NARPA

NATIONAL ASSOCIATION FOR RIGHTS PROTECTION AND ADVOCACY

Re: Senate Bill 453 (Unfavorable)

The National Association for Rights Protection and Advocacy is an independent member-supported organization of advocates, people who have experienced psychiatric intervention, lawyers, civil rights activists, academics and mental health service providers. For forty years our mission has been to protect people's right to choice and to be free from coercion, and to promote alternatives so that the right to choice can be meaningful. We believe outpatient commitment is inherently violative of people's autonomy, dignity and choice. We are writing to voice our opposition to the proposed legislation that would introduce it to the State of Maryland.

The euphemistically mis-termed "assisted outpatient treatment" is not about assistance but rather, coercion and force through the vehicle of civil commitment. The bills' proposed findings refer to people who "struggle to engage voluntarily in treatment." In our experience people often struggle to effectively refuse unwanted and unhelpful treatment — or conversely, to access wanted but unavailable services.

Despite its federal listing as an evidence based practice there is significant evidence suggesting outpatient commitment is ineffective in practice. What has been successful is the intensive services provided rather than judicial coercion accompanying them. Nor has it been demonstrated to be cost effective. One systemic review (Compulsory community and involuntary outpatient treatment for people with severe mental disorders, Kisely et al, 2011) concluded: "In terms of numbers needed to treat, it would take 85 outpatient commitment orders to prevent one readmission, 27 to prevent one episode of homelessness and 238 to prevent one arrest." (https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD004408.pub3/full)

Framing the choice to reject proposed treatment and avoid the mental health system as a result of lack of insight denies even a possibility of reasonable refusal.* But for many people psychiatric treatment is ineffective or harmful or both. A system of care that overrides choice, incorporates community coercion and diverts scarce resources to effect it undermines the therapeutic alliance between providers and clients and drives people further away from services. Transforming carers into enforcers and creating a self perpetuating system of monitoring and control will not create high quality equitable care.

We ask that you closely examine the evidence and reconsider this proposed legislation. If you decide to move forward we urge you to narrow it to a pilot project in one county, with an independent study of its outcomes to be reported back. Thank you for your consideration.

Bill Stewart, Board President, National Association for Rights Protection & Advocacy
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* Please see the accompanying brief article Anosognosia: How Conjecture Becomes Medical "Fact" by psychiatrist Sandra Steingard

https://www.psychologytoday.com/us/blog/bipolar-advantage/201208/anosognosia-how-conjecture-becomes-medical-fact

Psychology Today
Sandra Steingard, MD

PSYCHOSIS
Anosognosia: How Conjecture Becomes Medical “Fact”
How ideas become mainstream without any research basis.

Posted August 30, 2012

I was so moved by this article that I asked Sandra Steingard MD for permission to repost it. I do so here without changes.

Neurologists use the term anosognosia to describe a peculiar syndrome in which a person has a profound lack of awareness of an obvious deficit. For instance, a person who has a stroke on the right side of his brain and is paralyzed of the left side of his body has no awareness of the problem. He might not recognize his left arm as his own. When given a page to read, he might only read the words on the right side of the page. He would only put his shirt on his right arm but when asked if he was adequately dressed, he would answer, yes. This phenomena is regularly associated with damage to the right side of the brain in the section called the parietal lobe.

In the 1990′s, a psychologist, Xavier Amador, began to use this term in the context of describing a person who was experiencing psychotic symptoms and did not believe that his problems were due to an illness. For instance, if a person heard voices that no one else heard, he might conclude that he was communicating with dead relatives. When his doctors or family told him that he was sick, he would disagree. Doctors would call this “lack of insight” and Amador was one of the first to appropriate the neurological term anosognosia to describe this.

There is a history in neuroscience of trying to apply what has been learned from studying the cognition and behavior of people who have had strokes to develop a more general understanding of the connection between brain function and behavior. In that spirit, there have been multiple studies to address whether there were changes in the brains of people who were psychotic and were described as having a “lack of insight” that were similar to the changes found in people who had right hemisphere strokes.

Readers on this site have wondered how the notion of a “chemical imbalance” could have been accepted by so many when the research did not actually support the concept. A recent paper from the Treatment Advocacy Center that summarizes studies of anosognosia in psychosis gives some clue as to how this type of thinking becomes entrenched and accepted.

The paper reviewed 18 studies of brain imaging of people who were identified as having this syndrome. This is from the conclusion to that study:
"Regarding localization, it is now clear that anosognosia is not caused by damage to one specific area. Rather a person’s awareness of illness involves a brain network that includes the prefrontal cortex, cingulate, superior and inferior parietal areas, and temporal cortex and the connections between these areas. Damage to any combination of these areas can produce anosognosia, but damage to the prefrontal and parietal areas together make anosognosia especially likely.

Anosognosia, or lack of awareness of illness, thus has an anatomical basis and is caused by damage to the brain by the disease process. It thus should not be confused with denial, a psychological mechanism we all use."
This conclusion, which will now likely be repeated in TAC publications and elsewhere as a definitive statement of scientific “fact”, involves some slight of words. What the paper reports is that 15 of 18 studies found group differences between the study subjects and the controls but the findings were highly variable between studies. In the summary above, they mention that differences were found in multiple brain regions but the findings did not overlap much between the studies, i.e., although 15 studies had “positive” findings, they were often different findings in each study. My assumption from reading this review is that, despite this research, if one were to show a scan to a doctor, he would not be able to make a diagnosis from the scan. In other words, the differences are subtle and do not clearly distinguish a person with “lack of awareness” of psychotic symptoms from any one else.

If one were to do a similar study of patients who had strokes and subsequently had the classic form of anosognosia, the findings would be strikingly different. In every study, there would be profound abnormalities in the brain and they would all be found in the right parietal lobe of the brain. If you showed me a series of scans of people with left sided neglect due to strokes and those of people who did not have this syndrome, I believe I could

easily pick out those with left neglect. In this case the brain damage would be obvious and the resulting deficit would be easy to predict.

In the TAC summary, the use of the word “damage” is misleading. Abnormalities – or in this case group differences – do not equal damage. I am left handed. I imagine that with some types of brain imaging, my brain would look different from my right handed friend but that does not mean my brain is damaged; it only means my brain is different.

The final statement in this conclusion, that anosognosia “should not be confused with denial, a psychological mechanism we all use,” makes no sense to me. Why do they believe that there are no brain changes underlying the so-called psychological condition of denial? In most of the studies reviewed, they would ask people questions while they were in the scan. A sample question was “If someone said I had a mental illness they would be right.” The type of “psychological denial” that the authors want to distinguish between this so-called anosognosia would presumably be something along the lines of someone who has lost a loved one but does not report being sad. The only way one could conclude that the findings in the psychosis studies were different and somehow distinct would be to scan the brains of people who were found to have “psychological denial” and compare those to brain scans from individuals who had “good insight” and as well as those who are identified as having lack of insight of psychosis. As with the notion of “chemical imbalance”, the term anosognosia has crept into the psychiatric lexicon. Its use confers a certain sophistication of understanding and knowledge that is not supported by the data.
Sandra Steingard, M.D. is the Medical Director of HowardCenter and Clinical Associate Professor of Psychiatry at the University of Vermont College of Medicine in Burlington. She was educated and trained at Harvard and Tufts Universities in Boston and received her specialty certification in psychiatry from the American Board of Psychiatry and Neurology in 1986.
Her areas of interest include community mental health and the diagnosis and management of psychotic illnesses. She was named an Exemplary Psychiatrist by the National Alliance for the Mentally Ill of Vermont in 1996, and has been listed in the Best Doctors in America since 2003.

About the Author

Tom Wootton founded Bipolar Advantage with the mission to help people with mental conditions shift their thinking and behavior so that they can lead extraordinary lives.