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Briefing Paper

OPTIONS FOR ASSISTED TREATMENT

It is known that there are over 3 million individuals with schizophrenia and manic-depressive illness (bipolar disorder) in the United States. Approximately 800,000 of them are individuals who, before deinstitutionalization began 30 years ago, would have been hospitalized in state psychiatric hospitals (Torrey 1997).

It is also known that approximately 40 percent of all individuals with schizophrenia and manic-depressive illness are not under treatment at any one time (Regier et al. 1993). Many of these are homeless, in jail on misdemeanor charges, and responsible for increasing episodes of violence (Torrey 1997). A major reason why so many severely psychiatrically ill individuals are not being treated is that, because of the effects of the illness on their brain, they lack awareness of their illness. Studies have shown that approximately half of all patients with schizophrenia (Amador et al. 1991) and mania (Ghaemi 1997) have markedly impaired awareness of their illness as measured by tests of insight; thus they are similar to some patients with cerebrovascular accidents (strokes) and with Alzheimer's disease. Such individuals consistently refuse to take medication because they do not believe they are sick. In most cases they will take medication only under some form of assisted treatment.

Possible options for assisted treatment are the following:

- **Advance directives**

Increasingly used in all areas of medicine, individuals formulate directives at the time they are well regarding what they want to happen when they become sick. In a few states, individuals with severe psychiatric disorders, during a period of remission, can sign an advance directive instructing that they be treated (in which case it would be a form of assisted treatment) or that they may not be treated if they become sick again. Advance directives are also known as "Ulysses contracts" after the Greek hero who, while sailing past the island of the deadly seductive Sirens, instructed his crew to bind him to the mast and "be strictly enjoined, whatever he might say or do, by no means to release him till they should have passed the Sirens' island" (Bulfinch 1959).

The efficacy of advance directives as assisted treatment has not been studied (Backlar and McFarland 1996). One possible problem is that advance directives could be signed by individuals who had no awareness of their illness at the time they signed. In states where advance directives must be certified by a psychiatrist, the certification could be done by psychiatrists who are unalterably opposed to assisted treatment under any circumstances. In such cases advance directives would become an impediment to necessary treatment rather than being a form of assisted treatment.

- **Assertive case management**

Under assertive case management, case managers actively seek out at their homes or elsewhere in the community patients who do not follow up with appointments. The Program of Assertive Community Treatment (PACT or ACT teams) is the best known example of this. Multiple studies have demonstrated that PACT teams decrease rehospitalization days. In a Baltimore study of homeless individuals with severe psychiatric disorders, 77 were assigned to a PACT team and compared with 75 others assigned to traditional outpatient treatment. During the following year, those treated by the PACT team had fewer hospital days (35 versus 67), fewer days living on the streets (10 versus 24), and fewer days in jail (9 versus 19) (Lehman et al. 1997). Those treated by the PACT team also had increased medication compliance (either intermittently or fully compliant) from 29 percent at the start to 55 percent after one year; however, "approximately one-third of the subjects were noncompliant at any given time point" (Dixon et al. 1997). Assertive case management would therefore appear to be an effective method of assisted treatment for some patients but not others.

- **Representative payee**

To assist with money management, a patient's SSI, SSDI, or VA disability check can be assigned to the patient's family, case manager, or psychiatric clinic as the representative payee. Studies have shown that using a representative payee reduces hospitalization days (Luchins et al. 1998), substance abuse (Rosenheck et al. 1997), and days spent homeless (Stoner 1989). No study has been done on the effect of using representative payees to improve medication compliance. Anecdotal information, however, suggests that this arrangement is not unusual, e.g., the patient must accept a depot antipsychotic injection as a condition for being given his/her monthly check. In a U.S. Third Circuit Court of Appeals ruling, the court ruled that a man with epilepsy and borderline mental retardation was not entitled to SSDI benefits unless he demonstrated compliance with his anti-epileptic medication (Brown v. Bowen, 845 F2d 1211, 3rd Circuit, 1988).

- **Conditional release**

Patients who have been legally committed to a hospital can be released on the condition that they are compliant with medication. Violation of the condition can result in rehospitalization. In most states the hospital director has the authority to do this without asking permission of the courts. Forty states have laws permitting conditional release (Slobogin 1994). In the past, this form of assisted treatment was widely used for both civil and forensic (criminal) cases, but now it is used mostly for the latter.

New Hampshire is apparently the leading state using conditional release for civilly committed patients; in 1998, 27 percent of patients released from the New Hampshire State Hospital were put on conditional release (Gorman 1998). In the only study of the effectiveness of conditional release on medication compliance reported to date, 26 severely psychiatrically ill patients were conditionally released from the New Hampshire State Hospital with assessment of various measures for the year prior to hospitalization and the two years following conditional release. The results were as follows (O'Keefe et al. 1997):

	Year prior to hospitalization	First year on conditional release	Second year on conditional release
Months of medication compliance	2.9	10.4	10.7
Episodes of violence (rated on a 7-point scale)	5.6	2.4	1.1

The patients on conditional release thus had markedly improved medication compliance ($p < .001$) and decreased episodes of violence ($p < .001$).

Among forensic (criminally committed) psychiatric patients, conditional release is more widely used. The best known example is Oregon's Psychiatric Security Review Board, which has been studied and reported to be highly effective in reducing future criminal behavior (Bloom et al. 1986). Additional studies on the effectiveness of conditional release for insanity defense acquittees have been carried out in Maryland, Illinois, California, New York, and Washington, D.C. (Bloom et al. 1991).

- **Outpatient commitment**

Outpatient commitment involves a court order for the patient to comply with treatment (usually including medication) as a condition for remaining in the community. Violation of the condition can result in rehospitalization. Some form of outpatient commitment is available in 37 states but is used in very few of them (Torrey and Kaplan 1995).

The effectiveness of outpatient commitment in decreasing hospital admissions has been clearly established. In Washington, D.C., admissions decreased from 1.81 per year to 0.95 per year before and after outpatient commitment (Zanni and deVeau 1986). Similarly, in Ohio the decrease was from 1.5 to 0.4 (Munetz et al. 1996), and in Iowa from 1.3 to 0.3 (Rohland 1998). In North Carolina, admissions for patients on outpatient commitment decreased from 3.7 to 0.7 per 1,000 days (Fernandez and Nygard 1990). The only study that failed to find outpatient commitment effective in significantly reducing admissions was a Tennessee study; however, in that study it was evident that "outpatient clinics are not vigorously enforcing the law" and thus nonadherence had no consequences (Bursten 1986).

Outpatient commitment has also been shown to be effective as a form of assisted treatment in increasing treatment compliance. In North Carolina only 30 percent of patients on outpatient commitment refused medication during a six-month period compared to 66 percent of patients not on outpatient commitment (Hiday and Scheid-Cook 1987). In Ohio, outpatient commitment increased patients' compliance with outpatient psychiatric appointments from 5.7 to 13.0 per year and with attendance at day treatment sessions from 23 to 60 per year (Munetz et al. 1996). In Arizona, among patients who had been outpatient committed "71 percent of the patients voluntarily maintained treatment contacts six months after their orders expired" compared to "almost no patients" who had not been put on outpatient commitment (Van Putten et al. 1988). And in Iowa "it appears as though outpatient commitment promotes treatment compliance in about 80 percent of patients while they are on outpatient commitment. After commitment is terminated about three-quarters of that group remain in treatment on a voluntary basis" (Rohland 1998).

Long-term assisted outpatient treatment (LT-AOT) combined with routine outpatient services (3 or more outpatient visits per month) has been shown to be significantly more effective in reducing violence and improving outcomes for severely mentally ill individuals than routine outpatient care without LT-AOT. Results from a North Carolina study showed a 36% reduction in violence among severely mentally ill individuals in long-term assisted outpatient treatment (LT-AOT - 180 days or more) compared to individuals receiving less than LT-AOT (0 to 179 days) (Swartz et al. 2000). Among a group of

individuals characterized as seriously violent (i.e. committed violent acts within the 4 month period prior to the study), 63.3% of those not in LT-AOT repeated violent acts while only 37.5% of those in LT-AOT did so. LT-AOT combined with routine outpatient services reduced the predicted probability of violence by 50%.

Another significant finding of the North Carolina study was that for individuals who had a history of multiple hospital admissions combined with arrest and/or violence in the prior year, LT-AOT reduced the risk of arrest by 74%. The predicted risk of being arrested for individuals with LT-AOT was 12%, compared to 47% for those who had no AOT (Swartz et al. 2001).

In another report from the North Carolina study, LT-AOT reduced hospital admissions by 57% and length of hospital stay by 20 days compared to individuals without court ordered treatment (Swartz et al. 1998). The results were even more dramatic for individuals with schizophrenia and other psychotic disorders for whom LT-AOT reduced hospital admissions by 72% and length of hospital stay by 28 days compared to individuals without court ordered treatment.

- **Conservatorship**

Conservatorships and guardianships occur when a court appoints an individual to make treatment decisions for another individual who is believed to be mentally incompetent. They are used most frequently for individuals with mental retardation and with severe neurological diseases such as Alzheimer's disease; they are less often used for individuals with severe psychiatric illnesses except in California. In one study done in that state, "of the 35 patients who were placed on conservatorship, 29 (83 percent) remained stable as long as the conservatorship lasted," but for the 21 patients whose conservatorship was terminated, only 9 (43 percent) remained stable after termination" (Lamb and Weinberger 1992).

- **Substituted judgment**

This is closely related to outpatient commitment and conservatorship. In Massachusetts, which does not have an outpatient commitment statute, patients with severe psychiatric illnesses have the right to refuse medication. A mental health professional can take such an individual to court; if the court finds that the patient is incompetent, it may use a substituted judgment standard, appoint a guardian, and order the patient to take medication. In a six-month study of patients subjected to such a procedure, their admissions decreased from 1.6 to 0.6, and hospital days decreased from 113 to 44 (Geller et al. 1998). Reflecting on substituted judgment, Dr. Jeffrey Geller noted: "In one of the more ironic

outcomes of mental health law over the last two decades, the right to refuse treatment court decisions have become the basis in Massachusetts for involuntary community treatment orders" (Geller 1993).

- **"Benevolent coercion"**

"Benevolent coercion" is Dr. Geller's term for threatening to institute legal proceedings to compel treatment for patients who do not comply with treatment. Geller reported that he informed his patients that "if the lithium level fell below 0.5 meq/liter, the patient would be involuntarily admitted to a state hospital" (Geller 1986). According to Geller, such "benevolent coercion" is an effective method of assisted treatment. Anecdotal evidence suggests that it is used widely but rarely discussed publicly.

- **Threat of incarceration**

In one mental health center in upstate New York, the staff has an informal working arrangement with the local judge. Patients with severe psychiatric disorders who are noncompliant with medication and who are considered to be potentially dangerous to themselves or others are picked up by the police on misdemeanor charges. On arraignment, the judge refers them to the mental health center and suspends sentence pending their compliance with treatment. If they do not comply, they can be put in jail. There is no published account of such an arrangement, but anecdotal data suggest that it is not rare, especially in rural areas where a single judge may cover the entire population.

Conclusions

Assisted treatment for individuals with severe psychiatric disorders can be achieved by different methods. In publications it is usually implied that only one such method is being used, but in fact more than one are often being used at the same time. For example, the PACT program of assertive case management is sometimes combined with the use of guardianship in Wisconsin (Isaac and Armat 1990). And many of the patients in the Baltimore PACT study of homeless individuals were given representative payees as well as assertive case managers (Lehman 1998).

Although all forms of assisted treatment appear to be effective for some patients with severe psychiatric illnesses, efficacy for treatment compliance has only been clearly established for outpatient commitment. The paucity of research on assisted treatment is surprising given its importance.

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