Department of Legislative Services

Maryland General Assembly
2019 Session

FISCAL AND POLICY NOTE
Third Reader - Revised

House Bill 427 (Delegate Barron, *et al.*)
Health and Government Operations Finance

Behavioral Health Administration – Outpatient Civil Commitment Pilot Program – Revisions

This bill requires the Behavioral Health Administration (BHA) within the Maryland Department of Health (MDH) to allow an eligible individual to request enrollment in, and allow an immediate family member of an eligible individual to request voluntary enrollment for the individual in, an existing authorized pilot program for outpatient civil commitment (OCC). BHA must include specified information in its annual report for individuals admitted into the program both voluntarily and involuntarily.

Fiscal Summary

State Effect: The bill's requirements can be handled with existing budgeted resources. Revenues are not affected.

Local Effect: Additional individuals may be enrolled in the pilot program in Baltimore City, but any such impact is likely minimal.

Small Business Effect: None.

Analysis

Current Law: Chapters 576 and 577 of 2017 authorized BHA to establish an OCC pilot program to allow for the release of an individual who is involuntarily admitted for inpatient treatment under the Heath-General Article on condition of the individual's admission into the pilot program. If a pilot was established, BHA was required to (1) adopt criteria for an individual to be admitted into the pilot program; (2) establish application, hearing, and

notice requirements; and (3) specify the rights of an individual who may be or who has been admitted into the pilot program.

A pilot program, limited to Baltimore City residents and funded by federal grants, was established under Maryland regulations (COMAR 10.63.07.03). To be *involuntarily* admitted into the pilot program, an individual must meet specified criteria:

- have a mental disorder;
- be at least 18 years old;
- be a Baltimore City resident;
- have had at least two involuntary inpatient facility admissions within the preceding 12 months, including the most recent admission, before submitting an application for admission;
- have a demonstrated history of refusing community treatment that has been a significant factor in contributing to the current involuntary inpatient admission;
- have a treatment history and behavior that indicates the need for outpatient treatment to prevent deterioration after discharge and is substantially likely to result in the individual becoming a danger to self or others in the community in the foreseeable future;
- have been offered, and refused, the opportunity to accept voluntary outpatient admission into the pilot program on discharge from the inpatient facility;
- be substantially likely to benefit from outpatient treatment;
- not be a danger to self or others if released into the pilot program; and
- be someone for whom treatment in the program is the appropriate least restrictive alternative.

To be *voluntarily* admitted into the pilot program, an individual must (1) meet the criteria for involuntary admission, with the exception that the individual has been offered, and refused, voluntary outpatient admission; (2) participate in a settlement conference with an administrative law judge (ALJ), the legal service provider, and a representative of the inpatient facility; and (3) enter into a settlement agreement whereby the individual agrees to adhere to program recommendations including a treatment plan or support services, or

both, as needed by the individual. An individual's participation in the pilot program does not prevent involuntary admission to a hospital under the Health-General Article.

Under the Health-General Article, an application for involuntary admission of an individual to a facility or Veterans' Administration (VA) hospital may be made by any person who has a legitimate interest in the welfare of the individual.

An application must (1) be in writing; (2) be dated; (3) be on the required form of BHA or the VA hospital; (4) state the relationship of the applicant to the individual for whom admission is sought; (5) be signed by the applicant; (6) be accompanied by the certificates of either one physician and one psychologist or two physicians; and (7) contain any other information that BHA requires. Pursuant to Chapter 330 of 2015, certificates may also be given by one physician and one psychiatric nurse practitioner.

Additionally, within 12 hours of receiving notification from a physician, a licensed psychologist, or a psychiatric nurse practitioner who has certified an individual for involuntary admission, MDH must receive and evaluate the individual for involuntary admission if certain requirements are met, including that the certifying physician, psychologist, or psychiatric nurse practitioner is unable to place the individual in a facility not operated by MDH.

A facility or VA hospital may not admit an individual under involuntary admission unless (1) the individual has a mental disorder; (2) the individual needs inpatient care or treatment; (3) the individual presents a danger to the life or safety of the individual or of others; (4) the individual is unable or unwilling to be admitted voluntarily; and (5) there is no available, less restrictive form of intervention that is consistent with the welfare and safety of the individual.

Specified health professionals and other interested parties may petition for an emergency evaluation of an individual, which may result in the involuntary admission of the individual to a mental disorder treatment facility, if the petitioner has reason to believe that the individual (1) has a mental disorder and (2) presents a danger to the life or safety of the individual or of others. Petitions for an emergency evaluation must contain specified additional information. If an emergency evaluee meets the requirements for an involuntary admission and is unable or unwilling to agree to a voluntary admission, the examining physician must take the steps needed for involuntary admission of the emergency evaluee to an appropriate facility, which may be a general hospital with a licensed inpatient psychiatric unit. If the examining physician is unable to have the emergency evaluee admitted to a facility, the physician must notify MDH, which must provide for the admission of an emergency evaluee to an appropriate facility within six hours of receiving notification.

Within 12 hours after initial confinement to a facility, the facility must provide the individual with a form (provided by BHA) that explains the individual's rights, including the right to consult with a lawyer. An individual who is proposed for involuntary admission must be afforded a hearing to determine whether the individual should be involuntarily admitted or released, which must be conducted within 10 days of initial confinement.

Background:

Outpatient Civil Commitment – Generally

OCC involves providing court-ordered community-based services, including medication, to adults with severe mental illness who are nonadherent to treatment. It is, in essence, the community treatment version of traditional inpatient commitment. According to the Treatment Advocacy Center, almost all states have statutory authority for some form of OCC. However, many states that allow OCC have not implemented it because it is perceived as too costly.

New York authorizes a form of OCC, termed "assisted outpatient treatment" (AOT), for persons with serious mental illness deemed at risk of failing to live safely in the community and unlikely to participate in voluntary services. In authorizing AOT, New York significantly increased funding to support AOT and expand outpatient services. Studies have found that New York's AOT program has resulted in overall cost savings; greater engagement in outpatient services; and a reduction in hospitalization rates, use of psychiatric emergency and crisis services, clinician visits, and criminal justice involvement.

Proponents of OCC contend that, for individuals who refuse treatment, the practice can, among other benefits, increase treatment exposure and medication adherence, reduce acts of violence, lead to less inpatient confinement and incarceration, and improve quality of life. However, opponents of OCC contend that the practice is overly coercive, anti-therapeutic, disempowering, and stigmatizing; violates civil rights; and has been implemented in a racially discriminatory manner. Critics assert, moreover, that OCC fails to address the challenge of underfunded systems of care and inadequate services.

Outpatient Civil Commitment Pilot Program – Workgroup

In April 2016, MDH formed a workgroup, consisting of members of MDH, BHA, the Office of Attorney General, the Mental Health Association of Maryland, Behavioral Health System Baltimore (BHSB), Disability Rights Maryland, and the National Alliance on Mental Illness, to apply for a federal AOT grant. The application process required the workgroup to identify the purpose, site, and objectives of its proposed outpatient treatment program. Grant applicants were required to operate in jurisdictions that have in place an

existing, sufficient array of services for people with serious mental illness, such as Assertive Community Treatment, mobile crisis teams, supportive housing, supported employment, peer supports, case management, outpatient psychotherapy services, medication management, and trauma-informed care.

The workgroup determined that Baltimore City met these jurisdictional grant requirements and would be the site of the OCC pilot program. The workgroup concluded that implementation of the OCC pilot program would help to address critical gaps in Baltimore City's Public Behavioral Health System, such as repeat hospitalizations, inconsistent assertive outreach, provider accountability, and services for individuals with serious mental illness within Maryland's legal system.

Outpatient Civil Commitment Pilot Program – In Practice

The OCC pilot program started in October 2017. Despite a funding setback in 2018, the program was restarted in October 2018. According to MDH, the pilot program has received 16 referrals and enrolled 9 participants (6 voluntarily and 3 involuntarily). Eight of the participants are connected to behavioral health services.

The goals of the pilot program include (1) reducing inpatient hospitalizations; (2) increasing connections to outpatient behavioral health services; (3) realizing cost savings to the public behavioral health system; and (4) improving program participants' health outcomes and quality of life. The pilot program allows individuals to participate voluntarily, but participants may also be ordered into the program involuntarily.

Both voluntary and involuntary admission begins with a referral from an inpatient psychiatric facility to BHSB. Within three business days, BHSB confirms eligibility and sends an approved referral to Bon Secours. Upon receipt of the referral, a peer recovery specialist from Bon Secours begins engagement and treatment planning in preparation for a hearing (involuntary admission) or settlement agreement conference (voluntary admission) before an ALJ at the Office of Administrative Hearings (OAH). At either a hearing or a settlement agreement conference, a patient is entitled to have representation.

Participation in the program lasts for six months, during which time the program provides intensive peer support and outreach to assist individuals to connect with care in the community. Current program funding comes from a federal grant. Current (partial year) funding for fiscal 2019 totals $371,120, which supports (1) two full-time peer specialists and one part-time clinical supervisor; (2) client support funds; (3) a consumer quality team; (4) attorney representation for patients; and (5) one OCC monitor to oversee individuals' engagement in services.

Additional Information

Prior Introductions: None.

Cross File: SB 403 (Senator Augustine, *et al.*) - Finance.

Information Source(s): Maryland Association of County Health Officers; Judiciary (Administrative Office of the Courts); Office of the Public Defender; Maryland Department of Health; Office of Administrative Hearings; Mental Health Association of Maryland; Substance Abuse and Mental Health Services Administration; Treatment Advocacy Centers; Department of Legislative Services

Fiscal Note History: First Reader - February 18, 2019
mm/jc Third Reader - March 25, 2019
Revised - Amendment(s) - March 25, 2019

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