March 7, 2022

House Bill 1017 – Frederick County – Mental Health Law – Assisted Outpatient Treatment Pilot Program – SUPPORT

Chair Pendergrass, Vice Chair Pena-Melnyk, and members of the House Health and Government Operations Committee,

The National Alliance on Mental Illness, Maryland and our 11 local affiliates across the state represent a statewide network of more than 45,000 families, individuals, community-based organizations and service providers. NAMI Maryland provides education, support and advocacy for persons with mental illnesses, their families and the wider community.

House Bill 1017 would create an Assisted Outpatient Treatment pilot program in Frederick County, Maryland. Maryland is one of a handful of states without this law that helps individuals access health care when they need it the most.

Assisted outpatient treatment (AOT) is a practice used in most states where civil court orders mandate participation in treatment for people with serious mental illness (SMI). AOT was established to ensure that people who are experiencing severe negative consequences from serious mental illness participate in treatment. Throughout the years, AOT has evolved to include community-based treatment models that ideally encourage individuals to be actively involved in decisions regarding their treatment plan. This includes peer-informed care, involvement of family members, and coordination between courts and mental health providers.

Civil court-ordered treatment, or AOT, should be a last resort, considered only after efforts to engage people voluntarily in treatment have been tried and have not succeeded. Inpatient treatment must be an option for individuals – including court ordered treatment when an individual:

- presents a danger to the individual or another; or
- is gravely disabled, which means that the person is substantially unable to provide for basic needs, such as food, clothing, shelter, health, or safety; or
- is likely to substantially deteriorate if not provided with timely treatment; or
- lacks capacity, which means that, because of the serious mental illness, the person is unable to fully understand or lacks judgment to make an informed decision about his or her need for treatment, care, or supervision.

Studies have shown that assisted outpatient treatment may be a less restrictive and less costly treatment alternative to involuntary inpatient treatment and/or involvement with the criminal justice system.

NAMI believes that AOT works when it is done right. Although opponents of AOT claim that it doesn't work, the research that has been done in states that have implemented it

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carefully such as New York show that it does work, both in improving outcomes and in reducing costly and harmful consequences of lack of treatment, including hospitalizations, homelessness, and arrests. And, the data also shows that while there may be an initial increase in costs when implemented, AOT does not result in long term increases in costs because of the reductions in hospitalizations and other costly outcomes – like imprisonment.

A system of comprehensive, enhanced services and supports must be available for recipients of AOT. This is the key to successful implementation and the fact is that recipients of AOT need Assertive Community Treatment, supported housing, mental health and substance use treatment, and other services. Despite a fragmented system of care in Maryland, NAMI is hopeful Frederick County is prepared to invest in the variety of community supports to show that AOT works.

Although AOT is frequently characterized as "coercive," it is not forced treatment. There are no states which authorize AOT recipients to be automatically administered medications involuntarily and that is not a condition of this program that NAMI Maryland would support. States must still meet separate legal criteria for medications over objection set forth in state laws. AOT not forced care, it is not coercive. It is a system for engaging people in services and for committing the mental health system to serve those most in need.

In states such as New York (where most of the research has occurred), AOT has not been shown to displace others from needed services over time. In fact, because AOT can stimulate the development of more comprehensive systems of care, others (not subject to AOT but needing comparable levels of services) stand to benefit from increased service, program, and provider availability as well.

Any AOT program in Maryland should be implemented with the goal of helping people take more active roles in their own care. AOT programs should include peer supports, shared decision making, and other methods to engage people to participate actively in decisions about their own care.

AOT is not a substitute for a good system of community based mental health services. It should be used judiciously and for those people who meet legal criteria like repeated hospitalizations or arrests, a history of non-participation in voluntary care, strong due process, and more. Even in states that actively use AOT such as NY and NC, relatively small numbers of people are under AOT orders. AOT is a tool Maryland needs and this proposed pilot program is a step in the right direction.

For these reasons, NAMI Maryland asks for a favorable report on **HB 1017.**

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