Department of Legislative Services

Maryland General Assembly
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FISCAL AND POLICY NOTE
Revised

Senate Bill 882 (Senators Pugh and Kelley)
Finance Health and Government Operations

Department of Health and Mental Hygiene - Outpatient Services Programs Stakeholder Workgroup

This bill requires the Secretary of Health and Mental Hygiene to convene a stakeholder workgroup to examine the development and implementation of assisted outpatient treatment (AOT) programs, assertive community treatment (ACT) programs, and other outpatient service programs in the State; develop a proposal for a program in the State; and evaluate the dangerousness standard for involuntary admissions and emergency evaluations. By November 1, 2014, the Secretary must submit a report to specified committees of the General Assembly.

The bill takes effect July 1, 2014, and terminates June 30, 2015.

Fiscal Summary

State Effect: The Department of Health and Mental Hygiene (DHMH) can likely handle the additional workload and reporting requirements associated with the workgroup with existing resources. Revenues are not affected.

Local Effect: None.

Small Business Effect: None.

Analysis

Bill Summary: The workgroup must develop a proposal for a program that (1) best serves individuals with mental illness who are at high risk for disruptions in the continuity of care; (2) respects the civil liberties of individuals to be served; (3) addresses

the potential for racial bias and health disparities in program implementation; (4) is based on evidence of the effectiveness of AOT programs, ACT programs, and other outpatient services programs with targeted outreach, engagement, and services in other jurisdictions; (5) includes a data-monitoring strategy; (6) promotes parity between public and private insurers; (7) addresses the potential for variance in program implementation among urban and rural jurisdictions; and (8) assesses the cost of the program to DHMH and other State agencies, including the feasibility of securing federal funding for services provided by the program.

The workgroup must also evaluate the dangerousness standard for involuntary admissions and emergency evaluations of individuals with mental disorders. The evaluation must include how the standard should be clarified in statute or regulations, and initiatives the department should adopt and implement to promote the appropriate and consistent application of the standard.

DHMH must recommend draft legislation as necessary to implement the program included in the proposal.

Current Law/Background: DHMH already provides ACT services throughout Maryland, but on a limited basis. As currently undertaken, ACT serves more than 2,100 individuals with a total of 19 teams located in Anne Arundel, Baltimore (two), Carroll, Frederick, Harford, Howard, Montgomery (two), Prince George's, and Washington counties; Baltimore City (six); and the Lower-Shore and Mid-Shore areas. DHMH oversees health care providers who are part of the ACT teams and ensures these providers comply with DHMH and federal standards for ACT programs.

ACT teams have access to on-site evidence-based practice (EBP) center trainers and consultants for DHMH-sponsored training and ongoing technical assistance for EBP supported employment, EBP family psychoeducation, and person-centered care. Providers receive training and must meet various program guidelines as determined by DHMH. DHMH then preapproves providers who evaluate and provide services to ACT program clients.

Additionally, Maryland's Public Mental Health System has a multilevel Crisis Response System in place to help Marylanders with mental illness by addressing mental health emergencies and assuring individuals with mental illness receive an appropriate level of treatment. According to its website, key elements of the Crisis Response System include call centers to screen and evaluate psychiatric emergencies; mobile crisis teams that provide triage and referral to additional levels of care as necessary; residential crisis services and crisis beds which provide a less restrictive environment for care to ameliorate a psychiatric crisis and prevent an inpatient hospitalization; urgent care;

community-based alternatives for individuals with co-occurring illnesses; transportation to care; and disaster response, which is linked to county emergency response systems.

At the direction of Governor O'Malley, DHMH convened the seven-member Continuity of Care Advisory Panel, which published a report in January 2014 that offers recommendations to improve continuity of care for individuals with serious mental illness. The report addresses AOT and recommends that the Secretary of Health and Mental Hygiene convene a workgroup to further examine the implementation of an AOT program in Maryland. The report states that the workgroup should address specific concerns in the development of a proposal for an AOT program. The bill requires the proposal to address all of the report's specified concerns regarding AOT.

AOT is also known as outpatient civil commitment (OCC) and 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, 45 states permit OCC. Many states that allow OCC have not, however, implemented it because it is perceived as being too costly. Much of the discussion has revolved around Kendra's Law in New York, which authorized a form of OCC – termed "Assisted Outpatient Treatment" – for persons with serious mental illness who were deemed at risk of failing to live safely in the community and unlikely to participate in voluntary services. An initial court order may have a maximum duration of one year and specify treatment that includes an array of intensive services. Failure to comply with treatment may result in involuntary inpatient hospitalization. In authorizing AOT, New York significantly increased funding to support the program and expand outpatient services for all consumers.

While there is debate about the strength of the evidence, studies have found that New York's AOT program has resulted in overall cost savings; greater engagement in outpatient services; and declines in hospitalization rates, the 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, among other things, can increase treatment exposure and medication adherence, reduce acts of violence, lead to less inpatient confinement and incarceration, and improve quality of life. Opponents of OCC contend, however, that the practice, among other things, is overly coercive, anti-therapeutic, disempowering, stigmatizing, violative of civil rights, and implemented in a racially discriminatory manner. Critics assert, moreover, that OCC fails to address the challenge of underfunded systems of care and inadequate services.

Additional Information

Prior Introductions: None.

Cross File: HB 1267 (Delegate Hubbard, *et al.*) - Health and Government Operations.

Information Source(s): Montgomery and Prince George's counties, Baltimore City, Department of Health and Mental Hygiene, Department of Public Safety and Correctional Services, Maryland Association of County Health Officers, Department of Legislative Services

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