

November 15, 2013

CHILDREN & FAMILIES COMMITTEE
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Exhibit 22

Dear Members of the Children, Families, Health and Human Services Interim Committee:

As there has been some discussion of adopting Assisted Outpatient Treatment (AOT) in conjunction with the HR 16 study, it seemed appropriate to provide the Committee with comments from our perspective.

AOT or Outpatient commitment varies from state to state. Basically, however, the hallmark of the program is significantly lowering the standard for a court to impose an order upon a person with a mental illness to comply with treatment, be it medication or other intervention. The penalty for non-compliance is mandatory institutionalization for a period of time.

Current law - civil/involuntary commitment

In Montana, courts already have the ability to require compliance with treatment in the community by involuntary commitment to community services. M.C.A. § 53-21-127; 53-21-149.

However, to infringe on people's constitutional right to liberty in this way, the state must prove that the person not only has a mental illness, but:

- * the respondent is substantially unable to provide for the respondent's own basic needs of food, clothing, shelter, health, or safety;
- * the respondent has recently, because of a mental disorder and through an act or an omission, caused self-injury or injury to others;
- * there is an imminent threat of injury to the respondent or to others because of the respondent's acts or omissions; or
- * the respondent's mental disorder, as demonstrated by the respondent's recent acts or omissions, will, if untreated, predictably result in deterioration of the respondent's mental condition to the point at which the respondent will become a danger to self or to others or will be unable to provide for the respondent's own basic needs of food, clothing, shelter, health, or safety. Mont. Code .Ann. 53-21-126 (2013).

All of these elements require at least risk, albeit just a possible future one, of harm to the person or to others. It is hard to imagine a lower standard, such as would be brought about by AOT, that could legitimize state intervention into a Montanan's life that would be consistent with our collective respect of autonomy and dignity. An involuntary commitment results in many deprivations of liberty. The stigma of such a commitment can affect many aspects of person's other opportunities, including the ability to gain employment.

As the law currently stands, it could be used to help people be successful in the community. However, this option is not used as much as was anticipated when it was passed. This is not because the standard to commit is not low enough. Instead, what has been reported to us is that there are insufficient community services to which someone can be committed. This problem will not be solved by lowering the commitment standard. It will be solved by increasing community capacity and ensuring that treatment is available to people who need it.

Current law - criminal commitment

For those who are in prison or the forensic unit at Montana State Hospital, state law already allows treatment compliance to be a condition of both parole and probation. In addition, the parole board can require participation in a mental health care program as a condition of parole. Mont. Code Ann. §46-23-201 (2013).

However, in this system too, Montana faces the same problem of lack of access to mental health services for a variety of reasons, including cost and the built-in delay in the beginning of federal disability benefits, and the health insurance that comes with them, for those released from criminal confinement. Again, there is no need for any change in criminal laws to require compliance, nor would any change in the standard help. The issue is the community capacity to provide mental health services to all who need them.

The AOT and outpatient commitment controversy

All the studies that have found a benefit to AOT base it on a premise that services are **actually available**. It is self evident that court-ordered compliance with treatment is wholly unfair if the person cannot get that treatment.

In a system like we have in Montana where many lack prompt access to voluntary mental health treatment, AOT for those who have not committed crimes would result in the perverse allocation of the greatest treatment resources to those who least want them, and the concomitant reduction in care for those who most want it and would accept it voluntarily. This may very well lead to worse outcomes overall, given that voluntary treatment has a far higher likelihood of long term success than forced involuntary treatment.

Notably, even where an AOT sort of involuntary treatment was imposed *with well-coordinated mental health services*, “compulsory treatment and supervision does not reduce the rate of readmission for patients with serious mental illness.” Tom Burns, et al., *Community Treatment Orders for Patients with Psychosis (OCTET): A Randomised Controlled Trial*, 381 *Lancet* 1627 (2013). This is consistent with a well-regarded study a decade prior, which compared a group of individuals under involuntary community treatment to a control group and found that court orders did not lead to lower rates of crime, hospitalization or compliance with treatment. H. Steadman, et al., *Assessing the New York City Involuntary Outpatient Commitment Pilot Program*, 52

Psychiatric Services 330, 335-36 (2001).¹

Without sufficient community services, any discussion of AOT puts the cart before the horse. Before we talk about using court orders and imposing sanctions on people that have not done anything wrong, we need to ensure that mental health services are available to those who need them and want them.

Thank you,

A handwritten signature in black ink, appearing to read 'Beth Brenneman', followed by a long horizontal line extending to the right.

Beth Brenneman, Staff Attorney, Disability Rights Montana

¹ Even studies that have shown some positive outcomes from outpatient commitment emphasize that it is only one aspect of a broad-based package of reforms. Swartz, Marvin, et al., "New York State Assisted Outpatient Treatment Program Evaluation", Office of Mental Health NY, (2009) ("Swartz 2009"). *See also*, *RAND Report* at 99 ("**There is no evidence that simply amending the commitment statute to add an outpatient commitment program will make benefits accrue to persons with severe mental illness**"); Phelan, JC, et al., *Effectiveness and Outcomes of Assisted Outpatient Treatment in New York State*, *Psychiatric Services* 61:137-143, 137 (2010) ("Phelan 2010") (study found "modest" improvements in lives of test subjects, but given "treatment and other enhancements" included in outpatient program, evidence does "not support the expansion of coercion in psychiatric treatment").