal and social relationships, their own healthcare and how they spend their waking hours. Worse, they could be subjected to the compulsory drawing of their blood – a bodily intrusion from which other citizens who are neither accused nor convicted of a crime are protected under Maryland's Declaration of Rights and the U.S. Constitution.

Given the civil liberty implications of a preventive OCC model, the Legislature directed the Department to examine the evidence supporting involuntary and voluntary programs, and to address potential disparities in implementation. As outlined below, the Department chose not to comply with this directive.

B. The Department Provides No Evidence to Support Its Underlying Assumptions About The Causes Of Disruptions in Continuity of Care

As a preliminary matter, it is necessary to reasonably identify the population described by the Legislature as being at high risk for disruptions in continuity of care. In 2013, the Department advised the Continuity of Care Advisory Panel (COC Panel)[3] that high emergency room and inpatient utilization are two measures used in medicine as indicators of challenges in coordination of care, and provided data[iii] showing that, during fiscal year 2012, 503 people in the Public Mental Health System were admitted to emergency departments six times or more or had psychiatric hospital inpatient admission costs that exceeded $69,900.[4] The Department defined this cohort as the basis for investigating continuity of care challenges leading to frequent contact with the State's psychiatric facilities.[iv]

[3] The Department established the Continuity of Care Advisory Panel in 2013 to review and recommend potential solutions to disruptions in continuity of care.

[4] Assuming a hospital rate of $1,000 per day, the inpatient population had approximately 70 total hospital days during a twelve-month period.

In its proposal, the Department similarly describes the target population for preventive OCC as "individuals who have frequent contact with the State's psychiatric facilities."[v] We would therefore expect that the Department would further define this "frequent contact" population in line with the "high-utilization" cohort of 503 individuals considered by the COC Panel. Instead, and without discussion, the Department defines "frequent contact" with a psychiatric facility quite broadly, proposing a preventive commitment criteria of a mere two involuntary admissions within the past 48 month period. The Department then casts "treatment refusal" as the *cause* of frequent hospital admissions, stating that:

> While hospitalized and adherent to treatment, these individuals' conditions improve. However, when they return to the community, many refuse to engage in treatment, and their condition deteriorates. Consequently, individuals with serious mental illness who refuse to engage in treatment may experience homelessness, frequent hospitalizations, increased contact with law enforcement, and incarceration.[vi]

The Department fails to provide any support for this sweeping statement, including any evidence that the unspecified "many" individuals it claims refuse treatment have actually been provided reasonable access to comprehensive and coordinated community services, or that refusal of mental health treatment is the cause of repeated hospital admissions.

Indeed, data presented to the COC Panel calls into question the Department's underlying assumptions. This data reveals that, during the following year (FY13), 450 out of the 503 individuals in the high utilization population - 89% - were accepting community-based services.[5] In other words, nearly nine out of ten individuals in the target pool will, in fact, voluntarily accept services. It is unknown whether these 450 individuals had previously refused care – and if so, what motivated them to subsequently accept services – or whether they had instead slipped through the cracks of a system that failed to provide coordinated community care upon discharge. Either way, coercion is clearly not necessary to engage the vast majority of individuals identified as being at risk for multiple hospital admissions.

With respect to the remaining 53 individuals not receiving community services in FY13, it is unknown whether they were offered enhanced services, such as Intensive Case Management or Assertive Community Treatment, but refused, or whether they were instead simply discharged to standard care with no follow-up care coordination. Without further investigation into what actually occurred in these cases, it is grossly unfair to simply assume, as the Department does, that the fault lies with the individuals. In addition, demographic data on the Maryland "high risk" cohort

[5] For unknown reasons, the Department chose not to publish this data.

revealed that three out of every four individuals have a substance use disorder diagnosis, but less than one-third received substance use treatment during the fiscal year in which they had multiple hospital and emergency department admissions.[vii] This data suggests that untreated substance use, not untreated mental illness, may be the single most significant characteristic driving high-utilization rates for emergency department and hospital admissions.

Finally, the Department provided the COC Panel with data revealing that 50% of the 503 people "at-risk for disruptions in continuity of care" in FY12 did not appear in the at-risk categories in FY13. More data is necessary to determine whether these individuals were provided standard care or whether enhanced strategies were employed, how effective each approach was in reducing hospital-based care, and by how much admissions and bed days were reduced. Nevertheless, the data demonstrates that *voluntary* services reduced hospital admissions and emergency department visits. This outcome is consistent with systematic reviews of OCC studies, outlined in Section I.C. below, which conclude that voluntary services are as effective as court orders in improving outcomes, including reduced hospital admissions.

C. There Is Little or No Evidence That Outpatient Civil Commitment Produces Better Outcomes Than Voluntary Services

In its report, the Department merely asserts that OCC would "improve continuity of care by decreasing interruptions in treatment, stabilizing the individual in the least restrictive environment, and reducing preventable hospitalizations, including inpatient civil commitment."[6][viii] As the Department should know, this is *not* a legally sufficient basis for an OCC law. Because preventive OCC restricts the civil liberties of individuals who do not currently meet the involuntary inpatient treatment criteria, there must be compelling evidence that court ordered community treatment has such significantly better outcomes, *as compared to voluntary services*, that it is necessary to achieve the stated purpose of the proposed law.

It is a daunting task to assess the entire body of research on whether OCC results in better outcomes than what can be achieved with voluntary services. The research is generally classified into two generations of studies, based not on when the study was conducted, but on the sophistication and rigor of the design.[ix] First generation studies consist of case reports and observational studies that are characterized as being "plagued by significant methodological limitations," that undermine their validity.[x] Second-generation studies include randomized controlled trials and nonrandomized observational studies that employ sophisticated strategies to

[6] The Department also states that homelessness, increased contact with law enforcement, and incarceration are negative outcomes associated with untreated mental illness. However, the Department provides no evidence that OCC would have any impact on those areas, and makes no attempt to connect its target population to those experiencing these negative outcomes.

overcome the problems inherent in first-generation studies. A randomized controlled trial (RCT) is considered the best method for ensuring equivalence between the intervention (OCC) and control (voluntary services) groups on both known and unknown factors.[xi] Nevertheless, any individual RCT or observational study may be poorly designed and thus its purported outcomes are of limited value in accurately assessing an intervention's effectiveness. Further, even under the most rigorous study design conditions, a single study rarely provides definitive results.[xii]

To date, RCT studies have been conducted in England (2013),[xiii] New York (2001),[xiv] and North Carolina (1999).[xv] The England and New York RCTs concluded that there is no evidence that OCC is more effective than voluntary services in improving outcomes. The North Carolina RCT had conflicting results, depending on whether a bivariate or multivariate analysis was used. The North Carolina study authors also conducted a non-randomized comparison and concluded that orders lasting greater than six months resulted in significantly greater outcomes for the OCC group. In addition to these RCTs, there have been several longitudinal observational studies using two large data sets from Australia[xvi] and New York.[xvii] The Australian studies produced conflicting conclusions, but most found that the OCC group had more admissions and longer lengths of hospital stays than the voluntary group, while the New York studies found better outcomes for the OCC group across a variety of domains.[xviii]

Viewed in total, the studies present conflicting conclusions about the effectiveness of OCC as compared to voluntary services. Individually, each study has been criticized for various reasons, including flawed methodology or the lack of valid comparison groups. However, a few of the researchers involved with one or more of these studies are media savvy and have published or been interviewed in multiple articles touting their own flawed research outcomes. This inflated volume of articles creates the perception that research has settled the issue in favor of the effectiveness of OCC. Unsurprisingly, proponents selectively trumpet results that appear to favor their position, while refusing to acknowledge contrary findings or criticisms about a study's methodology. Perception, however, is not fact. For example, the North Carolina RCT is frequently cited as proof that OCC is effective. The results of this study, however, are of dubious value, as reflected in the following critique:

> Study populations in these reports were sometimes poorly specified and, being subject to missing data and losses to follow-up, the analyses often involved smaller numbers of highly selected patients than would have been used in the original studies. Therefore, many of the datasets might not have been properly representative of the source population. Most of these reports present the findings of multiple, sometimes post hoc, analyses, often involving complex models which looked at the effects of multiple explanatory variables

(often categorized in several different ways), and the interactions between these, on multiple outcomes . . . . Multiple analyses of this kind are at increased risk of resulting in false positives (Type I Errors). Furthermore, in regression analyses, all observed associations should be seen as observational and potentially confounded by other unknown or unmeasured factors and, even though attempts might have been made to limit the possibility, confounding by other factors may still have been possible. The need for cautious interpretation of these data cannot be over-emphasized. These analyses can be seen as exploratory and potentially hypothesis-generating only."[xix]

It is clear that without knowing the reported outcomes of <u>all</u> second-generation research, the strengths and weaknesses of study design, and validity of published findings, it is impossible to accurately assess the effectiveness of OCC as compared to voluntary services. To navigate this terrain and arrive at a well-informed conclusion, it is critical to review the results of the highest level of research – the systematic review.[xx] A systematic review is an independent "high-level overview of primary research on a particular research question that tries to identify, select, synthesize and appraise all high quality research evidence relevant to that question in order to answer it."[xxi] Quality systematic reviews provide the most accurate overall assessment of the effectiveness of an intervention.[xxii]

As summarized below, there are six independent systematic reviews that collectively have synthesized and analyzed all qualified OCC studies to date. These six systematic reviews, including two meta-analyses, are consistent in their conclusion that there is little or no evidence that court orders are more effective than voluntary services in improving outcomes**.** One additional review of three selected studies conducted by consultants contracted by the Department differed only in concluding that there is "moderate" evidence that court orders may reduce hospital admissions.

<u>Kisely & Hall</u>: In 2014, researchers at the University of Queensland School of Medicine[xxiii] conducted an updated meta-analysis of the three existing RCTs conducted in England, New York, and North Carolina. Considered the highest level of systematic review, a meta-analysis collects, combines and analyzes the primary data, giving it greater statistical power.

<u>Conclusions</u>: OCC orders did **not** result in a greater reduction in hospital readmissions or bed days, and there were no significant differences between the study and control groups in social functioning or psychiatric symptoms.

Maughan & Molodynski, et al: In 2013, researchers published a systematic review of the 18 qualifying studies published between January 2006 and March 2013, including the England RCT and the observational studies using the New York and Australian data bases. [xxiv]

Conclusion: There is now a strong level of evidence that OCC orders have **no** significant effect on hospitalization outcomes or community service use.

Maryland Department of Health and Mental Hygiene: In 2013, the Department hired consultants to review three studies – the New York and North Carolina RCTs and the New York observational study.[xxv]

Conclusions: There is a **moderate** amount of evidence that OCC reduces hospital admissions, but not days. There is emerging evidence on greater engagement in treatment, but these studies have considerable limitations, and the only RCT in this area found no effect on medication adherence. There is **little solid** evidence on reductions in criminal justice interactions or on costs (i.e., that OCC reduces system costs).

Churchill, Owen, Singh & Hotopf: In 2007, researchers published the single most comprehensive systematic review of the OCC research conducted through 2005.[xxvi] All data based empirical studies were included in the review, including the New York and North Carolina RCTs and the Australian nonrandomized observational studies. There were no restrictions on language, year, study-quality or study sample size. In total, there were 72 data-based empirical studies, 47 conducted in the U.S., 10 in Australia, five in New Zealand, four in Canada, three in the UK, two in Israel and one was world-wide.

Conclusion: There is **very little** evidence to suggest that OCC orders are associated with any positive outcomes.

Kisely, Campbell & Scott: In 2007, researchers conducted a systematic review of five studies, including New York, North Carolina and three controlled before and after studies using the Australian database.[xxvii]

Conclusion: The evidence for involuntary outpatient treatment in reducing either admissions or bed days is **very limited**, and the effects on other outcomes uncertain. It therefore cannot be seen as a less restrictive alternative to hospital admission.

Cochrane Collaboration: In 2005 and updated in 2010, the Cochrane Collaboration

(Cochrane) conducted a meta-analysis of the North Carolina and New York RCTs.[xxviii]

Conclusions: Compulsory community treatment results in **no significant difference** in service use (hospital admissions and medication compliance), social functioning or quality of life compared with standard care. People receiving compulsory community treatment were, however, less likely to be victims of violent or non-violent crime. It is unclear whether this benefit is due to the intensity of treatment or its compulsory nature.

In addition, Cochrane used a methodology that enables "numbers needed to treat" (NNT) to be calculated from the statistically non-significant results. Used to assess the effectiveness of an intervention, NNT is the average number of patients who need to be treated for one to benefit compared with a control. Based on its NNT calculation, Cochrane found that it would take 85 OCC orders to prevent one hospital admission and 236 orders to prevent one criminal arrest.[xxix] As the reviewers aptly stated:

> "It is difficult to conceive of another group in society that would be subjected to measures that curtail the freedom of 85 people to avoid one admission to a hospital or of 236 to avoid one arrest."[xxx]

RAND Corporation: In 2001, RAND Corporation (RAND) conducted a systematic review of studies on the effectiveness of OCC, including the New York and North Carolina RCTs. [xxxi] Twenty-two articles reporting outcomes of OCC studies met the criteria for review.

Conclusion: Studies reviewed "[did] **not** prove that treatment works better in the presence of coercion or that treatment will not work in the absence of coercion."

RAND also analyzed peer-reviewed, published literature on evidence-based reviews of voluntary alternatives to OCC and found "strong evidence of the effectiveness of ACT (assertive community treatment)."[xxxii] Thus, RAND also concluded that "evidence-based reviews prove that alternative interventions such as assertive community treatment have similar positive effects" to OCC.[xxxiii]

In summary, six independent systematic reviews, including two meta-analyses, uniformly concluded that there is little or no evidence that OCC orders result in better outcomes than voluntary services. One limited review, contracted by the Department, concluded that there is "moderate evidence" that OCC has a greater effect on reducing hospital admissions, but not on any other outcome. All review teams highlighted the urgent need for well-designed studies. It is possible that a body of future studies will be created that withstand systematic review scrutiny and

lead to a different conclusion about the effectiveness of OCC as compared to voluntary services. Until such time, there is simply no evidence-based support for enacting such a law, most particularly the radical preventive OCC program proposed by the Department.

D. A Fully Implemented Outpatient Civil Commitment Program Is Costly And Reduces The Availability Of Voluntary Services

Basing its estimate on New York and California, the Department states that it would cost an additional $3.0 million per 100 individuals served under its proposed OCC program, excluding defense counsel and Office of Administrative Hearing costs.[xxxiv] California is a curious choice as a model for comparison given its very limited experience with OCC implementation. Nevada County is the only county in the state to have authorized and implemented OCC and, to date, only 30 unduplicated individuals have been placed under court order.[8][xlii] New York courts, by contrast, have placed 12,129 people under OCC since the November 1, 1999 implementation of "Kendra's Law,"[xliii] making it a more useful comparison in a cost analysis. New York spends approximately $32 million dollars annually for direct support of its OCC program, excluding associated defense counsel and court costs, equaling approximately $40,000 annually per individual under court order. The Department's per person cost estimate of approximately $30,000 annually ($25,000 in service costs, plus administrative support costs) thus appears low in light of the proposed program's similarity to New York's program.

Of greater concern, however, is the Department's failure to adequately address the significant impact that OCC would have on the availability of voluntary services. New York provides approximately $126 million annually in *additional* funding for enhanced community-services under its public mental health system, to serve those on OCC as well as those voluntarily seeking such services.[xliv] Despite this annual influx of dollars, New York experienced a 50% reduction in the availability of voluntary intensive case management and ACT services state-wide during the three-year period following implementation of Kendra's law.[xlv] There are concerns that the service capacity created during the early years of the program with the massive influx of additional funding is now fully utilized and, coupled with flat funding over the program's fifteen-year history, voluntary services may once again become unavailable for many mental health consumers.[xlvi]
The Department only mentions the potential service capacity issues under its proposal to enhance access to voluntary services. The Department states in that section that it was "unclear whether resources were diverted" in New York as a result of OCC, while at the same time acknowledging

[8] Neighboring Yolo County established a pilot program in 2013, designed to serve a total of four individuals, and Los Angeles (Orange County) established a pilot program in 2010, designed to serve approximately ten individuals per year. Although both counties, along with San Francisco, have recently authorized full implementation of OCC, it has not yet gone into effect in these locations.

that "preference for intensive case management was given to outpatient civil commitment cases," meaning that "individuals who were not under an outpatient order were less likely to receive case management services."[xlvii] Giving individuals on treatment orders preference in access to services *is* diverting resources from voluntarily those seeking such services.

The Department does at least recognize that it must increase funding to expand ACT services if an OCC law is enacted, but fails to estimate the overall cost and how expansion would be accomplished state-wide. Instead, the Department simply states that it would cost $600,000 to create one ACT team.[xlviii] However, an individual team only serves mental health consumers residing in the specific county or city in which it is located and, therefore, one team cannot serve people across the state placed on OCC orders. The Department fails to address current regional disparities in the availability of ACT, stating simply that it "should consider jurisdictional need,"[xlix] and fails to address deficits in the availability of mental health professionals that comprise ACT teams in those regions, particularly psychiatrists. Finally, the Department fails to acknowledge the impact on voluntary accessibility to the services provided via ACT, including housing. Certainly, given the difference in population totals, it would not cost Maryland $158 million a year to implement OCC, as it does in New York. However, we believe that the Department's apparent suggestion that OCC could be implemented for a mere $3.6 million per year, while at the same time keeping voluntary services intact, is wildly inaccurate.

Moreover, while the New York program evaluators claimed that OCC results in overall cost-savings due to reduced hospital and jail admissions, the Department's own consultant rated this evidence as "weak."[l] Thus, it is clear that OCC is costly, would likely not generate overall savings and that, without significant additional annual funding, it would greatly reduce the availability of voluntary services. Based on the current lack of evidence that OCC is necessary to improve outcomes for individuals at risk for disruptions in continuity of care, we urge that Maryland instead focus on fully funding community-based services and creating an enhanced voluntary program to engage the at-risk population.

E. Studies Reveal Significant Racial, Insurance And Geographic Disparities In The Implementation Of Outpatient Civil Commitment

House Bill 1267/Senate Bill 882 required that a program proposal address the potential for racial, geographic and insurance disparities in implementing a recommended program. The Department's OCC proposal fails to adequately address *any* of these critical issues.

1. Racial Disparities

The single comment the Department makes on potential racial disparities is its assertion that having an OCC program administered by a singly petitioning entity will "help avoid health disparities and racial bias in program implementation."[li] The Department's lack of analysis, and concern, is puzzling, given that available information strongly predicts that minorities, and African Americans in particular, will experience disparate rates of coercion should OCC be enacted and implemented in Maryland.

North Carolina and New York are among the few states that have the type of "preventive" commitment law proposed by the Department. Studies in those two states show that African Americans are grossly overrepresented in the pool of OCC order recipients. In North Carolina, **two-thirds** of persons subjected to a mandated treatment order in the study were African American, despite only representing approximately 22% of the total state population.[lii] The evaluation of the New York OCC program[liii] revealed that disparate rates based on race/ethnicity have plagued the program since its implementation in 1999:

	Subject to Court Orders	Total State Population
Blacks	34%	17%
Hispanics	30%	18%
Whites	34%	61%

African Americans are subjected to court orders **five times** more frequently than whites, while Latinos are **two and half times** more likely than whites to be under a court order.[liv] The New York program evaluators concluded that there is no proof of intentional racial bias in the selection of individuals placed on OCC, finding that the overrepresentation of African Americans is a "function of [their] higher likelihood of being poor, higher likelihood of being treated by the public mental health system (rather than by private mental health professionals), and higher likelihood of having a history of psychiatric hospitalization."[lv] The evaluators further state that the "underlying reasons for these differences in the status of African Americans are beyond the scope of the report."[lvi]

The institutional racism infecting the mental health system must be of paramount concern, however, precisely because it greatly contributes to the overrepresentation of African Americans in

the target population for OCC. The historical roots trace back to the waning days of Slavery and the decades of oppression that followed, as summarized in this historical account:

> According to the 1840 US Census, insanity was 11 times more likely among African Americans living in Northern free states than in the South. Slavery proponents claimed that the 'burdens of freedom' drive African Americans insane and that slavery saves them from certain 'mental death.' Between 1860 and 1880, the incidence of insanity rose five-fold among African Americans. The 1886 New York Medical Journal concluded that 'African Americans lack the biological brainpower to live in freedom.' During this period, African Americans were incarcerated in increasing numbers in mental institutions, jails and poorhouses. At the turn of the century, African Americans in the United States were diagnosed with schizophrenia in numbers that far outpaced whites. The 1921 American Journal of Psychiatry provided the rationale that "African Americans are not sufficiently biologically developed and thus are prone to psychotic illnesses."[lvii]

The same distressing state of affairs continues, with African Americans being disproportionately diagnosed with the severest forms of mental illness and disproportionately subjected to involuntary inpatient treatment. Nationwide, African Americans are up to four times more likely to receive a schizophrenia diagnosis than whites – even after controlling for all other demographic variables[lviii] – and are more than twice as likely as whites to be involuntarily committed to state psychiatric hospitals.[lix]

The impact of these historical factors is not confined to New York alone, and the New York program evaluators acknowledged that, "insofar as outpatient commitment by statute targets a 'revolving door' population, that of involuntarily hospitalized patients who are concentrated in the public mental health system, it will inevitably select a greater proportion of African Americans than their share in the general population, because that is the racial distribution of the target population – for historical reasons . . . ".[lx] The Department is proposing to target precisely this "revolving door" population,[lxi] and available Maryland data shows that African Americans comprise 46% of the Public Mental Health System, while representing only 30% of the state's total population.[lxii] Thus, as in New York, African Americans are overrepresented in the insurance category from which the target pool for OCC is most likely to be drawn.

By failing to closely examine racial and ethnic minority disparities, an opportunity was lost to develop a thoughtful and comprehensive approach to better engage and serve these populations in a culturally sensitive manner. We are disappointed that the Department proposes instead that Maryland use the sledgehammer of coercion against historically oppressed and disadvantaged groups.

2. Insurance Disparities

The Department failed to address the potential for disparity based on insurance status and instead simply recommends that, "an inability to obtain access to appropriate treatment because of inadequate health care coverage or an insurer's refusal or delay in providing coverage for the treatment" should not be considered a "refusal to comply."[lxv] Thus, while the Department does not explicitly limit the target population to those eligible for Maryland's Public Mental Health System, it appears to recognize that OCC would likely only be effectively implemented with this population.

3. Geographic Disparities

The Department failed to adequately address the potential for variance in program implementation among urban and rural jurisdictions, again simply declaring that such variances would be eliminated with a single petitioning entity. Geographical disparity is an extremely critical concern, however, given the experience with OCC in New York where 82% of all mandatory treatment orders originated in New York City and Long Island.[lxvi] The regional variation in New York is believed to be a function of available resources and differing attitudes about service engagement approaches.[lxvii] In more rural jurisdictions, there are fewer resources and additional funding provided under Kendra's law is used to beef up the available voluntary services. Thus, in those counties, a person thought to meet the OCC criteria is first provided with enhanced voluntary services ("EVS"), with OCC being used as a last resort. County mental health officials and providers expressed a very different attitude than their urban counterparts with respect to use of coercion, as captured by the following quotes from the program evaluations:

> "We don't do it like downstate or OMH wants. We use the voluntary order first. We don't approach it in an adversarial way."[lxviii]

As a result, only 16% of OCC orders originate outside of New York City and Long Island. By contrast, New York City and Long Island are better funded and take a far more impersonal and adversarial approach:

> "If you meet the criteria, it would be foolish to do less [than a court order]."[lxix]

Thus, few if any attempts are made to voluntarily engage people, with OCC orders being routinely issued for people as part of their "discharge plan" from hospitals.

The Department is proposing the same requirement found in New York's law that the "individual has been offered an opportunity to participate voluntarily in treatment but declines to do so."[lxx] The concern is that, as in New York, the manner in which this "opportunity" is presented may vary greatly among jurisdictions, based both on community attitudes and the availability of resources. While community attitudes may or may not be as sharply divided in Maryland, there are existing urban/rural disparities with respect to where people eligible for the Public Mental Health System (PMHS) are concentrated and where resources are allocated. For example, Baltimore City represents 33% of those receiving PMHS services, while representing just 11% of the total State population, and its expenditures account for 35% of total PMHS expenditures.[lxxi]

In sum, it is reasonable to expect that racial and ethnic minorities concentrated in urban areas and living in poverty would populate the ranks of people under OCC orders, yet the Department made no effort to acknowledge or address these disparities.

F. People Under Outpatient Civil Commitment Orders Lose The Right to Make Decisions About Psychiatric Medications That May Be Ineffective Or May Pose Serious Risks To Their Health

The Department states that there was support to have program eligibility criteria include consideration of an individual's capacity to make treatment decisions, and then proposes the criterion that an individual "fails to adhere to treatment recommendations."[lxxiii] We are troubled by the Department's failure to explain whether this "fails to adhere to treatment" criterion encompasses lack of capacity to make treatment decisions and, if so, how it envisions implementing such a standard. There are many critical issues, including who has oversight to ensure that the individual's health and interests are protected;[9] whether a finding that an individual lacks capacity with respect to decisions about psychiatric treatment would extend to all medical decisions and other personal life decisions, such as housing and finances; and whether there would be any impact on the terms of the OCC order should the individual regain capacity.

We are also concerned that the Department's recommendation may be reflective of a growing trend among ardent proponents of involuntary treatment to make refusal of psychiatric treatment the equivalent of lacking the capacity to make informed decisions about the risks and benefits of psychotropic medication. For example, these proponents claim that 50% of people with

[9] Under current Maryland law, an individual found by a court to lack capacity to make treatment decisions must be appointed a guardian of the person. A guardian, along with continuing court monitoring, ensures that a person's interests are protected. The Department appears to be proposing that a person who lacks capacity to make treatment decisions will be ordered to comply with a treatment plan designed by a treatment provider, with no monitoring by an independent person or entity. This is would be another radical departure from existing law.

schizophrenia and 40% of people with bipolar disorder have "anosognosia," a neurological condition associated with stroke and brain-injury victims. According to this theory, people with anosognosia refuse treatment because they are literally unable to recognize the symptoms of their mental illness due to brain damage.[lxxiv] To date, anosognosia has not been established or widely accepted as a medical condition related to severe mental illness,[lxxv] and it is not a diagnosis identified in the most current edition of the Diagnostic and Statistical Manual (DSM-V), which is used by clinicians to diagnose and treat mental disorders. Nevertheless, these proponents argue that people who refuse treatment have anosognosia and therefore lack capacity but, only with respect to accepting a psychiatric diagnosis and agreeing to take prescribed medications.

Fundamentally, of course, proponents of OCC are concerned with medication compliance, regardless of the reason a person may refuse prescribed medication. There is, however, increasing public acknowledgment of significant limitations in the diagnosis and treatment of mental illness. Dr. Thomas Insel, Director of the National Institute on Mental Health, is a strong supporter of the medical model of psychiatry, yet is also an honest critic of its limitations. He recently characterized the state of psychiatry as lacking "biomarkers to identify who should get which treatment," and lacking "effective treatments for many aspects of mental illness."[11][lxxvii] For example, research on long-term outcomes for individuals with schizophrenia indicates that those who did not use antipsychotic drugs actually experienced *better* outcomes than their counterparts continuously taking medications.[lxxviii] In light of this research, Dr. Insel correctly observed that, "we need to ask whether in the long-term, some individuals with a history of psychosis may do better off medication."[lxxix] Indeed, physicians in Switzerland, Sweden and Finland have developed programs that involve minimizing use of antipsychotic drugs, and are reporting much better results than what is being obtained in the United States.[lxxx] One such program reports that five years after initial diagnosis, 82% of psychotic patients were symptom free, 86% returned to jobs or school, and only 14% were on antipsychotic medication.[lxxxi] Furthermore, poor medication outcomes are not restricted to classes of antipsychotics. According to the National Institute of Mental Health's STAR-D study, the largest and longest study ever conducted to assess the effectiveness of depression treatment, only one in three individuals achieves remission on the first trial of antidepressants. By the time an individual is on his or her fourth medication trial, there is a one in ten chance of remission through medication use.[lxxxii]

In addition to growing doubts about diagnostic accuracy and the long-term benefits of medication, there are many serious, sometimes fatal, side effects of these drugs. All antipsychotic medications increase the risk of sedation, sexual dysfunction, postural hypotension, cardiac arrhythmia, and

[11] Dr. Insel also called on psychiatry to atone for its lack of humility because "so much of mental health care is based on faith and intuition, not science and evidence."

sudden cardiac death.[lxxxiii] Older antipsychotic medications are associated with movement disorders, including tardive dyskinesia, a neurological disorder causing involuntary, abnormal movements, particularly of the face and neck.[lxxxiv] Second generation drugs are associated with metabolic problems, including obesity and diabetes. Weight gain, often rapid and significant, is a common side effect, and antipsychotic drugs "can contribute to a wide range of glycemic abnormalities, from mild insulin resistance to diabetic ketoacidosis."[lxxxv]

In response to these findings, some psychiatrists have started to voice concern over the appropriateness of long-term use of antipsychotic drugs. For example, Dr. Sandra Steingard recently wrote in an editorial in the Washington Post that, reviewing longitudinal studies and witnessing the severe side effects that many people experience prompted her to support a client's choice to discontinue medication.[lxxxvi] Unfortunately, and with potential tragic consequences, the Department is proposing a mandatory community treatment regime that dismisses the experiences and valid concerns of people diagnosed with a mental illness, and which may actually impede the formation of therapeutic alliances with mental health professionals.

In summary, there is no evidence to date that OCC is necessary to reduce hospital admissions – the stated goal of the Department's proposal – and implementation of such a law is costly and fraught with racial, economic and geographic disparities. Worse, it may cause significant harm to the health of many individuals due to side effects, while not being effective for an unknown number of those who will be mandated to adhere to prescribed medications. As detailed in Section II below, Maryland must choose instead to address disruptions in continuity of mental health care by establishing a voluntary program that targets at risk individuals for outreach and engagement, and provides individualized and evidence-based services while increasing provider and system accountability for outcomes. In other words, the program would "commit the system, not the individual."

Section II. A Voluntary Alternative to Outpatient Civil Commitment

The Department recommends increasing funding to expand the availability of voluntary ACT services. The Department further recommends that additional funding should be appropriated or increased to (a) expand peer support services; (b) further integrate and enhance crisis services within each jurisdiction; and (c) increase funding for rental subsidies. We support additional funding and expansion of all of these services. However, we strongly believe that enhanced services should not be expanded *in addition* to an OCC program, but should instead be integrated into a voluntary services model that serves as an *alternative* to involuntary treatment.

During the 2014 session, House Bill 1267 and Senate Bill 882, originally entitled Assertive Community Treatment – Targeted Outreach, Engagement and Services (ACT-TOES) were introduced to implement a comprehensive voluntary service program developed by a team of stakeholders, including advocates, former mental health department officials from Maryland and New York, and representatives of agencies currently responsible for overseeing the administration of mental health services in local jurisdictions. The team reviewed the non-coercive elements of New York's program, Maryland pilot programs using innovative practices, and a previous unfunded proposal for a comprehensive voluntary program to serve as an alternative to OCC, called Individual Options. Essential components of a successful program were identified as including (a) having specific eligibility criteria and a matching program to connect services to need; (b) a single point of access where family members and others could go when they recognized that a person had a need for intensive services; (c) financial restructuring to allow for ongoing engagement efforts; and (d) a system of accountability with regular quality assessments.

The legislation was then developed incorporating these essential components. First, eligibility was limited to a similar target pool found under current preventive OCC laws in other states, and Assertive Community Treatment (ACT) was identified as the service delivery model. ACT is an evidenced-based practice and one of the most extensively researched models of community care for people diagnosed with severe mental illness. Systematic reviews of over 55 studies, including 25 randomized controlled trials[lxxxvii] of ACT, conclude that, compared to usual community care, it is highly successful in engaging clients in treatment, substantially reduces psychiatric hospital use (50%-76%), lowers rates of substance use, increases housing stability, and moderately improves symptoms and subjective quality of life.[lxxxviii]

Second, ACT-TOES enhanced the traditional ACT model by requiring peer support, a feature that has demonstrated positive outcomes. For example, Baltimore City conducted a peer support engagement pilot to determine whether enhanced peer support would enable consumers who are at high risk for repeated hospitalization to be served and supported in the community and thus avoid inpatient care. An analysis of outcomes for the consumers participating in the pilot showed that it reduced emergency department visits by 24%; inpatient hospital admissions by 53%; inpatient days by 42% and public mental health system costs by 18%.[lxxxix]

Third, ACT-TOES required the Department to identify individuals who may currently meet the eligibility criteria and to establish a process for family members and other specified individuals to file a petition for enrollment in the program, i.e., a single access point. Fourth, ACT-TOES incorporated provider incentives and accountability. Providers would be reimbursed for ongoing efforts to engage individuals so that trust can be built over time, if necessary. In addition, the

circumstances under which providers may involuntarily discharge clients would be limited, and alternative providers would have to be identified prior to discharge to ensure continuity of care. Persons who voluntarily terminate services would remain eligible for immediate reinstatement should they need that level of care and service coordination. Support funds would be provided for housing, food and other basic necessities and are attached to the individual to maintain stable living conditions as the person moves from more to less intensive care and service needs. Finally, ACT-TOES would build-in system accountability by requiring the Department to engage in continuous quality improvement efforts by improving existing accountability and outcome systems.

We had anticipated that, during the review process envisioned by the Legislature, the ACT-TOES model would be strengthened and that the broader stakeholder workgroup would have the opportunity to ultimately determine that this voluntary approach, based on sound empirical research, should be the recommended program for Maryland. We are deeply disappointed that the Department chose not to allow review of ACT-TOES as an alternative to OCC. We remain confident, however, that the Legislature will recognize that this model has the potential to generate better outcomes than those produced in clinical trials involving voluntary and involuntary groups receiving traditional services, while avoiding the controversy, costs and civil rights implications attendant to an OCC program.

Section III. Definition of Dangerousness

We support the Department's recommendation to promulgate regulations, rather than propose a statutory amendment, to define "danger" for purposes of detention for psychiatric evaluation and involuntary admission to a facility, and to provide necessary training to law enforcement, emergency department physicians, judges and administrative hearing officers. We also support the Department's decision to exclude "psychiatric deterioration" in its proposed definition. Simply because a person's symptoms of mental illness may be worsening, does not equate to a need for inpatient treatment, and including "psychiatric deterioration" would violate the constitutionally-required present dangerousness standard for involuntary confinement. As noted by the Department, the Supreme Court held forty years ago that states may not confine a "non-dangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends."[xc]

Predictions of future dangerousness are notoriously unreliable. Studies have consistently found that unstructured clinical assessments of future dangerousness are "accurate in no more than one out of three predictions"[xci] and only "slightly more reliable than chance."[xcii] Adding the variable of "deterioration" and extending the potential "event" date (danger to self or others) to an unspecified

distant future will increase the already high error rates of involuntary detention and commitment. And certainly, if trained and experienced mental health professionals would struggle with accurately predicting distant future dangerousness based on "psychiatric deterioration," it seems reasonable to assume that law enforcement and lay persons would perform exponentially worse. While police officers may be able to assess, based on direct observation, whether a person is currently acting in a dangerous manner, they have no expertise to form a reasonable basis that someone is experiencing "psychiatric deterioration" which will result in future dangerousness. With respect to lay persons, a petition for a psychiatric evaluation currently requires a description of the dangerous behavior that is believed related to mental illness, which enables a judge or district court commissioner to determine whether there is an objectively reasonable basis for involuntary detention. This review provides at least some minimum level of due process protection against speculative subjective opinions rendered by non-professionals. Under a "psychiatric deterioration" standard, however, petitions would have to be approved based precisely on such subjective speculation that a person's mental health *is* declining and that this decline *will* eventually result in dangerousness to self or others.

While detention in an emergency department is seen as an acceptable intrusion on liberty when based on reasonable belief that a person is presently a danger to self or others, the entire process can be a traumatic and humiliating experience. The individual is handcuffed by law enforcement and led out of his or her residence, often in full view of their neighbors, for transport to the emergency department. Upon arrival, she is under guard by police or hospital security, ordered to remove clothing and, if she refuses, may be forcibly stripped by security. Protestations may be met with physical or chemical restraints or periods of isolation. Widening the net of potential victims of such iatrogenic trauma to include virtually all persons diagnosed with a mental illness would be unconscionable.[12]

Finally, complying with a "psychiatric deterioration" standard for psychiatric evaluations would also exert tremendous pressure on the healthcare system and significantly increase costs. Increasing demand would overwhelm the capacity of emergency departments to conduct assessments in a timely manner as well as the current inpatient bed capacity, leading to overcrowding and lengthy emergency department stays before an inpatient bed becomes available. This would potentially leave the State vulnerable to lawsuits for "psychiatric boarding," in which individuals are illegally detained in emergency departments beyond the statutory limit of 30 hours.[xciii] With respect to

[12] Recovery is not linear. People who faithfully take prescribed medications may, over the course of lifetime, experience periods in which their symptoms reappear or worsen. Many will not, however, need hospital level care before their symptoms abate. In other instances, situational stressors, such as the loss of a loved one, may be the culprit, not lack of treatment. But again, symptoms can and do abate without medical intervention, yet a "psychiatric deterioration" standard would leave everyone vulnerable to being picked up for evaluation and involuntary admission at some point in time.

costs, during the 2014 session legislation was introduced to change evaluation and involuntary admission standards to include "psychiatric deterioration," and the Department estimated that, if bed days for psychiatric inpatient care increased by 5% to 10%, total expenditures for psychiatric care in the State would increase by $20 million to $40 million annually. The Office of the Public Defender, the Office of Administrative hearings and the Judiciary would also face increased costs to respond to petitions and involuntary admission hearings.

For all these reasons, we urge that the Legislature reject any proposal to include a "psychiatric deterioration" standard for the purposes of evaluation and involuntary inpatient admission.

IV. Conclusion and Recommendations

Despite the lack of empirical evidence that mandated treatment orders are more effective than voluntary services in improving outcomes for individuals at high risk for disruptions in continuity of care, proponents continue to strenuously lobby legislatures across the country and internationally to adopt preventive OCC laws. These proponents continue to believe, despite overwhelming evidence to the contrary, that a court order, in and of itself, is the essential ingredient of OCC, due to the "black-robe effect." According to this theory, the judicial process and a judge's "imprimatur" increase the likelihood that the individual will comply with prescribed medication.[13][xciv] We urge that the Legislature not consider depriving people of their civil liberties based on a hope that a magical "black-robe" effect will solve the complex problem of engaging at-risk individuals. Yet perhaps the most distressing aspect of some OCC proponents' advocacy is that it promotes pseudo science about "brain damaged" people who are somehow less worthy of civil protections and reinforces ugly stereotypes about mental illness and violence. As one team of researchers summarized the issue:

> There is strong evidence that liberty is being substantially curtailed without any obvious clinical benefit to justify it . . . if we believe that psychiatry should be an evidence based profession and clinical trials are a worthwhile exercise, than we should not ignore the findings . . . we believe that there should be a moratorium on further imposition of [OCC] . . . unless and until convincing evidence of their effectiveness is obtained. It may be time to cease pursuing risk-based coercive interventions (which lack evidence) and refocus our efforts into restoring enduring and trusting relationships with patients."[xcv]

[13] To the extent that there is a "black-robe effect," it requires a judge in a black robe and a formal courtroom. See, e.g., Chase, O., Thong, J. (2012), Judging the Judges: The effect of courtroom ceremony on participant evaluation of process fairness-related factors. Yale Journal of Law & Humanities, Volume 24: Issue 1, Article 10. We note that in an administrative process, as proposed by the Department, hearings would take place in ordinary conference rooms with hearing officers in business attire.

We strongly agree with this assessment. Certainly there are people who have frequent contact with psychiatric facilities and other negative outcomes due to disengagement from community services and supports. However, it is time to recognize and address the inescapable fact that the mental health system often guarantees failure by not requiring outpatient providers to make contact with these individuals in the hospital, assertively follow-up post discharge or coordinate care across systems. Financing mechanisms discourage collaboration and coordination between inpatient and outpatient care and do not allow for the financial flexibility necessary to meet the needs of these individuals. As one former New York official involved with implementing Kendra's law stated: "[t]he increasing use of the courts reflects not only the desire for simple answers to complex problems but reflects our failure as a mental health community."[xcvi] Unfortunately, the appeal for many elected officials in passing an OCC law is that it is viewed as solving these problems. As noted by the Cochrane Collaboration researchers, however, the reality is that "such initiatives give the impression the legislators are addressing the needs of patients and carers while actually doing very little at all."[xcvii]

We applaud the Legislature for recognizing that complex issues demand more than simplistic responses and for directing the Department to oversee a process to develop an evidence-based program that minimizes or avoids deprivations of civil liberties and racial, economic and geographic disparities. Unfortunately, the proposed program lacks supporting evidence of efficacy and is based on unsupported declarations about the nature and cause of disengagement from community services. Worse, it does absolutely nothing to address current gaps and failures in Maryland's mental health system. As detailed in this report, existing evidence supports the development of a voluntary program that identifies the high-risk population, provides ongoing outreach and engagement efforts, and delivers high-quality individualized services and supports.

We therefore make the following recommendations:

1. Reject proposals for outpatient civil commitment in the absence of compelling future evidence, confirmed by the weight of systematic reviews, that treatment orders are necessary to reduce hospital admissions and bed days, or any other asserted significant state interest. Further, require that any such future proposals provide a detailed cost analysis, including the impact on voluntary services, and specifically outline how racial, economic and geographic disparities will be eliminated.
2. Recognizing that there is a significant projected state budget deficit that may not allow for full implementation of a comprehensive voluntary program, require the Department to develop, implement and study outcomes of a five-year pilot of a voluntary program

in selected jurisdictions. The program design shall be based on ACT-TOES and developed with input from stakeholders.

3. Require the Department to report annually on the pilot program outcomes, including: (a) number of eligible individuals identified; (b) number of outreach attempts and narrative summary of engagement techniques and outcomes; (c) number of enrolled participants and narrative summary of services provided; (d) outcomes including pre-enrollment and post-enrollment data on hospital and jail admissions, hospital bed days, service use, social functioning (housing, law enforcement contact, psychiatric symptoms), and participant satisfaction.

Endnotes - Citations

---

[i] Morrissey, J., Domino, M., Desmarais, S., Involuntary outpatient commitment: current evidence and options (October 30, 2013), A report prepared for the Continuity of Care Panel, Maryland Department of Health and Mental Hygiene. The Department contracted with Dr. Morrissey and his team to review selected outpatient commitment studies.

[ii] Department of Health and Mental Hygiene, Outpatient Services Programs Workgroup, Proposal 1 – Establish an Outpatient Civil Commitment Program in Maryland

[iii] Department of Health and Mental Hygiene, Mental Hygiene Administration, Data Shorts, Behavioral Health Data and Analysis, December 2013, Vol. 2, Issue 12.

[iv] Id.

[v] Department Proposal 1

[vi] Id.

[vii] MHA Data Shorts, Behavioral Health Data and Analysis, January 2014, Vol. 3, Issue 2.

[viii] Department Proposal 1.

[ix] Ridgely, M., Borum, R., and Petrila, J., The Effectiveness of Involuntary Outpatient Treatment: Empirical Evidence and the Experience of Eight States (2001) RAND Corporation (2001). Retrieved from http://www.rand.org/content/dam/rand/pubs/monograph_reports/2007/MR1340.pdf.;See also Morrissey, Involuntary outpatient commitment: current evidence and options, pp. 7-8.

[x] Id. at 17.

[xi] Ioannidis JP (2005). Contradicted and initially stronger effects in highly cited research. JAMA, 294:218-228.

[xii] Id.

[xiii] Burns T, et al. Community treatment orders for patients with psychosis (OCTET): a randomized controlled trial. Lancet 2013; 381: 1627-33. Retrieved from http://download.thelancet.com/pdfs/journals/lancet/PIIS0140673613601075.pdf?id=baaHU2QjOyud4epf0zCLu

[xiv] Steadman H, Gounnis K, Dennis D, Hopper K, Roce B., Swartz M et al (2001) Assessing the New York City involuntary outpatient commitment pilot program. Psychiatr Serv 52(2):330-336. Retrieved from http://psychrights.org/research/Digest/OutPtCmmtmnt/AssessingNYCIOCPsychSvcs2001.pdf

[xv] Swartz MS, Swanson JW, Wagner HR, Burns BJ, Hiday VA, Borum R (1999) Can involuntary outpatient commitment reduce hospital recidivism?: Findings from a randomized trial with severely mentally ill individuals. Am J Psychiatry 156(12):1968-1975. Abstract retrieved from http://www.ncbi.nlm.nih.gov/pubmed/10588412.

[xvi] Burgess P., Bindman J., Leese M., Henderson C., Szmukler G. (2006) Do community treatment orders for mental illness reduce readmission to hospital? An epidemiological study. Soc Psychiatr Epidemiol 41:574-579; Seal S., Burgess, P. (2006) Conditional release, a less restrictive alternative to hospitalization? Psychiatr Serv 57:1600-1606; Segal S., Burgess, P. (2008) Use of community treatment orders to prevent psychiatric hospitalization. Aust N Z J Psychiatry 42:732-739; Segal S., Burgess P (2006) The utilitiy of extended outpatient civil commitment. Int J Law Psychiatry 29(6):525-534.

[xvii] Bush A., Wilder C., Van Dorn, R., Swartz, M., Swanson, J. (2010) Changes in guideline-recommended medication possession after implementing Kendra's Law in New York. Psychiatr Serv 61:1000-1005.; Swartz, M., Wilder, C. Swanson, J., Van Dorn, R. Robbins, P.,(2010) Assessing outcomes for consumers in New York's assisted outpatient program. Psychiatr Serv 61:976-981; Van Dorn, R., Swanson, J., Swartz, M. Wilder, C. Moser, L. Gilbert, A. et al (2010) Continuing medication and hospitalization outcomes after assisted outpatient treatment in New York. Psychiatr Serv 61:982-987.

[xviii] For a review of the Australian and New York Study outcomes, *see* Maughan D, Molodynski A, et al. A systematic review of the effect of community treatment orders on service use, Soc. Psychiatry Psychiatr Epidemiol 2013; published online 18 October 2013; Churchill, R., Owen, G., Hotopf, M. Singh, S. (2007). International experiences of using community treatment orders, Institute of Psychiatry. London, http://www.iop.kcl.ac.uk/news/downloads/final2ctoreport8march07.pdf.

[xix] Churchill, International experiences of using community treatment orders, p. 163-164.

[xx] Phillips B, Ball C, Sackett D et al; Levels of Evidence, Centre for Evidence-based Medicine, (March 2009).

[xxi] Cochrane Collaboration, accessible at http://www.cochrane.org/about-us

[xxii] Freeman SR, Williams HC, Dellavalle RP, Journal of Investigative Dermatology (2006). 126, 2357-2360.

[xxiii] Kisely SR, Hall K, Community Health Systems: An updated meta-analysis of randomized controlled evidence for the effectiveness of community treatment orders (March 2014). Canadian Psychiatric Association. Retrieved from http://www.4-traders.com/COMMUNITY-HEALTH-SYSTEMS-12247/news/Community-Health-Systems--An-Updated-Meta-Analysis-of-Randomized-Controlled-Evidence-for-the-Effect-19366714/

[xxiv] Maughan,A systematic review of the effect of community treatment orders on service use.
[xxv] Morrissey, Involuntary Outpatient Commitment: Current Evidence and Options.
[xxvi] Churchill, International experiences of using community treatment orders.
[xxvii] Kisely, S.R, Campbell, L.A, Scott, A (2007). Randomised and non-randomised evidence for the effect of compulsory community and involuntary outpatient treatment on mental health service use. Psychol Med 37(1), 3-14.
[xxviii] Kisely S.R, Campbell L.A, Preston N.J. Compulsory community and involuntary outpatient treatment for people with severe mental disorders. Cochrane Database Syst. Rev. 3:CL004408. The review was updated in 2011. Cochrane Database Syst. Rev. 2.
[xxix] Id. at 18.
[xxx] Id. at 1-2.
[xxxi] Ridgely, The Effectiveness of Involuntary Outpatient Treatment: Empirical Evidence and the Experience of Eight States.
[xxxii] Id.
[xxxiii] Id.
[xxxiv] Department Proposal I
[xlii] Assisted Outpatient Treatment, The Nevada County Experience, Michael Heggarty, et.al. Retrieved from http://www.mynevadacounty.com/nc/hhsa/bh/pages/Assisted-Outpatient-Treatment.
[xliii] New York State Office of Mental Health, Assisted Outpatient Treatment Reports, Program Statistics, current through October 30, 2014. Retrieved from http://bi.omh.ny.gov/aot/statistics?p=under-court-order.
[xliv] Swartz, M., Swanson, J., Steadman, H., Robbins, P., Monahan, J., New York State Assisted Outpatient Treatment Program Evaluation (June 30, 2009), p. 46.
[xlv] Id. at 48.
[xlvi] Id. at 56.
[xlvii] Department Proposal 2 – Enhance Access to Voluntary Services.
[xlviii] Id.
[xlix] Id.
[l] Morrissey, Involuntry outpatient commitment: Current evidence and options, p.26.
[li] Department Proposal 1.
[lii] Swartz, M., Swanson, J., Hiday, V. et al. A Randomized Controlled Trial of Outpatient Commitment in North Carolina, 52 *Psychiatric Services* 325, 327 (2001); http://quickfacts.census.gov/qfd/states/37000.html
[liii] New York Program Evaluation, p.12.
[liv] Implementation of Kendra's Law is Severely Biased, New York Lawyer's for the Public Interest, Inc. (April 7, 2005), p.1. Retrieved from http://www.prisonpolicy.org/scans/Kendras_Law_04-07-05.pdf
[lv] Swartz, New York Program evaluation, pp. vii, 13-5
[lvi] Id.
[lvii] Whitaker, R., Mad in America: Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill. DeCapo Press (2003).
[lviii] Barnes, A., Race, schizophrenia, and admission to state psychiatric hospitals (2004), Administration and Policy in Mental Health, Vol.31, No.3; Barnes, A., Race and Hospital Diagnosis of schizophrenia and mood disorders (2008), Social Work, Volume 53, Number 1.
[lix] Lewis, A., Davis, K., Zhang, N., Admissions of African Americans to state psychiatric hospitals, International Journal of Public Policy (2010). Volume 6, Number 3-4, pp. 219-236; Lawson, W.B., Heplar, H., Holladay,J., Cuffel, B. (1994) Race as a factor in inpatient and outpatient admissions and diagnosis. Hospital and community psychiatricy, 45, 72-74; Lindsey, K.P.& Paul, G.L. (1989) Involuntary commitments to public mental institutions: (2010), Davis (2010).
[lx] Swanson, J., Swartz, M., Van Dorn, R.A., Monoahan, J., McGuire, T.G., Steadman, H.J., Robbins, P.C. (2009). Racial disparities in involuntary outpatient commitment: Are they real? *Health Affairs*, 28, no.3 (2009):816-826.
[lxi] Department Proposal 1.
[lxii] MHA Data Shorts, Behavioral Health Data and Analysis, February 2014, Vol. 4, Issue 2; http://quickfacts.census.gov/qfd/states/24000.html
[lxv] Department proposal, p. 4
[lxvi] Swartz, New York program evaluation, p.6.
[lxvii] Id. at 6-8.
[lxviii] Id. at 5.
[lxix] Id. at 5.
[lxx] Department Proposal 1.

[lxxi] Statistics about mental health in Baltimore city, Behavioral Health System Baltimore, retrieved from http://www.bhsbaltimore.org/site/wp-content/uploads/2013/08/Mental-Health-in-Baltimore-City-Fact-Sheet.pdf
[lxxii] Department Proposal 1.
[lxxiv] http://www.nami.org/Content/NavigationMenu/Mental_Illnesses/Schizophrenia9/Anosognosia_Fact_Sheet.htmhttp://www.treatmentadvocacycenter.org/problem/anosognosia.
[lxxv] Davidson, L., Mental illness fallacies counterproductive, Hartford Courant, OP-ED (April 26, 2013); Steingard, S., Anosognosia: How conjecture becomes medical "fact", Psychology Today (August 20, 2012).
[lxxvii] Insel, T., Atonement, Director's Blog, Nat'l Inst. Of Mental Health (Oct. 8, 2014). Retrieved from http://nimh.nih.gov/about/director/2014/atonement.shtml.
[lxxviii] Harrow, M, Jobe, T.H. (2013). Does Long-term treatment of schizophrenia with antipsychotic medications facilitate recovery?, 39 Schizophrenia Bull. 962; Wunderink, et al. (2013). Recovery in remitted first-episode psychosis at 7 years of follow-up of an early dose reduction/discontinuation or maintenance treatment strategy, 70 JAMA Psychiatry 913, 919; Harrow, M., Jobe, T.H., (2007) Factors involved in outcome and recovery in schizophrenia patients not on antipsychotic medications: A 15-year follow-up study, 195 J. of Nervous & Mental Disease 406, 412-413.
[lxxix] Insel, T., Antipsychotics: Taking the long view, Director's Blog, Nat'l Inst. Of Mental Health (August 28, 2013). Retrieved from http://www.nimh.nih.gov/about/director/2013/antipsychotics-taking-the-long-view.shtml
[lxxx] Ciompi, L. et al. "The pilot project Soteria Berne." British Journal of Psychiatry 161, supplement 18 (1992): 145-53; Cullberg, J. "integrating psychosocial therapy and low dose medical treatment in a total material of first-episode psychotic patients compared to treatment as usual." Medical Archives 53 (1999): 167-70; Cullberg J. "One-year outcome in first episode psychosis patients in the Swedish Parachute Project. Acta Psychiatrica Scandinavica 106 (2002):276-85; Lehtinen V, et al. "Two-year outcome in first-episode psychosis according to an integrated model. European Psychiatry 15 (2000):312-320.
[lxxxi] Seikkula J, et al. Five-year experience of first-episode nonaffective psychosis in open-dialogue approach. Psycotherapy Research 16/2 (2006):214-228.
[lxxxii] National Institute of Mental Health. (2009). Sequenced Treatment Alternatives to Relieve Depression (STAR*D).
[lxxxiii] Muench, J. & Hamer,A., Adverse effects of antipsychotic medications, 81 Am. Family Physician, 617 (2010).
[lxxxiv] Id. at 617, 620.
[lxxxv] Id. at 621.
[lxxxvi] Steingard, S., A psychiatrist thinks some patients are better off without antipsychotic drugs, The Washington Post, Dec. 9, 2013.
[lxxxvii] Marshall A, Lockwood A, (2004) Assertive community treatment for people with severe mental disorders (Cochrane Review). In: The Cochrane Library. Issue 3.
[lxxxviii] Bond GR, Drake, RE, Mueser KT, Latimer E (2001). Assertive community treatment: Critical ingredients and impact on patients. Disease management and Health Outcomes, 9(3), 141-159; Dixon I (2000). Assertive community treatment: Twenty-five years of gold. Psychiatric Services, 51(6), 759-765.
[lxxxix] Behavioral Health System Baltimore, Annual Report, Fiscal Year 2012, p. 12. Retrieved from http://www.bhsbaltimore.org/site/wp-content/uploads/2013/08/FY-12-Annual-Report-and-One-Year-Plan-Final
[xc] *O'Connor v. Donaldson*, 422 U.S. 563 (1975).
[xci] Monahan, J., Structured Risk Assessment of Violence, *Textbook of Violence Assessment and Management* 17, 20-21 (Simon and Tardiff eds., 2008).
[xcii] Mossman, Assessing Predictions of Violence, *J. Consulting and Clinical Psychol.* 62:783, 790 (1994).
[xciii] *See, e.g., In re the Detention of D.W., et. al. v. the Department of Social and Health Services*, No. 90110-4 (Supreme Court of Washington, August 7, 2014)
[xciv] Treatment Advocacy Center Backgrounder, No relevance to assisted outpatient treatment (AOT) in the OCTET study of English compulsory treatment (Revised October 2014).
[xcv] Burns T, Molodnski A, Community treatment orders: background and implications of the OCTET trial. Psychiatric Bulletin (2014) 38, 3-5.
[xcvi] Rosenberg, L., Assisted outpatient treatment: We can do better, The National Council for Behavioral Health (December 11, 2013). Retrieved from http://www.thenationalcouncil.org/lindas-corner-office/2013/12/five-ways-agree-assisted-outpatient-treatment/
[xcvii] Kisely, et.al, Compulsory commun and involuntary outpatient treatment for people with severe mental disorders, Cochrane Database at 2.