Disability Rights Maryland

Empowerment. Integration. Equality.

1500 Union Ave., Suite 2000, Baltimore, MD 21211
Phone: 410-727-6352 | Fax: 410-727-6389
www.DisabilityRightsMD.org

**SENATE FINANCE COMMITTEE**

**Senate Bill 988: Maryland Medical Assistance Program – Self-Directed Mental Health Services Pilot Program**

**March 8, 2024**

**Position: Support**

Disability Rights Maryland (DRM) is the protection and advocacy organization for the state of Maryland; the mission of the organization, part of a national network of similar agencies, is to advocate for the legal rights of people with disabilities throughout the state. In the context of mental health disabilities, DRM advocates for access to person-centered, culturally responsive, trauma-informed care in the most integrated setting available. DRM appreciates the opportunity to provide testimony in support of SB 988, which would create a self-directed mental health care pilot program and facilitate access to services for individuals with disabilities whose needs are not met in existing mental health program models. DRM supports SB 988 because research demonstrates that self-directed care is effective at promoting community integration and reducing unnecessary institutionalization. Most importantly, self-directed care is generally preferred by people with disabilities.

Maryland's existing mental health system has a mismatch in resources, which results in appropriate community support being unavailable to those that most need it. Many people with mental health disabilities have complex needs requiring specialized clinical care that is too often unavailable in the public behavioral health system. Yet, the intensive, ongoing case management, and non-clinical supports many individuals need to successfully engage in clinical mental health services are typically limited to service packages that require individuals to receive all their care from one provider, even if that provider is unable to adequately meet the individual's clinical mental health or social support needs. This forces many individuals with the highest support needs to choose between surviving with inadequate support; enrolling in more intensive, but less clinically appropriate programs; or receiving no care at all.

For example, one of DRM's elderly, multiply-disabled clients needs services that can be delivered to her in her home, assistance with paying for her medications, and assistance with transportation, along with psychotherapy for a complex trauma disorder. In order for her to get her psychiatry and social support needs met, she has to enroll in mobile treatment services, but this program does not offer the specialized therapy she needs to treat her complex trauma disorder. Consequently, she is forced to choose between essential needs, which has left her without appropriate clinical support, while also forced to satisfy other program requirements that are not relevant to her needs, leading to constant frustration and inadequate care that impedes her recovery. DRM also represents a client who needs assistance with activities of daily living along with clinical care that can support her in managing symptoms of multiple co-occurring mental health diagnoses. Because she cannot get her daily living needs met in any existing program, she has been unable to engage in services, causing her to get terminated

from every program in her county. Thus, she is left without any mental health services, causing her to rely on 911 for basic needs. The services currently available in the public behavioral health system create an impossible situation for many people with complex mental health needs who are inevitably left without access to appropriate services and support when they have to balance competing essential needs in order to fit themselves into existing programs with rigid requirements. This causes far too many individuals with complex support needs to unnecessarily cycle in and out of hospitals or be terminated from community programs.

Self-directed mental health care addresses this problem by granting program participants flexibility to design a recovery plan that works with their needs, rather than trying to make individuals adapt to our existing system. Participants enrolled in self-directed mental health care work with a support planner to develop an "individualized recovery plan" and then utilize an allocation of state funds known as an "individual budget" to achieve their recovery goals. By planning and funding services based on impacted individuals' needs, participants can access a diverse array of supports, including private therapists that may better meet unique cultural or clinical needs, housing support, educational opportunities, and technology to enhance communication access.[1] This individualized approach supports service users in identifying the services and supports that are best suited to their unique mental health, somatic, and social needs[2] and better matches individuals who have the greatest needs with the highest quality, most clinically appropriate support. Notably, self-directed care does' not necessarily create new services, but rather, changes how we deliver and coordinate services; studies generally find the self-directed care model is budget neutral.[3] However, the flexibility, creativity, and individualized care planning offered in self-directed care programs has allowed many individuals who were previously institutionalized to thrive in their communities.

Self-directed mental health care has already been successfully implemented in 6 states: New York, Michigan, Pennsylvania, Florida, Texas, and Utah.[4] Two decades of experience consistently demonstrates positive results when self-directed mental health care is compared to traditional mental health care models. In fact, recent research illustrates the efficacy of self-directed mental health care finding that self-directed care participants experienced reduced hospitalizations, enhanced employment and educational outcomes, greater housing stability, and reductions in the impact of psychiatric symptoms relative to individuals using traditional mental health services.[5] Self-directed mental health care is not just more effective, but is

---

[1] NAT'L RESOURCE CTR. FOR PARTICIPANT-DIRECTED SERVS., SELF-DIRECTION IN MENTAL HEALTH 9-10 (2019).

[2] *Id*. at 2–4 (2019); CTR. ON INTEGRATED HEALTHCARE & SELF-DIRECTED RECOVERY, UNIV. ILL. CHICAGO, SELF-DIRECTED CARE IMPLEMENTATION GUIDE (2017).

[3] Judith A. Cook, Ph.D. et al, *Mental Health Self-Directed Care Financing: Efficacy in Improving Outcomes and Controlling Costs for Adults with Serious Mental Illness*, 74 PSYCHIATRIC SERVS. 191-201 (Mar. 2019).

[4] NAT'L RESOURCE CTR. FOR PARTICIPANT-DIRECTED SERVS., SELF-DIRECTION IN MENTAL HEALTH 3 (2019).

[5] Judith A. Cook, Ph.D. et al, *Randomized Controlled Trial of Self-Directed Care for Medically Uninsured Adults With Serious Mental Illness*, 74 PSYCHIATRIC SERVS. 1027, 1032–34 (Oct. 2023); Judith A. Cook, Ph.D. et al, *Mental Health Self-Directed Care Financing: Efficacy in Improving Outcomes and Controlling Costs for Adults with Serious Mental Illness*, 74 PSYCHIATRIC SERVS. 199, 191-201 (Mar. 2019); Bevin Croft, et al., Housing and Employment Outcomes for Mental Health Self-Directions Participants 69 PSYCHIATRIC SERVS (May 2018); CTR. ON INTEGRATED HEALTHCARE & SELF-DIRECTED RECOVERY, UNIV. ILL. CHICAGO, SELF-DIRECTED CARE IMPLEMENTATION GUIDE 12 (2017).

preferred by program participants who reported greater perceived autonomy, increased competence in managing their care and improved satisfaction with services, which leads to greater opportunities for wellness.[6] When people with mental health disabilities are given the option to choose services and goods that honor and support their stated needs, they are more likely to voluntarily engage and remain engaged in those services over the long term.

Importantly, Maryland already offers the self-directed care model to individuals with other types of "severe chronic disability[ies]." However, the existing self-directed services statute explicitly excludes people with a "sole diagnosis of mental illness."[7] This exclusion is based on inequities in the funding of behavioral health services and stereotypes that people with mental health disabilities are incapable of knowing their own needs; ideas that have contributed to long-term under-investment in high-quality, innovative, person-centered community mental health services for those who most need them. However, in 2024, we know such ideas are both discriminatory and inaccurate, so we must take steps to address this disparate treatment of mental health disabilities by ensuring self-directed care is available to all who could benefit. SB 988 takes an essential step to get us closer to that goal by creating a self-directed mental health care pilot program that tailors services to the needs of individuals with mental health disabilities.

DRM requests a favorable report on SB 988 because self-directed mental health care is crucial to creating an innovative, equitable, and integrated behavioral health system that meets the needs of all Marylanders with mental health disabilities.

Please contact Courtney Bergan, Disability Rights Maryland's Equal Justice Works Fellow for more information at CourtneyB@DisabilityRightsMd.org or 443-692-2477.

[6] Judith A. Cook, Ph.D. et al, *Randomized Controlled Trial of Self-Directed Care for Medically Uninsured Adults With Serious Mental Illness*, 74 PSYCHIATRIC SERVS. 1027, 1032–34 (Oct. 2023) (finding that participants in self-directed services reported greater perceived autonomy and competence in managing their care, enhanced employment outcomes, and a reduction in the impact of psychiatric symptoms relative to individuals using traditional mental health services).

[7] Md. Code Ann., Health-Gen § 7-403 (c).