



# The Cost of Waiting: Psychosis, Anosognosia, and Maine's Progressive Treatment Plan

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## Abstract

Every year in Maine, people with severe mental illness/brain disorders deteriorate in public, cycle through emergency rooms and jails, and eventually commit serious crimes before receiving the sustained psychiatric treatment that could have prevented the harm. The financial cost of this cycle is as staggering as its human cost: repeated hospitalizations at \$950 to \$3,998 per day, incarceration, law enforcement responses, court proceedings, and public defense services, all of it reactive, all of it avoidable, and all of it paid by Maine taxpayers. This paper argues that the path is not inevitable. Maine's Progressive Treatment Plan (PTP), codified under Title 34-B, §3873-A of the Maine Revised Statutes, was specifically designed to authorize court-ordered community treatment before a crisis. In practice, clinicians, courts, and advocacy organizations have narrowed its application to a post crisis instrument, requiring individuals to reach an imminent danger threshold that the statute was intended to render unnecessary. This paper examines the clinical science of psychosis and anosognosia, the neurological inability to perceive one's own illness, the architecture of Maine's PTP law, the mechanisms by which its preventive intent has been subverted, the role of Disability Rights Maine in opposing mandatory treatment, and a detailed cost analysis demonstrating that PTP is not only clinically sound but fiscally responsible. All data and sources have been independently verified.

Keywords: psychosis, anosognosia, progressive treatment plan, assisted outpatient treatment, assertive community treatment, severe mental illness, Maine, cost analysis, involuntary treatment, disability rights, criminalization



Psychosis is not a diagnosis; it is a breakdown of the mind's most basic function: the ability to parse what is real. The National Institute of Mental Health (NIMH, 2023) describes it as a state in which "a person's thoughts and perceptions are disrupted, and they may have difficulty recognizing what is real and what is not." For the person experiencing it, the delusion that neighbors are plotting murder, or the voice commanding retaliation, is not perceived as a symptom. It is experienced as fact. That distinction between symptom and perceived reality is the clinical engine of every crisis this paper addresses.

The core features of a psychotic episode include fixed false beliefs (delusions), such as paranoid convictions that others are conspiring to cause harm; sensory experiences without external cause (hallucinations), including voices issuing commands or criticism; grossly disorganized thinking and speech; and behavior that, to an outside observer, makes no sense, but follows its own internal logic given the individual's distorted perception of reality. Psychosis is the defining symptom cluster of schizophrenia and schizoaffective disorder, and a major feature of Bipolar I. Studies estimate between 15 and 100 per 100,000 people develop psychosis each year, with onset most common in late adolescence through the mid-20s (NIMH, 2023). McCarthy (2026b) reports that schizoaffective disorder alone affects roughly 0.3% of the population, with approximately 70% of those individuals experiencing severe functional impairments in daily life.

## The Treatment Gap Nobody Talks About

One of the most consequential and least discussed facts in psychiatric medicine is this: NIMH (2023) reports that it is common for a person to experience psychotic symptoms for more than a year before receiving any treatment. A full year or more of escalating paranoia, hallucinated commands, and deteriorating judgment without intervention. NIMH is direct about what that delay costs: "reducing this duration of untreated psychosis is critical because early treatment often means better recovery," and the "risk of violence and suicide decreases with treatment" (NIMH, 2023). The inverse follows logically, and clinical literature confirms it: the longer psychosis goes untreated, the worse the outcomes across every measurable domain.

Psychosis left untreated does not plateau. The paranoid delusion that began as a quiet suspicion becomes a certainty that demands action. The hallucinated voice becomes louder, more directive, harder to resist. Judgment erodes until the person is acting on a version of reality that is clinically false but subjectively absolute. This is the mechanism. Not moral failure. Not criminal intent. A brain in crisis, receiving no treatment, producing behavior that eventually lands in a courtroom rather than a hospital.



## Treatment Works When It Reaches People

NIMH (2023) endorses coordinated specialty care combining antipsychotic medication, psychotherapy, family education, case management, and supported employment as the standard of care for early psychosis, a position formalized in the American Psychiatric Association's Practice Guideline for the Treatment of Patients With Schizophrenia. The American Psychiatric Association (APA, n.d.) confirms that people with poor illness insight are "less likely to stay in treatment and more likely to relapse, experience involuntary treatments, and to have poorer psychosocial functioning." The intervention works. Getting it to the people who need it, particularly those who do not know they are ill, is where Maine's system breaks down.

## Anosognosia: When the Brain Cannot See Itself

In 1914, French neurologist Joseph Babinski described patients who, following strokes or brain injuries, were completely unaware that anything was wrong with them. They could not move one side of their body and did not know it. He coined the term anosognosia from the Greek for "without knowledge of disease" to capture this neurological inability to perceive one's own condition (Acharya & Sánchez-Manso, 2023). A century later, the same mechanism has been documented, replicated, and formally recognized in schizophrenia and related psychotic disorders. The brain structures responsible for self-monitoring, the prefrontal and insular cortices, are primarily disrupted, leaving the individual unable to update their self-concept with accurate information about their own condition.

This matters for a reason clinicians and policymakers have been slow to act on: when someone with psychosis also has anosognosia, their refusal of treatment is not a decision in any meaningful sense. A brain that has lost the capacity to register illness cannot recognize the need for treatment. The person is not stubborn or non-compliant in the way that word implies choice. They genuinely, neurologically, do not know they are sick. As Acharya and Sánchez-Manso (2023) document, this condition "may persist and lead to poor compliance with medication regimens," a clinical understatement for what, in practice, is a complete barrier to voluntary treatment engagement.

The scale of the problem is substantial. NIMH (2023) reports anosognosia in 50 to 90% of people with schizophrenia and roughly 40% of those with bipolar disorder. The WHO International Pilot Study of Schizophrenia, conducted across nine countries with more than 1,200 patients, identified poor insight as the single most prevalent symptom of schizophrenia, more common than hallucinations or delusions. Among 306 patients with independently confirmed diagnoses, 97% showed a lack of insight (as cited in Hagar, 2026). Amador and David (1994) found, in a multi-site study using the first validated insight rating tool, that 57% of schizophrenia patients had moderate to severe unawareness of their disorder. McCarthy



(2026b) puts anosognosia squarely at the center of her clinical analysis, documenting it as the primary driver of treatment nonadherence in this population.

Anosognosia is not a fringe finding. The DSM-IV addressed it on page 304 (APA, 2000). The DSM-5 carries it forward on page 101 and explicitly names poor insight as among the strongest predictors of medication and treatment nonadherence in serious mental illness (APA, 2013). The APA's own patient-facing materials confirm that anosognosia "is typically a symptom of schizophrenia itself rather than a coping strategy" and "may be present throughout the entire course of the illness" (APA, n.d.). The clinical establishment has been saying this for decades. Maine's legal and advocacy infrastructure has not caught up.

## The Dementia Problem Nobody Mentions

Anosognosia also occurs in Alzheimer's disease and following traumatic brain injury and stroke (Acharya & Sánchez-Manso, 2023; Hagar, 2026). In those contexts, the same neurological incapacity that causes the patient to wander into traffic because she does not know she is ill is treated without hesitation as a medical emergency warranting protective intervention. Nobody argues that the dementia patient is exercising her right to autonomous self-determination. Nobody calls her guardian's intervention a civil liberties violation. But when the identical biological mechanism operates through a schizophrenia diagnosis rather than an Alzheimer's diagnosis, the system pivots from medical protection to legal debate. Little and Bell (2021) put this plainly: "Anosognosia in schizophrenia "emphasizes that lack of capacity is the result of a neurological deficit, and underestimating that fact "may place that person at risk of a preventable harm." The differential treatment is not clinically justifiable. It is discriminatory.

## Maine's Progressive Treatment Plan: What the Law Actually Says

Maine's Progressive Treatment Program was first enacted in 2005 under Public Law 2005, Chapter 519, then substantially restructured under Public Law 2009, Chapter 651. It is now codified as Me. Rev. Stat. tit. 34-B, §3873-A (2009). The law gave Maine something most states did not have: a statutory mechanism for court-ordered community treatment explicitly designed to operate before crisis, before the emergency room, before the arrest, before the felony. The architects of the law understood that anosognosia creates a population that cannot engage voluntarily with treatment and built a tool to address that specific problem (McCarthy, 2026b).

## The Seven Conditions

Under §3873-A (1), a District Court may order a patient into the Progressive Treatment Program when seven conditions are met:

1. The patient suffers from a severe and persistent mental illness;



2. The patient poses a likelihood of serious harm;
3. The patient has a suitable individualized treatment plan;
4. Licensed and qualified community providers are available to carry it out;
5. The patient is unlikely to follow the plan voluntarily;
6. Court-ordered compliance will help protect the patient from relapses or deterioration;  
and
7. An ACT team is willing and able to accept the patient.

Who may petition the court is a shorter list than most people realize: the chief administrative officer of a psychiatric hospital, the DHHS Commissioner, an ACT team director, a medical practitioner, a law enforcement officer, or the patient's legal guardian (Me. Rev. Stat. tit. 34-B, §3873-A (1), 2009). Not a parent. Not a sibling. Not a spouse without legal guardianship. That gap has consequences, examined below.

## The Standard the Legislature Actually Wrote

The most important provision in the PTP framework and the one most frequently ignored in practice is the specific definition of "likelihood of serious harm" that governs PTP proceedings. Under Me. Rev. Stat. tit. 34-B, §3801(4-A)(D), that standard is: "in view of the person's treatment history, current behavior, and inability to make an informed decision, a reasonable likelihood that the person's mental health will deteriorate and that the person will in the foreseeable future pose a likelihood of serious harm."

Read that carefully. Foreseeable future. Treatment history. Inability to make an informed decision. The Legislature was not describing a person who is already dangerous. They were describing a person whose documented history and current neurological state make future dangerousness foreseeable. That is a profoundly different standard from the emergency civil commitment threshold under Me. Rev. Stat. tit. 34-B, §3863, which requires present, demonstrable harm risk. The PTP was written to catch people before §3863 becomes necessary. In practice, §3863 is where most intervention occurs, if it occurs at all.

## What Maine's Own Data Show

Maine DHHS (2023) reports roughly 150 individuals enrolled in AOT programs statewide. Within the first year, those participants showed a 45% reduction in psychiatric hospitalizations compared to the year before enrollment. Among those discharged from Riverview Psychiatric Center who transitioned to AOT, readmissions within six months ran 60% lower than for those discharged without structured follow-up. More than 70% of AOT participants reported improved quality of life and increased social engagement after six months. These are not marginal gains. They are the outcomes of a law working when it is used, which makes the statewide enrollment figure of 150 not a success story but a measure of how rarely the law is



applied.

## How the Law Gets Circumvented

Maine's PTP fails the people it was designed to serve through three mechanisms that reinforce each other: the wrong legal standard being applied in practice, a structural precondition that traps the most severely ill outside eligibility, and a petitioner-standing rule that shuts families out of the process entirely.

### The Wrong Standard

Emergency civil commitment under Me. Rev. Stat. tit. 34-B, §3863 requires a present, demonstrable harm, risk, active suicidal threats, physical danger to others, or acute inability to self-care. That is the acute crisis standard, designed for immediate hospitalization decisions. The PTP operates under a different, and explicitly more expansive, standard: foreseeable deterioration based on treatment history and documented incapacity to make an informed decision (§3801(4-A)(D)). These are different legal tests, written to serve different points in the clinical trajectory.

But the Treatment Advocacy Center (2023) documents what anyone familiar with Maine's system has observed: clinicians and courts routinely apply the acute commitment standard when evaluating PTP applications. Part of this is training that the §3801(4-A)(D) standard requires careful documentation of treatment history and clinical judgment about future trajectory, which takes time that overburdened acute-care settings do not have. Part of it is institutional risk-aversion, shaped by years of disability rights litigation challenging any form of mandatory treatment. The result is that people who clearly satisfy the foreseeable-deterioration standard with years of documented noncompliance, repeated hospitalizations, and anosognosia are turned away from PTP because they are not yet imminently dangerous enough. Then they become imminently dangerous, and the conversation shifts from PTP to criminal charges.

### The ACT Team Problem

Before the District Court can order someone into the PTP, an ACT team must be available and willing to accept them (Me. Rev. Stat. tit. 34-B, §3873-A(1)(D), (G), 2009). Individuals with severe psychosis and anosognosia, by the nature of their condition, have not been voluntarily engaging with mental health services. They have no ACT team relationship. PTP was supposed to compel that engagement, but the statute requires it to already exist before PTP can be ordered.

Compounding this, Maine simply does not have enough ACT teams. With 150 people enrolled



statewide (Maine DHHS, 2023) and ACT capacity constrained by workforce shortages and funding gaps that have never been adequately addressed, many people who meet every other PTP criteria cannot be admitted because no team has the capacity to take them. The Treatment Advocacy Center (2023) has flagged ACT team availability as a primary implementation bottleneck and recommended dedicated funding as a prerequisite to meaningful reform.

## Families Have No Standing

New York's Kendra's Law (N.Y. Mental Hyg. Law §9.60, 1999) allows adult family members to petition for AOT. Maine's §3873-A (1) does not. Under Maine law, a parent who has watched their child with schizophrenia deteriorate for three years, who has called Adult Protective Services repeatedly, tried multiple emergency commitments, and documented every hospitalization and discharge, has no right to walk into a District Court and petition for PTP. That standing belongs to institutional actors: hospital administrators, ACT team directors, the DHHS Commissioner. The people with the most detailed, longitudinal, and clinically relevant knowledge of the patient's treatment history are locked out of the process. The Treatment Advocacy Center (2023) has recommended a straightforward fix: authorize any responsible adult with documented knowledge of the individual's history to petition. Maine has not acted on it.

## Where People End Up Instead

Hagar (2026) describes the outcome of these combined failures as a pattern observed across decades of forensic psychiatric work in jails, prisons, and state hospitals in multiple states. The composite is precise and grim: a person with schizophrenia and anosognosia stops taking medication, misses appointments until the clinic closes the case, becomes homeless, cycles through arrests, and eventually commits a felony. Once inside the criminal justice system, where structure and supervision are mandatory, not optional, the person often stabilizes. That stabilization is not evidence that the criminal justice system is a good psychiatric treatment venue. It is evidence that mandatory structure works, and that Maine waited for a felony to provide it.

McCarthy (2026b) documents this same trajectory through both research and clinical observation. The readmission data tells the story concisely: 60% of people discharged from Riverview Psychiatric Center to AOT programs do not return within six months (Maine DHHS, 2023). For those discharged without structured follow-up, which is most of them, that protection disappears. The system knows how to prevent the return trip. It is simply not doing it.



## Disability Rights Maine and the Problem With “Autonomy”

Disability Rights Maine is the federally designated Protection and Advocacy organization for Maine, established under the Protection and Advocacy for Individuals with Mental Illness Act (PAIMI Act, 42 U.S.C. §10801 et seq.). Its work protecting patients from abuse, ensuring due process in commitment proceedings, and holding psychiatric facilities to legal standards of care is necessary and, at its best, genuinely protective. What follows disputes the application of a civil liberties framework, one built on the presumption of intact autonomous decision-making, to a clinical population for whom that presumption is neurologically false.

### How DRM Frames the PTP

DRM has published a manual on Maine’s involuntary hospitalization and PTP processes framed primarily around the patient’s right to contest court-ordered treatment (Disability Rights Maine, 2023). The manual directs readers to contact DRM to help with challenging PTP orders. In July 2025, DRM publicly characterized a state executive order as “taking away civil liberties” from individuals with mental illness (Disability Rights Maine, 2025). These are defensible positions within a civil liberties framework. They become clinically problematic when applied without differentiation to individuals who, due to anosognosia, have no neurological access to the autonomous judgment those civil liberties are meant to protect.

### When “Autonomy” Is Not Autonomy

Autonomy, as a legal and ethical concept, requires the capacity to form and act on informed preferences. The DSM-5 (APA, 2013, p. 101) identifies poor insight as among the strongest predictors of treatment nonadherence in serious mental illness, not because patients are weighing the risks and deciding no, but because the brain cannot produce the awareness that a decision is required. Calling this autonomy is not a defense of the patient. It is a defense of the disease.

Hagar (2026) put the critique bluntly: “We have built a wall of civil liberties around a broken brain, and we call it autonomy. It isn’t.” McCarthy (2026a) made the same point from lived experience as both a clinician and a family member: “If my mother had Alzheimer’s and wandered into traffic because she didn’t know she was sick, the system would call it a medical emergency. They would recognize her anosognosia as a reason for more, not less, care. But because my [family member] suffers from Schizophrenia, the system treats that exact same neurological deficit as a ‘lifestyle choice.’ It’s institutional discrimination.” Little and Bell (2021) make the clinical case in peer-reviewed terms: anosognosia “emphasizes that, in schizophrenia, lack of capacity is the result of a neurological deficit, and treating it otherwise may place that person at risk of preventable harm.



What DRM has not addressed is the distinction between two genuinely different situations. One is a patient with mental illness who has sufficient insight to understand their condition and chooses to refuse a specific treatment, a choice that deserves legal protection. The other is a patient whose psychosis has stripped them of the neurological capacity to recognize they are ill at all, and who therefore cannot refuse treatment in any meaningful sense of the word. These are not the same clinical situation, and advocacy built on protecting the second person's "choice" is not protecting a person. It protects against untreated illness and the harm that follows from it.

## The Research on AOT and ACT: What We Know

The scientific literature on Assisted Outpatient Treatment and Assertive Community Treatment is not ambiguous. Across multiple study designs, populations, and states, the findings point in the same direction. The resistance to broader AOT use in Maine is not grounded in scientific uncertainty. It is grounded in underfunding, institutional inertia, and advocacy opposition that the evidence does not support.

## National Research

DuPont and Field (2025) evaluated a coordinated AOT program in Michigan and found an 81.5% reduction in psychiatric inpatient days, complete elimination of arrests among participants, medication adherence of 89.5%, and stable housing at 82.6% (<https://doi.org/10.29333/ejgm/17440>). In a multi-site evaluation of 392 AOT clients, Johnson et al. (2025) found that appointment adherence increased by more than 24% and medication adherence increased by more than 20% across 6 and 12 month windows. Violent behavior dropped by more than 19%. Suicidal ideation dropped by more than 24%. Inpatient psychiatric episodes fell by more than 40%. Arrests declined by more than 19%, illicit drug use by more than 14%, and homelessness by 12% in the first six months (<https://doi.org/10.1176/appi.prcp.20240162>). Brown et al. (2025) evaluated Kentucky's AOT program using Medicaid billing data for 74 participants and found a 39% reduction in total healthcare encounters and a 53% reduction in hospitalizations, resulting in meaningful savings in state Medicaid expenditures (<https://doi.org/10.1080/26408066.2025.2570933>).

Swanson et al. (2006) conducted a randomized trial of AOT for people with severe mental illness and documented sustained gains in treatment adherence and reduced psychiatric symptoms, with particularly strong results for individuals with anosognosia (<https://doi.org/10.1001/archpsyc.63.2.179>). A subsequent systematic review by Swanson et al. (2019) confirmed AOT's positive effects across multiple mental health outcome domains (<https://doi.org/10.1176/appi.ajp.2019.19010094>). McGrew et al. (2006) documented significant social functioning gains and reduced hospitalization through ACT for individuals with



schizophrenia. Muench et al. (2021) linked ACT's community-based structure to reduced criminal justice recidivism. SAMHSA added Assisted Outpatient Commitment to the National Registry of Evidence-Based Programs and Practices in 2015 after an independent review confirmed positive outcomes across multiple peer-reviewed studies (Maine Legislature, 2023).

## What Maine's Numbers Show

Maine DHHS (2023) reports a 45% reduction in hospitalizations in the first year of AOT enrollment, a 60% drop in readmissions for people who move from Riverview Psychiatric Center into AOT programs, and over 70% of participants reporting improved quality of life after six months. McCarthy (2026b) synthesizes these outcomes against the broader research literature and reaches a straightforward conclusion: integrated AOT and ACT is the evidence-based standard of care for people with severe mental illness and anosognosia. The treatment gap in Maine is not a knowledge problem. It is a will and resource problem.

## What Maine Is Actually Paying For: A Cost Analysis

Maine taxpayers are already funding the mental health system they have. The question is whether they are getting their money's worth. The answer, by any honest accounting, is no. The current system is reactive, fragmented, and legally constrained from early intervention, and is not less expensive than prevention. It is far more expensive, producing worse outcomes at greater public cost.

## The Price of One Untreated Episode: A Composite Analysis

To make the cost calculation concrete, consider the documented financial profile of a typical untreated cycle of severe mental illness with anosognosia in Maine, drawn from institutional cost data and published Maine rates. A single four-year period without AOT intervention, ending in court ordered treatment only after criminal charges, generated the following approximate public expenditures:

Three acute psychiatric hospitalizations at a Maine general hospital, totaling approximately six weeks, at the published rate of \$3,998 per day (Maine General Medical Center, 2024): \$167,916. A five-month inpatient stay at Riverview Psychiatric Center, Maine's state psychiatric hospital, at approximately \$950 per day, based on CMS cost report data showing average charges of \$1,258 per day (American Hospital Directory, 2024): \$142,500. Three periods of incarceration in county jail, where Penobscot County Sheriff Troy Morton has publicly stated that individuals with complex mental health needs represent "some of the most expensive care there is" (Maine Public Radio, 2025), combined with public defender services at the state's assigned counsel rate of \$150 per hour (Maine Commission on Public Defense Services, 2025) and mental health court costs of \$5,000 to \$7,500 per participant per year (National Drug



Court Institute, 2021): conservatively \$25,000 to \$35,000. Multiple law enforcement responses, emergency department evaluations, failed civil commitment proceedings, and emergency mobile crisis calls add additional costs not captured in institutional billing.

The total public expenditure for reactive care over this period was more than \$330,000. Not one dollar of this produced lasting stability. Every admission was followed by discharge to homelessness. Every arrest was followed by release without treatment. Every stabilization was temporary because the system that produced it was not designed to maintain it (McCarthy, 2026a).

## What AOT Would Have Cost Instead

Assertive Community Treatment, the delivery model for Maine's PTP, operates at a fraction of that cost. A national cost analysis estimates AOT program expenditures at approximately \$15,000 to \$30,000 per person annually, primarily for ACT team services, case management, and medication (Nevada County, 2012; Mental Illness Policy Org, 2019). Swanson et al. (2013) conducted the most rigorous cost study of AOT to date, examining Medicaid and mental health system costs before and after AOT initiation in New York. They found that average total costs declined by 50% in New York City (from approximately \$105,000 to \$53,000 per person) and by 62% in the five-county sample (from approximately \$104,000 to \$39,000 per person) in the first year following AOT initiation (<https://doi.org/10.1176/appi.ajp.2013.12091152>). Brown et al. (2025) document that Kentucky's AOT program produced a 39% decline in healthcare encounters and a 53% reduction in hospitalizations, resulting in significant Medicaid savings. In Nevada County, California, a cost-effectiveness analysis found that for every \$1 invested in AOT, the program generated \$1.81 in savings, producing a 45% net reduction in total program costs over 30 months (Nevada County, 2012).

Applied conservatively to the Maine scenario above: one year of AOT at \$20,000 in program costs would have replaced more than \$100,000 in acute hospitalizations in year one alone, representing a net savings to Maine taxpayers of \$80,000 or more in a single year, before accounting for incarceration costs, law enforcement responses, court proceedings, or the compounding costs of subsequent crises that AOT prevents.

## The System-Wide Picture in Maine

The individual calculation becomes even more striking when applied across Maine's system. In 2021, state and local governments in Maine spent \$264,201,000 on corrections, approximately \$192 per resident (Justice Reinvestment Initiative, 2023). Of the roughly 1,600 people booked into Maine's county jails in any given month, approximately 75% require some form of mental health or substance use treatment (Maine Public Radio, 2025). The U.S. Commission on Civil Rights' Maine Advisory Committee (2019) documented that incarcerated persons with mental



illness “cost taxpayers more per day incarcerated than those without mental illnesses” and serve longer sentences.

Maine’s 150 current AOT enrollees represent a tiny fraction of those who qualify. The Treatment Advocacy Center (2019) estimates that approximately 1% of individuals with serious mental illness, the most impaired, most costly, and most treatment-resistant, would benefit from AOT at any given time. In Maine, with an estimated adult serious mental illness population in the tens of thousands (Me. Rev. Stat. tit. 24, §2325-A, 1983), that suggests an eligible population several times the current enrollment. Reaching even a fraction of those individuals with AOT would not just improve their lives. It would measurably reduce corrections costs, emergency department utilization, law enforcement burden, and Medicaid expenditures across the state.

## What the Numbers Say Plainly

Maine is currently spending hundreds of millions of dollars annually to manage, incarcerate, hospitalize, and repeatedly stabilize people whose underlying illness could be treated far more effectively and far more cheaply through court-ordered community treatment. PTP exists precisely for this purpose. Expanding its use is not a budget risk. The status quo is the budget risk. Every year Maine does not expand AOT and ACT capacity, it pays for that choice in emergency rooms, county jails, Riverview admissions, and public defense budgets. The financial case for reform is as clear as the clinical one.

## Recommendations

Six specific changes would bring Maine’s PTP implementation in line with both the law as written and the clinical and fiscal evidence on what works.

1. Expand who can petition for PTP. Amend Me. Rev. Stat. tit. 34-B, §3873-A (1) to give adult family members and other responsible adults with documented knowledge of the individual’s treatment history the right to petition the District Court for PTP. New York’s Kendra’s Law (N.Y. Mental Hyg. Law §9.60, 1999) already does this. Maine’s current restriction to institutional actors excludes the people with the most complete and longitudinal understanding of the patient’s clinical history.
2. Make the forward-looking standard explicit in practice. Issue binding guidance or amend the statute clarifying that the harm standard governing PTP proceedings is the deterioration-based standard under Me. Rev. Stat. tit. 34-B, §3801(4-A) (D), not the present-danger standard under §3801(4-A)(A-C). Require courts and petitioning clinicians to identify in writing which subpart they are applying. Without that documentation requirement, the conflation of standards will continue undetected.
3. Fund ACT team expansion specifically for PTP intake. The eligibility catch-22, “you must already have an ACT team relationship to get into a program designed to compel that relationship,” is a resource problem with a resource solution. Appropriating dedicated

funding for ACT team intake capacity for new PTP referrals would not require a statutory change. It would require a budget decision. At \$15,000 to \$30,000 per person annually for AOT, the return on that investment, measured in avoided hospitalizations, incarcerations, and emergency responses, is substantial and well-documented.

4. Require insight assessment in every PTP application. Amend the statute or implement rules to require documentation of clinical insight assessment using a validated tool such as the Scale to Assess Unawareness of Mental Disorder (SUMD; Amador & David, 1994) as part of every PTP filing. Courts making decisions about a patient's capacity to refuse treatment should have documented clinical evidence about whether that capacity exists.
5. Mandate PTP review at discharge from state psychiatric hospitals. Every discharge from Riverview Psychiatric Center or Dorothea Dix Psychiatric Center for a patient with documented psychosis and a history of treatment noncompliance should trigger a mandatory, documented review of PTP eligibility. The 60% reduction in readmissions associated with post-hospitalization AOT enrollment (Maine DHHS, 2023) makes this the single highest-value intervention in the current system.
6. Engage Disability Rights Maine in building a differentiated framework. The goal is not to diminish DRM's role but to refine it. DRM's advocacy is most valuable when it protects patients who have genuine decision-making capacity from coercion. It is least valuable and potentially harmful when it blocks treatment for patients whose psychosis and anosognosia have neurologically removed the basis for meaningful consent or refusal. Working with DRM to develop clinical criteria that distinguish these two populations would yield a more defensible and just advocacy framework.

## Conclusion

Maine has a law designed to prevent tragedies that continue to occur in communities across the state. That law has a forward looking standard that allows intervention before imminent danger, a court mechanism to mandate treatment, and an ACT delivery model with documented clinical and fiscal outcomes. The problem is not that the law is inadequate. The problem is that the law is not being used.

Three decades of research have established what psychosis does to a person and what anosognosia does on top of that: it removes the neurological capacity to recognize the need for help. You cannot address that with a voluntary treatment system. You cannot address it by waiting for imminent danger. You cannot address it by telling families they have no standing to act. And you cannot address it by framing a symptom treatment refusal produced by neurological incapacity as an exercise of civil liberty.

The cost analysis presented in this paper is not an abstraction. It reflects what Maine taxpayers are already spending to manage the consequences of inaction: \$167,916 in acute



hospitalizations, \$142,500 in state psychiatric inpatient care, \$25,000 or more in incarceration and legal costs, and more than \$330,000 for a single untreated four-year episode, before counting emergency rooms, law enforcement calls, or the human cost to families and communities (McCarthy, 2026a). One year of AOT would have cost \$15,000 to \$30,000. Swanson et al. (2013) found that AOT reduced total system costs by 50-62% in the first year. Maine's own data show a 45% drop in hospitalizations and a 60% reduction in readmissions for those who get AOT after leaving Riverview (Maine DHHS, 2023). The math is not complicated. The will to act on it has been the missing variable.

The DSM has documented anosognosia since 2000. NIMH has confirmed the treatment gap. The research on AOT and ACT is unambiguous. Maine's own data show what works. What remains open is the policy question: how many more people need to commit a felony, and how many more millions in reactive public spending, before Maine uses the tool it already has?

As McCarthy (2026a) stated publicly, "Mental Health Awareness Month should advocate for Maine to move from the right to be sick to the right to be well." Maine has the law. Science has settled the question. The remaining work is political and overdue.



## References

- Acharya, A. B., & Sánchez-Manso, J. C. (2023). Anosognosia. In StatPearls [Internet]. StatPearls Publishing. <https://www.ncbi.nlm.nih.gov/books/NBK513361/>
- Amador, X. F., & David, A. S. (1994). *Insight and psychosis: Awareness of illness in schizophrenia and related disorders*. Oxford University Press.
- American Hospital Directory. (2024). Riverview Psychiatric Center: CMS cost report data. [https://ahd.com/free\\_profile/204008/Riverview\\_Psychiatric\\_Center/Augusta/Maine](https://ahd.com/free_profile/204008/Riverview_Psychiatric_Center/Augusta/Maine)
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders (4th ed.)*. American Psychiatric Publishing.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (5th ed.)*. American Psychiatric Publishing. <https://doi.org/10.1176/appi.books.9780890425596>
- American Psychiatric Association. (n.d.). What is schizophrenia? <https://www.psychiatry.org/patients-families/schizophrenia/what-is-schizophrenia>
- Brown, A. R., Jones, A., Herbert, E. M., Chavez, M. Q., Susman, D. T., Brewer, T. K., & Miller, J. (2025). Evaluating the impact of assisted outpatient treatment on healthcare utilization and Medicaid expenditures in Kentucky. *Journal of Evidence-Based Social Work*. Advance online publication. <https://doi.org/10.1080/26408066.2025.2570933>
- Disability Rights Maine. (2023). *Involuntary hospitalization and outpatient services: A basic guide to laws covering involuntary admission to psychiatric hospitals and to outpatient services*. <https://drme.org/resources/involuntary-hospitalization-outpatient-services-laws-a-basic-guide-to-laws-covering-involuntary-admission-to-psychiatric-hospitals-and-to-outpatient-services>
- Disability Rights Maine. (2025, July 25). Disability Rights Maine condemns executive order taking away civil liberties [Press release]. <https://drme.org/resources/know-your-rights/inpatient-psychiatric-settings/>
- DuPont, N. A., & Field, S. P. (2025). A coordinated AOT model to address behavioral health disparities through social determinants of health: A case study. *Electronic Journal of General Medicine*, 22(6), em704. <https://doi.org/10.29333/ejgm/17440>
- Hagar, [First name unconfirmed — verify before final submission]. (2026). Anosognosia and the criminalization of schizophrenia: Implications for clinical practice. *Psychiatric Times*. <https://www.psychiatrictimes.com/view/anosognosia-and-the-criminalization-of-schizophrenia-implications-for-clinical-practice>
- Johnson, K. L., Parish, W. J., Theis, E., Van Dorn, R. A., Callahan, L., Swanson, J. W., & Swartz, M. S. (2025). Clinical and social functioning outcomes of assisted outpatient treatment: Results from a multisite evaluation. *Psychiatric Research and Clinical Practice*, 7(3), 174–181. <https://doi.org/10.1176/appi.prp.20240162>
- Justice Reinvestment Initiative. (2023). *Maine criminal justice data snapshot*. Council of State Governments Justice Center.



- [https://justicereinvestmentinitiative.org/wp-content/uploads/2024/01/Maine-Criminal-Justice-Data-Snapshot\\_accessible.pdf](https://justicereinvestmentinitiative.org/wp-content/uploads/2024/01/Maine-Criminal-Justice-Data-Snapshot_accessible.pdf)
- Little, J. D., & Bell, E. (2021). Anosognosia and schizophrenia — a reminder. *Australasian Psychiatry*, 29(1), 17–19. <https://doi.org/10.1177/1039856220928866>
- Maine Commission on Public Defense Services. (2025). Assigned counsel rate schedule. <https://www.maine.gov/mpds/>
- Maine Department of Health and Human Services. (2023). Annual report on mental health services and outcomes. <https://www.maine.gov/dhhs/obh/support-services/rights-and-legal-issues/involuntary-admissions>
- Maine General Medical Center. (2024). Chargemaster/published rate schedule. [Retrieved via institutional cost disclosure.]
- Maine Legislature. (2023). Testimony: IMD waiver could increase the use of AOT-PTP in Maine. <https://legislature.maine.gov/legis/bills/getTestimonyDoc.asp?id=174459>
- McCarthy, B. (2026a, May). Maine's mental health system is failing families and taxpayers [Op-ed]. National Shattering Silence Coalition.
- McCarthy, B. (2026b, February 24). The efficacy of assisted outpatient treatment (AOT) and assertive community treatment (ACT) in managing schizoaffective disorder and anosognosia: A detailed narrative and case study. *Frontline Perspectives*. National Shattering Silence Coalition.
- McGrew, J. H., Wilson, R. G., & Bond, G. R. (2006). An exploratory study of what clients like least about assertive community treatment. *Psychiatric Services*, 57(2), 272–277. <https://doi.org/10.1176/appi.ps.57.2.272>
- Me. Rev. Stat. tit. 34-B, §3801. (2009). Definitions. <https://legislature.maine.gov/statutes/34-B/title34-Bsec3801.html>
- Me. Rev. Stat. tit. 34-B, §3863. (2009). Emergency procedure. <https://legislature.maine.gov/statutes/34-b/title34-Bsec3863.html>
- Me. Rev. Stat. tit. 34-B, §3873-A. (2009). Progressive treatment program. <https://legislature.maine.gov/legis/statutes/34-B/title34-Bsec3873-A.html>
- Mental Illness Policy Org. (2019). Estimate of number eligible for AOT by state and projected savings. <https://mentalillnesspolicy.org/national-studies/aotbystatecosts.html>
- Muench, J., Hamer, A. M., & Farquhar, J. (2021). Recent advances in assisted outpatient treatment: Effectiveness and implications. *Journal of Psychiatric Research*, 135, 123–130. <https://doi.org/10.1016/j.jpsychires.2021.01.001>
- National Drug Court Institute. (2021). Drug court costs and cost-effectiveness: A cross-site analysis. National Association of Drug Court Professionals.
- National Institute of Mental Health. (2023). Understanding psychosis (NIH Publication No. 23-MH-8110, revised). U.S. Department of Health and Human Services. <https://www.nimh.nih.gov/health/publications/understanding-psychosis>
- Nevada County, California. (2012). Cost-effectiveness analysis of assisted outpatient treatment implementation in the civil sector.



- <https://www.nevadacountyca.gov/DocumentCenter/View/10773/Cost-Effectiveness-Analysis-of-AOT-Implementation-in-CA-Civil-Sector-PDF>
- N.Y. Mental Hyg. Law §9.60. (1999). Kendra's Law: Assisted outpatient treatment.
- Pompili, M., Lester, D., Innamorati, M., De Pisa, E., Iliceto, P., Puccinno, M., Nastro, G., Tatarelli, R., & Girardi, P. (2021). Suicide prevention in schizophrenia: Do we need a different approach? *Crisis*, 42(2), 149–158. <https://doi.org/10.1027/0227-5910/a000670>
- Swanson, J. W., Swartz, M. S., Elbogen, E. B., Wagner, H. R., Burns, B. J., Borum, R., Hiday, V. A., & McCauley, B. J. (2006). A randomized trial of assisted outpatient treatment for individuals with severe mental illness. *Archives of General Psychiatry*, 63(2), 179–189. <https://doi.org/10.1001/archpsyc.63.2.179>
- Swanson, J. W., Van Dorn, R. A., Swartz, M. S., Smith, A., Elbogen, E. B., & Monahan, J. (2013). The cost of assisted outpatient treatment: Can it save states money? *American Journal of Psychiatry*, 170(12), 1423–1432. <https://doi.org/10.1176/appi.ajp.2013.12091152>
- Swanson, J. W., Easter, M. M., Robertson, A. G., Swartz, M. S., Alanis-Hirsch, K., Moseley, D., Dion, C., & Petrila, J. (2019). The impact of assisted outpatient treatment on mental health outcomes: A systematic review. *American Journal of Psychiatry*, 176(8), 674–682. <https://doi.org/10.1176/appi.ajp.2019.19010094>
- Treatment Advocacy Center. (2019). Estimate of number eligible for AOT by state. [https://www.tac.org/map\\_directory/maine/](https://www.tac.org/map_directory/maine/)
- Treatment Advocacy Center. (2023). Maine severe mental illness resources and helpful information. [https://www.tac.org/map\\_directory/maine/](https://www.tac.org/map_directory/maine/)
- Tsemberis, S., Gulcur, L., & Nakae, M. (2004). Housing first, consumer choice, and harm reduction for homeless individuals with a dual diagnosis. *American Journal of Public Health*, 94(4), 651–656. <https://doi.org/10.2105/AJPH.94.4.651>
- U.S. Commission on Civil Rights, Maine Advisory Committee. (2019). The criminalization of people with mental illnesses in Maine. <https://www.usccr.gov/files/pubs/2019/07-30-Maine-Criminalization-Mental-Health.pdf>
- Maine Public Radio. (2025, December 19). Costs are rising at Maine's county jails. Who will pay the price? <https://www.mainepublic.org/courts-and-crime/2025-12-19/costs-are-rising-at-maines-county-jails-who-will-pay-the-price>