Reimagining ONH:

A Report to the Vermont Department of Mental Health

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Introduction:

The Order of Non-Hospitalization (ONH) (18 V.S.A § 7618) is Vermont's version of a legal mechanism currently authorized in 46 states and the District of Columbia. Known by a variety of terms across the country, but most widely as "assisted outpatient treatment" (AOT), the core concept is civil commitment to outpatient care for individuals with severe mental illness who are considered unlikely to adhere to necessary treatment on a voluntary basis.

In recent years there has been growing recognition of studies indicating that AOT can substantially improve outcomes for individuals trapped in the "revolving doors" of the mental health and criminal justice systems by improving rates of adherence to mental health treatment and thereby reducing frequency and duration of hospitalization, arrests, incarceration, and acts of self-harm and violence[i] – all while allowing treatment systems to substantially reduce the extreme costs associated with providing care to "high utilizers."[ii] The federal government has been particularly active in drawing attention to these studies and promoting wider implementation of AOT, as reflected in the 2015 addition of AOT to the National Registry of Evidence-based Programs and Practices (NREPP) maintained by the Substance Abuse and Mental Health Services Administration (SAMHSA)[iii]; the 2012 rating of AOT as an effective crime reduction strategy by the National Institute of Justice (NIJ)[iv]; and federal legislation enacted in 2014 and implemented in 2016 to create a grant fund within SAMHSA to support the launch of new state and local AOT programs.[v]

However, these endorsements of AOT in academic literature and federal policy may ring hollow to those who have observed or participated in Vermont's ONH practice. While Orders of Non-Hospitalization have been employed routinely in the state for decades, the consensus among the mental health professionals consulted in the preparation of this report is that they are largely ineffective in helping patients maintain treatment adherence and avoid the pitfalls of repeat hospitalization and arrest.

To reconcile this disenchantment in Vermont with the rising enthusiasm for AOT elsewhere, it must first be understood that beyond the core concept stated above, there are great

variations in how AOT is practiced from one jurisdiction to the next. Some of these variances are dictated by differences in states' AOT laws; others by policy choices that local AOT programs have made in interpreting and implementing those laws. The purpose of this report is to identify any key differences between Vermont's ONH practice and the basic elements of the national "AOT Model" which may explain the discrepancy in results, and to make recommendations for reform arising from this analysis.

Dissatisfaction with ONH:

From the conversations conducted for this report with professionals involved in various facets of Vermont's ONH process, there appear to be three common points of dissatisfaction:

(1) In most cases, professionals see scant evidence of the "black robe effect" touted in other states, i.e., the notion that the being placed under court order has a meaningful impact on the patient's mindset and helps motivate the patient to maintain treatment engagement. While some noted that the court order did seem to influence those patients who were by nature highly deferential to authority, there is consensus that a greater number of ONH patients are decidedly unmoved by the knowledge of the court order.

(2) There is widespread frustration with the legal process that transpires when a patient fails to adhere to the terms of the ONH and the treatment team deems it appropriate to seek revocation of the order. In this situation, a DMH attorney files a Motion to Revoke the ONH with the court, and the court holds a revocation hearing. However, it is the sense of the professionals who take part in such hearings that the court will typically not revoke the ONH and return the patient to the hospital without a fresh evidentiary showing that the patient is a "person in need of treatment." This, of course, is the legal standard which would be applicable in the absence of an ONH. In other words, the ONH makes it no easier than it would otherwise be to return the patient to the hospital and seems to have no bearing on the court's decision-making.

(3) An ONH may be issued by either the Family Court or the Criminal Court. Patients who are identified by DMH as clinically appropriate for ONH are processed through the Family Court; those placed in the program by the Criminal Court are criminal defendants with mental illness who have typically been found incompetent to stand trial, for whom the District Attorney seeks ONH placement as a means to responsibly dispose of the criminal matter without having to wait indefinitely for competence to be restored. While DMH and the Designated Agencies are equally responsible for the monitoring and treatment of all ONH patients regardless of how they enter the system, there is a strong sense that Criminal Court-ordered patients are rarely individuals who would have been identified by mental health professionals as ONH-appropriate, and are especially unlikely to take the ONH seriously.

The Potential Remedy of Court-Ordered Medication:

In light of these perceived shortcomings of the current ONH practice, it is not surprising that many of the professionals consulted in the preparation of this report see an obvious solution

in integrating the use of Vermont's involuntary medication law (18 V.S.A. § 7624). Among other circumstances, the law empowers DMH to "commence an action for the involuntary medication of a person who is refusing to accept psychiatric medication and … has previously received treatment under an order of hospitalization and is currently under an order of nonhospitalization[.]"

Despite this clear statutory authority to medicate ONH patients over objection if clinically indicated, DMH's current practice is to limit this practice to the hospital setting. Those who advocate a broader implementation of the statute envision a system in which DMH would secure a court order authorizing the temporary removal of a non-medication-compliant ONH patient to an appropriate medical facility, administer medication, and return the stabilized patient to the community, thereby eliminating the need for revocation of the patient's ONH.

Whatever conclusion DMH leadership may reach about the merits of such a policy shift, it should be understood that it would make Vermont's ONH practice *less* like AOT programs elsewhere – not more. Court-ordered medication is not typically an element of the AOT Model. Indeed, many of the most successful programs operate in states where involuntary medication of non-adherent AOT patients is expicitly prohibited by law.[vi]

Vermont ONH vs. the AOT Model

While the lack of court-ordered medication is a point of commonality between Vermont's ONH practice and the national AOT Model, there are several highly consequential differences:

Key Difference #1: AOT programs leverage the "black robe effect" to motivate patients; Vermont's ONH practice forgoes any "black robe effect" by minimizing interaction between the patient and the court.

The "black robe effect" lies at the heart of all successful AOT programs. The premise is simply that the experience of visiting a courtroom, taking part in a hearing with both sides represented by counsel, and (most importantly) receiving direct, personal instructions from a judge, makes a profound impression upon the patient. It relies upon the inclination of most of us to hear the voice of authority in words delivered from the bench. The impact of this is heightened when the judge makes a concerted effort to connect with the patient in a manner that conveys compassion and respect, yet firmness of expectations.

When conveyed effectively, the "black robe effect" is not about scaring the patient into submission. On the contrary, the best AOT judges seize every opportunity to give *positive* reinforcement. It typically starts with impressing upon the patient that the reason he or she has been recommended for hospital release is that the treatment team and the judge are convinced of his or her ability to thrive in the community, but that it will take a team effort to make it happen; that everyone is on the same side, with mutual responsibilities to one another (for the patient's part, that means following the agreed-upon treatment plan, showing up for appointments, etc.); and that the patient also has a right to expect high quality care, and must let the judge know if it isn't delivered.

If indeed this black robe effect is the key ingredient in AOT -- and practitioners across the nation are convinced that it is -- it is fair to question whether Vermont's ONH practice is really AOT at all. In Vermont, ONH orders are almost always issued by the court upon

stipulation, without any hearing. The patient receives a copy of the court order and is informed by treatment personnel of what it means, but will never actually meet the judge unless things go poorly and it becomes necessary to appear at a revocation or modification hearing.

From a purely legal perspective, the stipulated ONH is perfectly sensible. If the patient welcomes the ONH application as a "ticket out" of the hospital and does not wish to contest it, a lawyer or judge might reasonably wonder what purpose is served by holding a hearing. The answer is that while an AOT hearing is unquestionably a legal exercise, it is also something else. Once the appropriateness of civil commitment to outpatient care is conclusively established, the AOT judge must embrace his or her function as the primary motivator of treatment adherence, which can only be performed by forging a personal connection with the patient.

It is typical of AOT programs that most applications are uncontested. As with ONH in Vermont, AOT is most often imposed upon discharge from a hospital stay, at a point when the patient is in stable condition and may have restored (if tenuous) recognition of his or her need for regular mental health treatment. In these situations, some AOT programs require any stipulations to take place in court, at the hearing. Stipulations allow the judge to move quickly through the first phase of the hearing, in which the appropriateness of AOT is considered, and onto the second phase, in which the judge imparts motivation and assures that both the patient and the treatment team fully understand their mutual responsibilities under the court order. Other programs allow the patient to reach a settlement agreement with the treatment team in advance of the hearing. But critically, these settlement agreements are certified by the court at a hearing, in the presence of the parties.

Key Difference #2: AOT courts play a vital role in monitoring patient progress during the period of the order. Vermont's ONH courts do not.

The best AOT programs reinforce the black robe effect throughout the AOT period, with regular "check-in" hearings or status conferences. These tend to occur more frequently at the beginning of the AOT period and less frequently as things settle into a smooth routine. Judges use the progress hearings as opportunities to make sure that any service gaps are quickly addressed, and to praise patients (building self-esteem) for their efforts and small victories. The patient's constant awareness that another progress hearing is approaching helps the treatment team keep the patient on track from day to day.

Nothing like this occurs under Vermont's ONH practice. Once the ONH is issued, the judge maintains no oversight unless and until a Motion to Modify or Motion to Revoke is made.

Key Difference #3: AOT programs have procedures to ease the process of re-hospitalizing a patient who is not adhering to treatment as directed. In Vermont, it is no easier to secure hospital care for a non-adherent ONH patient than it would be in the absence of an ONH.

For good reason, the AOT Model eschews the threat of punishment (i.e., contempt of court) which courts ordinarily rely upon to ensure compliance with their orders. (It would, after all, undermine the purpose of AOT if the court order were to ultimately create a new pathway *into* jail.) But that is not to say that an AOT patient should ever have reason to think that

violation of the court order will have no particular *consequence*. It is critical that AOT patients maintain a sense that their treatment adherence is being closely monitored and that a material violation of the court order is likely to result in re-hospitalization.

Again, it must be emphasized that this does not mean *automatic* re-hospitalization of an individual who does not currently meet hospital commitment criteria, simply because the court order has been disobeyed; such a practice would be plainly unconstitutional. Ultimately, recommitment to the hospital must only occur upon both *clinical and judicial* determinations that the patient meets inpatient criteria. In every state, meeting inpatient criteria is a matter of *both*:

- *status* (being deemed a current danger to self or others, however broadly or narrowly that may be defined under state law); and
- *current clinical needs* (requiring hospitalization as the least restrictive appropriate alternative treatment setting).

In states like Vermont with a shared set of criteria for both inpatient and outpatient commitment, moving a non-adherent AOT patient back to the hospital does not require a new judicial finding that the patient has the appropriate status for inpatient commitment. That finding was already made at the time AOT was ordered, and remains in effect until the court order expires or is vacated. The only question a court must decide upon a motion to revoke AOT is whether to accept the treatment team's finding that the outpatient setting is no longer the least restrictive appropriate alternative to meet the patient's current clinical needs. This empowers a treatment team that knows its patient to be non-adherent and taking the first steps down a familiar tragic path to intervene *now*, rather than defer action until the patient engages in behavior serious enough to convince the court of danger. It is generally understood that an AOT patient can and should be removed from the community at an earlier point in the cycle of decompensation than might be considered appropriate for a patient who does not currently have the status of a "person in need of treatment" (or whatever status terminology is used in that state). All parties accept the common-sense notion that the hospital is the appropriate treatment setting for "a person in need of treatment" who is not adhering to court-ordered treatment.

This should be no less true in Vermont. Under state law there is no difference in *status* between a hospital-committed patient and an ONH patient. When a patient moves from an inpatient commitment to an ONH -- or vice versa -- he or she retains the status of "a person in need of treatment" or "a person in need of further treatment." All that changes is the finding as to what is the least restrictive appropriate treatment setting.

According to the professionals consulted for this report, Vermont courts do not typically take this posture when considering a Motion to Revoke an ONH. Instead, these professionals say that Vermont judges demand new, current evidence that the ONH patient has the status of "a person in need of treatment" – essentially, asking DMH to litigate an issue that should not be in controversy. This makes the ONH revocation hearing indistinguishable from a hearing to impose a new civil commitment and renders the ONH itself irrelevant to the court's inquiry. For patients who have already been through the system a time or two, this only adds to the sense that the ONH is not to be taken seriously.

Key Difference #4: In AOT programs, the mental health professionals who operate the program also determine, subject to court approval, whom the program serves. In Vermont, providers are expected to serve many ONH patients who enter via order of the Criminal

Court, upon application of a District Attorney, without input from mental health professionals.

In typical AOT programs, the consideration of whether an individual is an appropriate candidate for AOT (i.e., whether the individual is capable of surviving safely in the community with treatment but is currently unprepared to make voluntary treatment decisions and is likely to benefit from court-ordered care) takes place in a purely clinical context. Treatment professionals conduct a clinical review of the person's needs and decide whether it is appropriate to file an AOT petition in the court with jurisdiction over civil commitments generally.

This also describes the process for roughly half of the patients placed under ONH in Vermont, who enter through the Family Court. However, the remainder of ONH patients enter the program without any input from the treatment system as to whether the ONH is the best means of serving their clinical needs. These are the patients placed under ONH by the Criminal Court, upon the petitions of District Attorneys.

Vermont is certainly not alone in needing alternatives to incarceration for lower-risk mentally ill criminal defendants. Other states employ a variety of mechanisms to provide offenders with supervised treatment in the community, including specialized mental health diversion courts and mandated treatment through probation and parole. But Vermont is highly unusual in permitting a criminal court to directly place a defendant under civil commitment -- with the usual responsibilities of treatment and oversight that imposes upon DMH and the Designated Agencies -- without regard to whether that defendant meets the same clinical standards of appropriateness that would normally be applied before DMH seeks an ONH from the Family Court.

While there appears to be no available data comparing ONH outcomes for Criminal Court vs. Family Court patients, the consensus among the professionals consulted for this report is that Criminal Court patients are often individuals that DMH staff would not have identified as good ONH candidates, and tend to be much more difficult for the Designated Agencies to engage in treatment.

Reimagining ONH: A Pilot Program Proposal

The Treatment Advocacy Center believes Vermont would achieve far greater results in helping its most vulnerable citizens with severe mental illness maintain wellness and stability in the community by transforming its ONH practice to follow the basic elements of the AOT Model. While this reform may seem a daunting challenge when considered on a statewide level, our recommendation is to limit any action for the time being to the establishment of a modest, two-year pilot program in a single city or county. We believe this program could be initiated without any need to amend state law. If the pilot program were to meet expectations in improving outcomes for participants, it would generate momentum for expansion of the AOT Model across Vermont.

Elements of the proposed pilot would include:

- Selection of a single city or county for the program to serve, with the local Designated Agency fully engaged as a partner.

- Assignment of a single Family Court judge, prepared to embrace the basic tenets of the AOT Model, to preside for the duration of the pilot. (This would require the agreement of the judiciary to suspend the usual practice of annually rotating judicial assignments.)
- Setting a maximum number of patients to be served by the pilot program at any time, based on the clinical and judicial resources that are realistically available to devote to the program;
- Exclusion from the program all patients placed under ONH by the Criminal Court. (Such patients would continue to be served by the Designated Agency under the current ONH process.)
- Integration with DMH's discharge planning process for patients transitioning from "Level I" inpatient care, such that Level I inpatients who reside in the pilot program locale and are deemed appropriate for ONH upon discharge may be placed in the pilot program as capacity permits.
- Establishment of a process to ensure that each participant in the pilot program, represented by counsel, receives a hearing before the court at the initiation of the ONH, which shall include the court's review of the treatment plan and follow the AOT model in maximizing the "black robe effect." (This need not preclude having willing participants sign voluntary settlement agreements prior to the hearing, so long as such settlements are approved by the court at a hearing with the parties present.)
- Status conferences during the period of each ONH, at which the judge shall convene the parties to the ONH with counsel to review the patient's progress and the treatment team's success in delivering services.
- Dedication of hospital beds within VPCH or other appropriate psychiatric hospital, adequate in number to ensure that an immediate bed will be available for any program participant whom the treatment team believes has come to require a more restrictive treatment setting.
- Recognition that the patient retains the status of "a person in need of treatment" throughout the period of the ONH, such that the only issue before the court upon a Motion to Revoke or a Motion to Modify is whether the hospital has become the least restrictive appropriate treatment setting for the patient;
- Holding a court hearing upon the expiration of each ONH, at which the court shall either consider any Motion to Renew the ONH or, in the absence of any such motion, shall commend the patient for his or her successful completion of the program and seek to ensure that appropriate voluntary services have been made available to the patient to allow him or her to continue to maintain stability in the community.
- Integration of a data collection component to track and compare outcomes for both pilot program participants and comparable individuals treated in the same city or county under the longstanding ONH practices.

The Treatment Advocacy Center, with experience in the development and launch of AOT programs across the U.S. and relationships with a broad array of current AOT practitioners, stands ready to provide technical assistance to Vermont in the development of such a pilot program. This would include facilitation of contacts (ideally including field visits) with public agencies, providers, judges and attorneys involved with highly successful AOT programs across the US. Many of these programs were established through legislative and judicial efforts to reform prior outpatient commitment practices regarded as ineffective or overly cumbersome.[vii]

[i] See e.g., Swartz MS, Swanson JW, Steadman HJ, Robbins PC, Monahan J. New York State assisted outpatient treatment evaluation. 2009; Munetz MR, Grande T, Kleist J, Peterson GA. The effectiveness of outpatient civil commitment. Psychiatr Serv. 1996;47(11); Swartz MS, Swanson JW, Wagner HR, Burns BJ, Hiday VA, Borum R. Can involuntary outpatient commitment reduce hospital recidivism?: findings from a randomized trial with severely mentally ill individuals. Am J Psychiatry. 1999;156(12); 1968-75.

[ii] See e.g., Swanson JW, Van Dorn RA, Swartz MA, Robbins PC, Steadman HJ, McGuire TJ, Monahan J. The Cost of Assisted Outpatient Treatment: Can It Save States Money? Am J Psychiatry. 2013; 170:1423–1432; Quanbeck C, Tsai G, Szabo K. Cost-effectiveness analysis of Assisted Outpatient Treatment implementation in California's civil sector.

[iii] Substance Abuse and Mental Health Services Administration, National Registry of Evidence-Based Programs and Practices. Assisted Outpatient Treatment, accessed March 10, 2017.

[iv] National Institute of Justice, Office of Justice Programs. Program Profile: Assisted Outpatient Treatment, accessed March 10, 2017.

[v] Substance Abuse and Mental Health Services Administration. Assisted Outpatient Treatment Grant Program for Individuals with Serious Mental Illness, accessed March 10, 2017.

[vi] *See e.g.,* N.Y. MHY § 9.60(n); Calif. Welf. & Inst. Code § 5346(f); Tex. Health & Safety § 574.034(c-4).

[vii] Examples include Summit County, Ohio; Butler County, Ohio; Bexar County, Texas; Tarrant County, Texas; Seminole County, Florida; Nevada County, California; and Orange County, California.