Testimony for SB0807 - Dire Need for AOT in Maryla

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Position: FAV

Testimony for SB0807

March 9, 2022, 1:00 pm, Finance Committee

Topic: Dire Need for AOT in Maryland

From: Cornelius Kuteesa, MA

Position: Senior Care Coordinator | Care Coordinator Mentor, Help In the Home. LLC

My name is Cornelius Kuteesa. I am a Senior Care Coordinator and Mentor with Help In the Home LLC. I am here today to bring to light the dire need for Maryland to pass legislation authorizing an evidence based, statewide, Assisted Outpatient Treatment (AOT) program, also known as Outpatient Civil Commitment (OCC). I have been a Care Coordinator at Help in the Home, LLC in Rockville for about 5years. Help in the Home specializes in supporting individuals with severe and persistent mental illness. We have a supported living community of five townhouses in Rockville and Individual Support Services for those who live independently in the D.C. metro area. We believe in client focused, team guided care and thrive in a culture that treats all clients as our own family with dignity and respect, so they can live the healthiest fullest lives possible.

AOT is the practice of placing an individual with severe mental illness under court order to adhere to outpatient treatment to maintain the individuals' health and safety. It is a tool appropriate for a small subset of high risk, very ill individuals who lack the capacity to recognize their illness, causing them to refuse and avoid voluntary treatment options.

Maryland is one of only three states that does not have a statewide statute authorizing involuntary treatment in the community or AOT. It is important that AOT not be restricted to those with involuntary hospital commitments but be available to help those with multiple voluntary hospitalizations, incarcerations, with a history of violence or those in the community who are unable to care for themselves. In order to explain this need I am going to give you information about some of our client stories followed by hard facts to support this need.

Our client, we will call him Jon, is a 64-year-old African American male who is diagnosed with Schizophrenia and has a long history of repeated hospitalization and release. From 2014-2017 Jon was emergency petitioned 12 times with one arrest and has been kicked out of 3 different apartments for property damage and disturbance of others due to his behavior. Each time he was discharged to a rehab or a crisis center for anywhere from 3 days to 2 weeks. In 2017 with no other choice he ended up at the men's shelter in Rockville. In a span of 2 months, he was emergency petitioned from the shelter 4 times. Out of the 4 times I was only able to convince a social worker to keep him for an extra couple days one time. She released him to a crisis program where he walked out and disappeared on the first day. Later

that year, Jon was kicked out of the homeless shelter because he threw a knife at a person. Thankfully it missed and embedded in the wall behind his human target. He was in an acute care hospital for little more than 7 days and was then released. It is only by chance that Jon has not harmed anyone yet. Jon continues on this vicious cycle with no government interference. If Maryland had an AOT plan in place this client would not be stuck in this cycle living a marginal life defined by instability, fear, and now poverty. In our current world violence is increasing at an alarming rate, so why do we have to wait for these individuals to add to the violence? Why should this man have to harm himself or another before the state will even consider intervening?

If I had more time I could go into detail about three other clients who also live in this vicious cycle but due to time I will just mention them briefly. We have a 30 yr old female client who stopped taking medications earlier this year. Prior to this, she was in school working and living a stable life under our care. Since then, she has been on her own randomly popping up in different states and hospitals. Her parents check in with us for help, but they are forced to live in a life of fear not knowing if she is safe, and hoping that her illness and actions won't lead to her death. On the same weekend I wrote this testimony we had a 21 yr old and a 30 yr old from our community emergency petitioned due to medication refusal and lack of safety. I was called on Saturday afternoon to go check on them. One was admitted and will be released next week and the other was released the same day. So, this cycle will continue, they will get "stabilized" and released with nothing but a promise to not go off meds or run off into the freezing cold. How is this fair or right when these individuals cannot process the severity of their illness or reality?

Besides the human tragedy, another consideration is the high cost of the current system to our county and state. Because of their unique treatment patterns, individuals typically have a history of utilizing high-cost resources, often in multiple systems. A substantial body of independent research has found that AOT reduces the incidence of psychiatric emergency/crisis services, inpatient psychiatric utilization, criminal justice involvement, and reduces costs for at-risk adults with severe mental illness(reference). Potential savings include reduced costs for providing health services – that is, direct costs – and indirect costs for non-health services that may be changed by the implementation of AOT. These costs include but are not limited to, inpatient outpatient psychiatric services, hospitalizations, pharmaceuticals, administrative costs at civil courts, shelter costs, and criminal justice costs. In one county in California, they saw a 45%

savings after implementation saving them $503,621. If it was implemented in all other counties the estimated savings would be $189,491, 479. A county in Florida saw a 42% reduction in hospital days, and a 72% reduction of incarceration days. This resulted in $303, 728 less spent on hospitalization prior to the court order. At $59 a day for incarceration they saw a saving of $14, 455(reference).

Given all these facts I am coming to you with extreme urgency to protect our mentally ill members of our community. They deserve to live a fulfilling life of stability, dignity, respect and happiness but they need the help and tools in order to do this. I fear that if an evidence based AOT plan is not implemented then the next time I share this story Jon and others will be dead.

SB807_DebraBennett_Fav.pdf
Uploaded by: Debra Bennett
Position: FAV

Testimony for SB807
March 8, 2022, 1:00 pm. Senate Finance Committee
From: Debra Bennett, 1217 Adeline Way, Capitol Heights, MD 20743
Position: FAVORABLE

Assisted Outpatient Treatment Program Can Help My Son Rebuild His Life with Dignity

My 33-year old son is diagnosed with schizoaffective disorder, bipolar type mania with psychotic features. At the age of 20, he started exhibiting symptoms of a mental illness while in his third year of college. He also has a severe, bilateral hearing loss since childhood. Despite having two chronic conditions, prior to COVID-19, he worked part-time, owned a car, and had his own apartment for almost two years in Frederick County, Maryland. Since he started refusing medication in 2020, he has had 11 hospitalizations—two in 2020, eight in 2021 and one in 2022. All were emergency petitions that required judicial, police, and mobile crisis involvement and emergency room (ER) admissions. In other words, they were traumatizing. And then there is the cost involved. One recent hospitalization for 36 days cost $47,000. He is a high inpatient user and his medical costs are now close to $200,000! February 7, 2022 he was readmitted to the hospital and went to the crisis residential program on February 22 where he is stabilizing while a permanent housing option is being sought. Because every hospitalization started with police and emergency rooms, my son has suffered terribly, is severely traumatized and is still homeless. This could have been avoided and tens of thousands in taxpayers dollars saved -- if Maryland had an Assisted Outpatient Treatment (AOT) Pilot Program.

Like many others with a psychotic illness, my son is caught in the cycle of repeat ER and hospital stays and homelessness.

After each hospitalization, he gradually stopped taking medications. This is very common among patients. Additionally, taking and keeping track of medications while homeless was almost impossible for him and his symptoms of paranoia, delusions, and psychosis greatly increased and affected his thinking, moods and behaviors. Because of his behaviors related to increased symptoms, he was issued stay away orders, trespassing notices, banned from staying in the local crisis, residential, and transitional housing programs, and even shelters and hotels. He had to seek crisis and shelter services outside of Frederick in other Maryland counties. He is unable to lease another apartment using his housing voucher. He waited for four years on a waitlist to obtain the voucher that is now in jeopardy of being revoked. His inconsistent engagement with outpatient treatment and his diminished awareness for the need for treatment, caused by the illness itself, creates the repeated cycle that has been very costly to him. He needs a program that allows time for lasting stabilization on medication, treatment, and adherence monitoring. AOT is that program. It provides court-ordered treatment, following the individual's progress and assisting in preventing deterioration. It ensures adherence or the patient can be re-hospitalized.

Unfortunately, his recurring situation is wearing heavily on me. I had to personally file the majority of the emergency petitions because of Maryland's danger standard definition. This has strained our relationship. When a family member has to file, it causes damage to the very support system our loved ones need to recover. I want my son well, healthy and our relationship restored. I want him to have a chance at a meaningful life.

Please support SB807. An AOT Pilot Program will provide an appropriate outpatient recovery program that my son must adhere to and afford him the opportunity to rebuild his life with dignity. It not only takes medication, it takes time with medication. AOT offers that lengthier time period to aid in recovery. For patients like my son, AOT is a lifesaver. My son deserves a chance at better health. Thank you.

SB0807_EricSmith_fav.pdf
Uploaded by: Eric Smith
Position: FAV

Testimony for SB0807
March 8, 2022, 1:00pm, Senate Finance Committee
From: Eric Smith, San Antonio, Texas
Position: FAVORABLE

Thank you for affording me an opportunity to be here today, and thank you for representing the wonderful people of Maryland. My name is Eric Smith, and an assisted outpatient treatment (AOT) program in Texas saved my life from being consumed by my diagnoses of bipolar disorder and schizoaffective disorder.

People languishing in the abyss of SMI need all the help we can get, but not everyone advocating on behalf of those diagnosed with SMI understand the needs of this population to which I belong. I support disability rights, civil rights, and other related advocacy groups. They help ensure people like me are not taken advantage of, neglected, or abused. That said, some people from these groups speak against AOT, and that is not a protection of my rights and liberties. It is advocating for me to remain tortured in the absence of life-saving care afforded to me by AOT, because AOT is the only proven method to help people like me who are not helped by voluntary services. Moreover, forced medication and forced treatment do not exist in AOT as I experienced it, nor were my rights violated by AOT. I have experienced forced meds and forced treatment in a hospital, but that can be true for any psych patient regardless of whether AOT exists or not. To be clear, AOT is not a factor as to whether a person meets criteria for forced meds or forced treatment in a hospital.

Looking back, I now realize how ill-equipped I was to make important decisions for myself in my pre-hospitalization and pre-AOT years. I once sat awake for three nights in-a-row surfing the internet for clues about threats against world leaders before showing up uninvited at my local FBI office, where I delivered a psychotic rant to several visibly concerned FBI agents. After my rant, one of the agents asked me if I had been prescribed psychiatric medication. I had a bottle of medication in my pocket that I took out and slammed down on his desk. He told me I needed better treatment from mental health professionals.

He was and is right, because a person who stays awake for several days using a hotel's business center to decipher a code that does not exist followed by a meeting with the FBI to discuss non-credible threats is a person in need of treatment and care. At that time, since I refused to drink water because I believed it was poison, and I only ate butter because voices in my head told me that was the one safe food to eat, I was posing a serious danger to myself that necessitated inpatient psychiatric hospitalization followed by AOT.

When living in the false reality of SMI's unforgiving landscape constructed by the usual suspects of symptoms mentioned above, freedom and choice do not exist until SMI is successfully treated. AOT is one of the best ways to accomplish this, and does so by way of civil (non-criminal) court proceedings, recognizing mental illness is not a crime. The civil court order and involvement of a judge added a layer of accountability for me and the AOT treatment team that made all the difference when compared to my earlier years. Involvement of a judge helped change everything for the better, because the judge held the treatment team accountable and ensured there would be no lapses in care for me. In the absence of the judge, there would have been lapses in my treatment on multiple occasions due to human error beyond my control, and the judge was able to get me the medication I needed after business hours when I would not have been able to otherwise get those meds.

I entered into AOT during a critical period of treatment that is not unique to me: A time when I was stable enough to no longer meet criteria to remain as a psychiatric inpatient, but not yet able to fully comprehend the need to remain engaged with treatment as a means to prevent me from being a danger to myself.

When I received AOT, I was regularly involved in decisions about my treatment and care with thanks to my AOT treatment team. Any argument that claims AOT participants are not involved in choices about their own treatment and care is categorically false. In fact, AOT is the first time I ever experienced my rights since I was free from psychosis, contrary to what people say about AOT violating rights. I see this in hindsight, and am able

to do so because AOT allowed me to gain sanity and perspective after many years of voluntary treatment not helping me do anything except cycle through psychosis and needlessly suffer.

Prior to AOT I did not understand I was suffering from SMI because of anosognosia, a condition experienced by people like me with SMI that prevents a person from understanding we are ill and need assistance similarly to how someone with advanced Alzheimer's and dementia cannot understand they are ill and need assistance due to changes in the brain.

More than a decade of voluntary treatment options had failed to provide me relief prior to AOT, and as you might guess, that contributed to me losing what little faith I had left in the voluntary avenues of counseling and psychiatry. That, combined with anosognosia, had some lasting effects when I exited the psych hospital and first entered into AOT. To that point, without AOT as step-down care from my psychiatric hospitalization, I would have stopped taking the medication I need to no longer be a danger to myself. I am basing that claim on my history and relationship with treatment (over many years) up to the point of first entering into AOT.

When I was not psychotic, my AOT treatment team valued my feedback, and when I was psychotic, my feedback was viewed as an illness in need of life-saving medical treatment -- which is exactly how it should be.

AOT took me from a path of delusion and danger to graduating *magna cum laude*, with a BA in psychology, followed by earning my master's degree with a 4.0 GPA

I reflect on my life like this: I was diagnosed with SMI...abused drugs...dropped out of high school...was incarcerated due to my SMI...and committed as a psych inpatient...then AOT enters my life.

Without AOT, the trajectory I was on was a downward spiral that could have easily ended my life, and if not that, certainly would have prevented me from finding health, happiness, and personal success.

Your support for AOT would not mean you are turning your back on other treatment options, nor would it mean you support violating the rights of others. Support for AOT is a recognition that a population of people exists (including me) who are best served by AOT, and are failed in the absence of it.

Thank you for your consideration, and I'll be glad to answer any questions you may have.

SB807_S&PAA-EvelynBurton_FAV.pdf
Uploaded by: Evelyn Burton
Position: FAV

Schizophrenia & Psychosis Action Alliance

Promoting support, research, treatment, and public policies that improve and save lives

Testimony on SB807, Senate Finance Committee
March 8, 2022
Position: Favorable

The Schizophrenia & Psychosis Action Alliance, advocating for individuals with severe mental illness and their families strongly supports SB807, which establishes and Assisted Outpatient Treatment pilot program in Frederick, Maryland. It offers a path to treatment for those currently left out of the Maryland mental health outpatient system which offers only voluntary services.

No treatment programs are available to those who are too ill to recognize their need for treatment and thus do not engage successfully with voluntary outpatient treatment programs or refuse treatment entirely. This is clear and simple discrimination against those with severe illness and unequal treatment under the law.

The result is that Maryland has discarded these vulnerable individuals to the streets and the jails which report up to 50% of their inmates with mental illness.

As before the first AOT program was established in New York, those who did not understand how AOT works, feared change and negative consequences. They confused AOT with involuntary inpatient treatment, which is highly restrictive and unlike AOT, allows for medication over objection. They were also concerned about the potential for racial bias.

However thorough research of the NY State AOT Program (attached) by Duke University Researchers found:
We find no evidence that the AOT Program is disproportionately selecting African Americans for court orders, nor is there evidence of a disproportionate effect on other minority populations. Our interviews with key stakeholders across the state corroborate these findings. The study also found that the court order itself resulted in additional benefits over increased services without the negative consequences that some feared. The report's summary on page viii states: "We find that New York State's AOT Program improves a range of important outcomes for its recipients, apparently **without feared negative consequences to recipients.**

We should not let unsupported fears violate the right of all those with severe mental illness to have appropriate treatment services offered.

Evelyn Burton, Maryland Advocacy Chair, Schizophrenia & Psychosis Action Alliance
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SB 807_CEGardner_fav.pdf
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Position: FAV

JAN H. GARDNER

Frederick County Executive

SB 807

Frederick County – Mental Health Law – Assisted Outpatient Treatment Pilot Program

County Position: FAVORABLE

Date: March 8, 2022
Committee: Finance

Frederick County Executive Jan Gardner urges a **FAVORABLE** report for Senate Bill 807 – Frederick County – Mental Health Law – Assisted Outpatient Treatment Pilot Program.

An accessible, responsive, culturally sensitive, 24/7 system of behavioral health care is critical to the well-being of individuals as well as our entire community. A comprehensive continuum of care that provides resources and services, via a robust combination of traditional and non-traditional means, is necessary to prevent individuals from falling through gaps. Such a system requires an intentional and collaborative effort by all sectors.

County Executive Gardner supports the provisions in the proposed legislation that:

- Establishes an Assisted Outpatient Treatment Pilot Program in Frederick County through legislation that will provide care for those individuals with severe and persistent mental illness who may lack the ability to direct and manage their care;
- Leverages the programming and the robust integrated system of behavioral health care currently in place in Frederick County, which is award-winning and has been nationally recognized for its innovation;
- Provides strong safeguards for respondents' rights with the requirement for representation by counsel at all stages, testimonial evidence by a psychiatrist, and specific criteria for "clear and convincing evidence" that a respondent should receive assisted outpatient treatment (AOT);
- Ensures accountability with the requirement of an annual report that will include the number of individuals receiving AOT, the percentage of individuals who adhered to their treatment plans, and a cost savings analysis with regard to the funds saved by individuals receiving treatment under the pilot program; and
- Creates a model that may be replicated and scaled to help to close gaps in the behavioral health care system for those individuals who have not found success in traditional voluntary and intensive services.

Frederick County Executive Gardner urges a **FAVORABLE** report for Senate Bill 807.

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SB807-_JanetEdelman_fav.pdf
Uploaded by: Janet Edelman
Position: FAV

Testimony for SB807
March 8, 2022, 1:30pm, Senate Finance Committee
From: Janet Edelman, 12038 White Cord Way, Columbia, MD 21044
Position: FAVORABLE

I have been an advocate for people living with a mental illness for forty years. I am currently chair of the Howard County Behavioral Health Advisory Board, but I am testifying as an individual. Please support SB807 to authorize the establishment of an evidence based Assisted Outpatient Treatment Pilot program in Frederick, Maryland to serve those with severe mental illnesses, such as schizophrenia and bipolar disorder, who are unable, because of their illness, to engage in voluntary outpatient services.

Over 20 years ago in 1999, both Maryland and New York studied the issue of Assisted Outpatient Treatment or AOT, also sometimes called Outpatient Civil Commitment (OCC) to provide support for people living with a mental illness that were the most difficult to treat because they do not engage voluntarily in treatment. New York moved forward with a program (Kendra's Law- Assisted Outpatient Treatment (AOT)) at that time and is now a model for the country. Maryland chose not to proceed. Maryland is basically in the same place as it was in 1999 on this issue, since the Baltimore OCC pilot program that it did implement in 2017 has tragically failed in serving the target population, and has reported enrolling only a handful of people over four years.

According to the Baltimore Pilot OCC enabling legislation (HB1383 of 2017), one of the main intents of the legislature was to "inform effective planning to implement community services that better serve State residents living with a serious mental illness who do not engage voluntarily in treatment". The Baltimore Pilot has failed completely in this regard. Only three people were reported as involuntarily enrolled in FY18 and none in the following years. Meanwhile, the Health Department's March 28, 2018 OCC report to the legislature included FY2015 claims data indicating over 5,000 individuals from Baltimore City received inpatient care, many having repeat hospitalizations over a short period of time. Those individuals cycling in and out of the hospital are the population that traditionally benefit from an evidence based AOT program. However, those in charge of the Baltimore pilot have steadfastly opposed admission criteria and operating procedures used by successful AOT programs.

The OCC Baltimore Pilot program was originally funded for four years by a SAMHSA Assisted Outpatient Treatment Grant, but SAMHSA terminated the pilot early because unlike the other 24 AOT pilots that SAMHSA funded at the same time, Baltimore could not meet the required minimum of 75 involuntary patients, and also the Baltimore pilot fundamentally failed to meet evidence based standards for AOT. For example:

- Many people are excluded from the OCC program because it requires that the patient must currently be an involuntary hospital patient that has been committed at a hearing before an administrative law judge. Very few patients meet this criterion because even if they were brought to the ER on an involuntary basis, they are always offered the opportunity to convert to a voluntary status both in the ER and after they are in the hospital.

- There is no consequence for non-adherence.
- The OCC court order does not specify a treatment plan to be followed such as psychiatrist or therapy visits, participation in ACT Teams services, substance abuse services or medication options in consultation with the individual served under the court order.

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The Baltimore OCC pilot has failed to generate any hard data on its outcomes. The March 2018 report stated that "An evaluation plan has been developed to capture the treatment outcomes of program participants." BHSB was to use weekly OCC pilot program reports to identify and monitor several items including:

> "• status of outcomes related to housing, employment, use of ambulatory health services as well as the use of emergency departments and inpatient services;
> • any high-risk issues, such as use of emergency room, hospitalization, arrest or loss of housing, or if they are not able to locate program participants".

No data on these outcomes has ever been presented. Their "outcome measures" consist only of select statements of appreciation from some of the enrollees. Not even hard data on the consumer feed-back as percentage of enrollees that liked the service or felt it helped with adherence to treatment.

In conclusion, the Baltimore OCC pilot in four years has failed to successfully show that it can routinely provide outpatient treatment to those who cannot or will not engage in voluntary treatment. It also has failed to show it can reduce hospitalization or involvement with the criminal justice system for those who fail to engage with voluntary services. Many studies have shown that evidence based AOT, as is authorized by SB807, is successful in all of the above.

I would hope that after 22 years of making the wrong decision on AOT, that the legislature will finally chose to implement an evidence based AOT program in Maryland. Those that are severely mentally ill and are cycling between hospitals, jails and homelessness deserve a program for which they are eligible and that works.

Sheppard Pratt written testimony SB807 : HB1017 Fr
Uploaded by: Jeffrey Grossi
Position: FAV

Sheppard Pratt

Written Testimony

Senate Finance Committee
House Health and Government
Operations Committee

SB807 / HB1017 Frederick County – Mental Health Law – Assisted Outpatient Treatment Pilot Program

March 7, 2022

Position: SUPPORT

Sheppard Pratt thanks the Maryland General Assembly for your longstanding leadership and support of mental and behavioral health providers in Maryland. This testimony outlines the Sheppard Pratt **support of SB807 / HB1017 Frederick County – Mental Health Law – Assisted Outpatient Treatment Pilot Program**. It is our hope that the Maryland General Assembly vote a favorable report on this legislation.

Assisted outpatient treatment (AOT) is the practice of delivering outpatient treatment under a civil court order to small, high-risk subsets of individuals with severe mental illness (SMI). The court and the mental health system work collaboratively to assist individuals with SMI to engage in treatment and ensure that the mental health system is attentive to their needs. The order requires following an individualized treatment plan, designed with input from the AOT participant, for one year, monitored by the local mental health system.

Importantly, AOT has been shown to significantly reduce hospitalizations, arrests, incarceration, homelessness, violence, and victimization in states where it is practiced.

Maryland is one of only three states without a statute enabling AOT. The Substance Abuse and Mental Health Services Administration (SAMSHA) has supported establishment of AOT programs in new communities with 40 grants since 2018. There are active AOT programs in more than 135 counties across 31 states. New York and New Jersey mandate AOT state-wide.

Sheppard Pratt stresses that AOT will be most effective if the individuals involved have access to stable and effective outpatient behavioral health services, and that will happen most effectively if the State continues to increase funding for services that are currently available and creates funding for new services not currently available such as Certified Community Behavioral Health Centers.

Sheppard Pratt urges you to vote a favorable report on **SB807 / HB1017 Frederick County – Mental Health Law – Assisted Outpatient Treatment Pilot Program.**

Jeffrey Grossi, JD, Chief of Government Relations | jgrossi@sheppardpratt.org | 410.938.3181

About Sheppard Pratt

Sheppard Pratt is the nation's largest private, nonprofit provider of mental health, substance use, developmental disability, special education, and social services in the country. A nationwide resource, Sheppard Pratt provides services across a comprehensive continuum of care, spanning both hospital- and community-based resources. Since its founding in 1853, Sheppard Pratt has been innovating the field through research, best practice implementation, and a focus on improving the quality of mental health care on a global level. Sheppard Pratt has been consistently ranked as a top national psychiatric hospital by *U.S. News & World Report* for nearly 30 years.

Jeffrey Grossi, JD, Chief of Government Relations | jgrossi@sheppardpratt.org | 410.938.3181

SB807_KathleenSmith_fav.pdf
Uploaded by: Kathleen Smith
Position: FAV

Testimony for SB807
March 8, 2022, 1:30pm, Senate Finance Committee
From: Kathleen Smith, Charles County
Position: FAVORABLE

AOT Could Have Changed My Son's Life

My 36-year old son who now has schizophrenia and is on the autistic spectrum spent ten years in prison, six in solitary confinement which exasperated his mental illness of bipolar to full blown schizophrenia/bipolar/paranoid type. Fifteen years ago if Assisted Outpatient Treatment (AOT) was in place, my son and our family could have been spared the pain of my son committing the felony crime of entering occupied homes while he was un-medicated, psychotic, homeless, on drugs and suicidal.

Since his release he has tried to be a functioning adult living with me, however with the pressures of a full time job, his medication dosage was lowered which set off the chain of medication non-compliance and its adverse effects. His life started to unravel and the beginning of decompensation started.

Over the past two years he:

- had three protective orders taken out on him in April & Nov 2021 and Jan 2022, including one by his adoptive father (that cannot live with us due to safety concerns)
- had 6 emergency evaluation petitions granted
- had 6 inpatient involuntary hospitalizations
- was discharged by the outpatient mobile team from the program due to "lack of participation" on Nov 2021
- was the subject of 3 missing person reports
- had two walkaways from crisis beds while in psychosis (medication non-compliant)
- had one elopement from a residential program as he was going to get emergency petitioned by the doctor on the grounds
- was committed to a VA hospital May & June 2021
- lost his job Dec 2021
- was homeless again Feb 2022 as he lost his apartment due to psychosis and safety of other tenants because of medication non-compliance.

He is currently hospitalized on an involuntary commitment in Baltimore. My son just started to take oral medication again on about the 15th day in the hospital (previously injectable medication was warranted due to medication non-compliance), however, as soon as he is discharged, as history has proven, he will not take oral medication or even receive injectable medication as an outpatient. This is a repetitive process of cycling in and out of psychosis, hospitalizations, discharge, non-compliance and return to psychosis again, then repeat, over and over and over.

Research in other states that have had AOT for years shows that the poor outcomes

experienced by people like my son can be improved. by having AOT available in all counties in Maryland. The ramifications of not having AOT in place and allowing people who suffer from psychosis are: lower cognitive function each time they go in psychosis, homelessness, unable to function for their basic needs, more likely to commit a crime, more likely to commit suicide, more likely to abuse drugs, more likely to be killed by a person in the community or by police.

We protect adults with a brain disease called dementia, so why are we not protecting adults with a brain disease called mental illness? Please pass SB807 to start to help those who are so sick that they cannot help themselves.

SB807_KristinaRolfes_fav .pdf
Uploaded by: Kristina Rolfes
Position: FAV

Testimony for SB807
March 8, 2022, 1:30pm, Senate Finance Committee
From: Kristina Rolfes, 13021 Gent Rd., Reisterstown, MD 21136
Position: FAVORABLE

AOT COULD HAVE AVERTED TRAGEDY FOR MY FAMILY, AND IF IMPLEMENTED, COULD SAVE MY NEPHEW IN FREDERICK COUNTY

If Assisted Outpatient Treatment (AOT) had been available for my brother, he would have been under treatment and might not have violently attacked my father, leaving my father with severe traumatic brain injury, resulting in my brother spending three years of his life in a locked psychiatric hospital. If AOT was available today in **FREDERICK COUNTY**, it could prevent my ill nephew from also experiencing tragedy and enormous suffering.

My brother suffered from paranoid schizophrenia. Once a promising student, stand-out athlete and ambitious young man who started a small business, he suddenly dropped out of college, could not hold a steady job, and began showing odd and troubling behavior. He experienced bizarre delusions and auditory hallucinations. My parents took him to see a psychiatrist, but he refused any medication or further visits because he didn't believe anything was wrong (lack of insight is a symptom of the brain disorder itself). Untreated, he continued to deteriorate and suffered a severe psychotic break. During a delusional episode, he violently attacked my father, leaving him with a severe traumatic brain injury.

My brother was charged with attempted murder and eventually found not criminally responsible, spending three years in a locked psychiatric hospital where he finally received treatment. He later received group housing and community services. Once treated, he regained insight, maintained medication compliance, and lived a productive life, including working and volunteering to help others with mental illness. But he lived with guilt for the rest of his life. My father suffered lasting cognitive, balance, and vision impairments and could no longer work. I often imagine how different our lives would be if a program had been available to help him accept treatment before he deteriorated.

Now, my nephew (whose parents both had schizophrenia) is showing early signs of psychosis. He is 20 and lives in Frederick with my 74-year-old mother. He has been hospitalized several times but refuses to take medication or see a psychiatrist. He is unable to hold down steady employment, makes poor decisions, shows inappropriate social behavior, and has frequent outbursts. He does not believe anything is wrong with him. He has shown signs of violence and has spent time in jail. I believe AOT could stave off psychiatric deterioration and emotional suffering, allowing him to live a happy and productive life. Without it, I fear another tragedy will occur. He will likely end up dead, in jail, homeless, attack and harm my mother or live with life-long suffering.

Please pass this bill to create a pilot AOT program in Frederick County. My nephew's life depends on it. Please spare my family additional tragedy, suffering and lasting trauma. Since my nephew lives in Frederick, he could benefit from the pilot program to be implemented by this bill.

SB807_MoCo_Frey_SUPPORT.pdf
Uploaded by: Leslie Frey
Position: FAV

Montgomery County
Office of Intergovernmental Relations

ROCKVILLE: 240-777-6550 **ANNAPOLIS: 240-777-8270**

SB 807 **DATE: March 8, 2022**

SPONSOR: Senator Hough

ASSIGNED TO: Finance

CONTACT PERSON: Leslie Frey **(leslie.frey@montgomerycountymd.gov)**

POSITION: SUPPORT (Department of Health and Human Services)

Frederick County – Mental Health Law – Assisted Outpatient Treatment Pilot Program

Senate Bill 807 creates an Assisted Outpatient Treatment (AOT) pilot program for mental health treatment in Frederick County. The Montgomery County Department of Health and Human Services supports the expansion of the utilization of AOT within Maryland.

Currently in Maryland, the only access to AOT is through a pilot program in Baltimore City (created by CH576 of 2017), which is available only for individuals transitioning out of involuntary inpatient treatment and who have a mental illness diagnosis. Maryland is one of only three states with no comprehensive AOT laws[1] in the country. Assisted outpatient treatment has been shown to reduce rates of hospitalization, arrest, and incarceration in states where it has been implemented.[2] In 1999, New York State enacted legislation commonly referred to as "Kendra's Law," which provides for assisted treatment for certain people with mental illness who are unlikely to survive safely in the community without supervision, based on their treatment history and present circumstances. The National Alliance on Mental Illness issued a report that includes interviews with family members, many of whom praise the program.[3]

The Montgomery County Department of Health and Human Services supports the legislature increasing access to AOT and respectfully urges the committee to issue a favorable report on Senate Bill 807.

[1] https://www.ncsc.org/__data/assets/pdf_file/0026/16964/mhf2-assisted-outpatient-treatment-jan-2020.pdf
[2] https://www.treatmentadvocacycenter.org/component/content/article/39
[3] https://www.naminys.org/ADTfinal.pdf

SB807_LisaHalpin_fav.pdf
Uploaded by: Lisa Halpin
Position: FAV

Testimony for SB807
March 8, 2022, 1:30pm, Senate Finance Committee
From: Lisa Halpin, Glenwood, Howard County, MD
Position: **FAVORABLE**

Our 30-year old son, once a successful professional, now has severe mental illness and refuses all help. I cry myself to sleep at night; waiting to receive a phone call that he is hurt, has hurt someone else, or worse. I implore you to please hear me – Assisted Outpatient Treatment (AOT) would help us save our son's life and protect our family and others from people like him who are suffering with severe mental illness.

My husband and I are Maryland business owners. We previously resided in Frederick County and have multiple family members that both live and work in Frederick. We are also the parents of four children, including a 30-year old son who is diagnosed with schizoaffective disorder and bipolar disorder and a 17-year old daughter who is developmentally disabled. I have championed both disability rights and have advocated and testified on behalf of mental health causes throughout the years. For this reason, I believe I am uniquely qualified to speak in support of this bill.

Our 30-year old son began his life as a beautiful, talented and kind young man who graduated with a B.S. in Economics from the University of Maryland. He was a Maryland homeowner working a six figure job before he suddenly began deteriorating mentally into someone we did not recognize. He suffered psychosis and began having religious delusions. He also began self-medicating with illegal drugs. Our beautiful son began spouting strange and hostile conspiracy theories, indignantly rebuffing any attempts to speak rationally to him about his changing behavior. Eventually we could only watch helplessly in horror as his life imploded. He suffers from anosognosia and does not know that he is severely mentally ill. Sadly, he showed up to our home in the middle of the night throwing large rocks through the glass windows. On one occasion he threw a rock through the window that just nearly missed hitting his developmentally disabled sister. We had to obtain a protective order and he was involuntarily hospitalized.

Once he was stabilized and released from the hospital, he got a new job and we had hope, however, he has now stopped taking his medicine and his mental health is declining rapidly again. He refuses all mental help. AOT would save my son's life. It would save him from hurting himself or others. Instead, I pleaded and begged him and was finally able to get him a telemed with a psychiatrist. We sat in the parking lot of a local mall while the psychiatrist told him he needed antipsychotic medication. He yelled at her and said it was not true. She told me she did not feel safe treating him and told me not to call back. I contacted multiple other psychiatrists who declined to see him. Now, he no longer wants to receive care and refuses to talk to us anymore.

In response to those who say that this bill would harm those with disabilities, I speak from a place of deep and personal knowledge to say that is simply just not true. My child with a disability needs protection from her brother; not protection from a generic, contrived threat that AOT could be used to cause her harm. Developmental disability is not a mental disability. However, my daughter with the developmental disability is at risk of schizophrenia. If that happens, AOT would help, not harm her as well. As a mother desperately trying to save her child; I ask you to please support this bill. It belongs in all of Maryland; not just in Frederick.

AOT Weinberg Senate testimony.pdf
Uploaded by: Lowell Martin
Position: FAV

Testimony for SB807 – Mental Health Law – Assisted Outpatient Treatment Pilot Program
Senate Finance Committee
Date: March 8, 2022, 1:00 pm
From: Claire Weinberg, Bethesda, Montgomery County

POSITION: SUPPORT

My son had Schizophrenia, and he took his own life. Assisted Outpatient Treatment might have saved his life.

I don't believe my son ever had any awareness of the causes of his suffering. Even though he was paranoid, delusional and hearing voices, he **NEVER RECOGNIZED THAT HE HAD AN ILLNESS so he REFUSED TREATMENT.**

Michael was diagnosed with schizophrenia as a teenager, after his first year in a U. of Md. Honors Program. Although he sometimes behaved bizarrely, he managed to get a degree in horticulture from the University of Maryland. He was too fearful to seek a professional job, but did some heavy tree work for a friend, and odd jobs.

His only violent behavior – he was too gentle a soul to ever seriously hurt anyone – was to give an occasional guy a punch when he thought - THROUGH THE VOICES IN HIS HEAD - that the guy was propositioning him!

When picked up by the police for this on one occasion, he was given his freedom on the condition he would see the doctor at the county clinic and take medication. He went a short while but when the doctor left, he stopped going and stopped the medication. T**here was no follow-up by the treatment provider.**

Michael had a history of non-compliance with treatment as well as an arrest, and the inability to care for himself. If the judge had issued an order for Assisted Outpatient Treatment, the provider would have been responsible for following up to encourage him to abide by the court ordered treatment plan. If my son had stayed in treatment for a year under AOT, he would have had a chance to stabilize and possibly live a satisfying life. If he had deteriorated again, the treatment provider could have more easily petitioned him for evaluation for hospitalization. If he didn't meet the criteria for hospitalization, the provider would be watching to facilitate hospitalization as soon as possible.

Instead, without any treatment, Michael deteriorated to the point where he was suffering so with fear, paranoia, hallucinations, and depression that **he shot and killed himself.**

Assisted Outpatient Treatment might have saved my son. Since he refused voluntary treatment, because of the severity of his illness, there was NO outpatient treatment option for him. How can Maryland continue to offer NO viable outpatient treatment option for the most ill and vulnerable? You cannot bring back my precious son, but you have the power to prevent the suicide of others by offering them the life-line of AOT.

Please support SB807.

Testimony Marianne Eichenberger SB807docx.pdf
Uploaded by: Marianne Eichenberger
Position: FAV

Testimony for SB807
March 8, 2022, 1:30pm, Senate Finance Committee
From: Marianne Eichenberger, Howard County
Position: FAVORABLE

I am an advanced practice mental health nurse of 40 years living in Howard County. I support the bill for Assisted Outpatient Treatment (AOT). I have worked with many seriously mentally ill clients that due to their illness (delusions and /or hallucinations) have refused treatment and ended up homeless or worse arrested for a criminal behavior and hospitalized in a forensic mental health facility. It is critical to get these individuals whose judgment, reasoning and/or inability to control their behaviors into treatment so they can make informed decisions regarding their future treatment.

The evidence shows that severely mentally ill clients that do not receive treatment in earlier stages of their illness or that have had to have multiple re-stabilization have a poorer response to future treatment and poorer long-term outcomes. AOT is less expensive as shown by a 2013 Duke research study where costs per person declined by 43% the first year with AOT. As a clinician this is a less restrictive and more humane treatment alternative that has worked in 47 other states.

I have worked with a client that due to delusions that she was being poisoned remained on the streets homeless, awake and fearful every night because the individual had been raped in a shelter and begging for food. The client was admitted numerous times to short stay admissions and discharged to the shelter. This client would not remain in the shelter and finally ended up in the forensic system where they were able to get treatment. I began treating this client in the outpatient setting after the forensic hospitalization and the client was on SSDI, living in a group home where they were able to get their first pet. It took the client 8 years to get to this point. The expression of happiness when discussing this animal is something I will never forget. AOT would have begun the treatment process at a time when the client judgment and ability to reason were seriously impaired. It would have been much more cost effective, safer for the client, and much more humane.

I ask all members to support this bill and the seriously mentally ill.

I appreciate the time you have taken to consider this vital issue.

Marianne Eichenberger, RN, PhD

AOT - MJM Senate.pdf
Uploaded by: Marilyn Martin
Position: FAV

Testimony for SB807
March 8, 2022, 1:30 p.m., Senate Finance Committee
From: Marilyn Martin, 11509 Emmanuel Way, Solomons, MD 20688
Position: FAVORABLE

My adult son has lived with schizophrenia for years but was diagnosed in 2008. He has been hospitalized at least 18 times since then. One of the worst periods was the two years preceding his psychosis-induced assault upon my then 71-year-old spouse. Assisted Outpatient Treatment (AOT) would have been enormously helpful in preventing his decline. My son had never been violent prior to this.

My son has never reacted well to change. When the nurse providing my son's monthly medication injection left his outpatient clinic, my son refused the prescribed injection from the new nurse. The only medication he would agree to taking was one that had previously stopped working for him. That was when my son needed AOT. Studies show that AOT can dramatically improve treatment outcomes and substantially reduce the likelihood of repeat hospitalization and criminal justice involvement for its target population.

Instead, my son deteriorated so much that he assaulted my then 71-year-old husband, who ended up on the floor, bloodied from head wounds, and traumatized. My son now has a criminal conviction. Only after committing a crime could my son get court-ordered outpatient service. Statistics from other states show that the program works due to the "black robe effect" of going before a special judge provided by the AOT program. He also received three years of probation and is now stuck with a criminal record. The State of Maryland compounded this unfair situation by passing legislation that requires a 15-year waiting period before any expungement can be attempted. I highly doubt that I'll still be around in 2034 to attempt an expungement on his behalf.

My son has succeeded in remaining effectively medicated since the assault. So, the "black robe effect" did work in his case. However, an Assisted Outpatient Treatment program would have achieved that same outcome much more compassionately than the criminal justice system.

Not only does AOT work compassionately for those with brain disorders, but it also saves money. It reduces costs for police, incarceration, judicial systems, and hospitals.

SB807_MelissaMulreany_fav.pdf
Uploaded by: Melissa Mulreany
Position: FAV

Testimony for SB807
March 8, 2022, 1:30pm, Senate Finance Committee
From: Melissa J Mulreany, 10237 Wesleigh Dr., Columbia, MD 21046
Position: FAVORABLE

The availability of evidence based Assisted Outpatient Treatment (AOT) could be a life changing tool for our family and friends with serious mental illness (SMI). My personal experience involved a relative who was unaware of his illness due to anosognosia, a neurological cognitive deficit caused by the mental illness, which prevents recognition of one's illness and the need for treatment. Therefore he refused voluntary treatment.

For twenty years my relative struggled to get and keep a job, but without medications and ongoing psychiatric assistance he was not able to maintain gainful employment or independent living. Had evidence based AOT been available in Maryland to provide treatment, he would not have suffered for so long and been unable to achieve his goals.

After finally getting on medication and psychiatric care, he has gained the ability to understand his illness and the benefits of treatment. He is also able to hold a job now.

Our family could have been spared over twenty years of grief and uncertainty as we struggled to protect him from his self and the ravages of an untreated serious mental illness.

Please support SB807 and its companion House Bill, to add evidence based Assisted Outpatient Treatment to the options available to mental health professionals and give individuals with untreated SMI (and their families) hope for life as a healthier and contributing member of society.

TESTIMONY FOR SB807.pdf
Uploaded by: Michael Robert
Position: FAV

TESTIMONY FOR SB807

MARCH 8,2022 1:30PM SENATE FINANCE COMMITEE

From: Michael and Ruby Robert

POSITION :FAVORABLE

We are Michael and Ruby Robert; this is our ongoing story.

Our son Andrew Robert is 34 years old. He is a husband to Lyric Robert since 2018 but they have been together since they were 17 years old. He is a father of a daughter Opal who is 3 and a son Laiken who is 18 months and a 3rd is to be born any day. For the last 10 years Andrew has been a full-time professional musician. A happy go lucky guy with lots of friends and family that love him.

Several years ago, while in Baltimore Maryland recording his second album two gunmen broke into the studio to rob them. It became quickly evident that they intended to harm them. Several of Andrews friends had small pocketknives, so when the gunmen began shooting, they pulled out the knives in hopes of saving themselves. Three of Andrews friends were shot. One man died within minutes with a fatal wound to the chest. Another was critically injured with a gun shot to the chest as well but survived because of the excellent care of the paramedics. The other friend was shot through the hand while trying to get the gun. The two gunmen were apprehended at the local hospital because they checked themselves into the ER for knife wounds. When Andrew came home that next morning he was covered in blood on his shoes, clothes and self. It was that moment un-beknown to Andrew, his loving and optimistic view of the world had been shattered and was soon to be replaced by fear, despair and isolation. He started drinking heavily and without control. At first the changes were subtle and slow. As more and more of the dominoes fell it left him overwhelmed with fear, paranoia and thoughts of suicide. When covid hit and the music venues closed he was unable to make a living for his family, that is when his life toppled.

In April of 2021 he came to us emotionally distraught and suicidal asking us for help. We were able to get him into Sun Behavioral Health not easily I might add, a psychiatric hospital in Georgetown Delaware. He spent 5 days at Sun Behavioral with a diagnosis of Major Depressive disorder, recurrent severe without psychotic features. He was released and put on a waiting list for outpatient counseling months passed without openings available. His mental condition continued to deteriorate.

In July 2021, he had his first contact with police. He had erratic paranoid behavior throughout the day, and he was obviously a danger to himself and his community at this point. He was taken by paramedics and sedated and put under suicide watch at the local hospital than transferred to Sheppard Pratt. He stayed there for 5 days and was released diagnosed with PTSD with psychosis and bi-polar. Because he has not gotten outpatient counseling or support after his first hospitalization his mental state has become grave. When he was released from Sheppard Pratt he was still in psychosis and needed mandatory outpatient support, but he still felt he wasn't sick and would not agree to it. You may ask why doesn't Andrew help himself? Because he is sick but believes he is well. This is his mental catch 22 that so many people in his condition find themselves facing. In the last few weeks, he has been in contact with police 6 times and been taken 5 times to the ER for evaluation at Union Hospital in Cecil County Md each time he was released they stated he was not a danger to himself or his community even though he was picked up by police for walking on the yellow line on a dark busy highway. Once was even through a emergency court petition and he was still released within 5 hours. Our fear at this point is that It will come to Andrew breaking a law or hurting himself or others before he can get the help he needs.

What would you do if this was your child, your wife, your husband or best friend? We are asking you to make the hard decisions so that the mentally ill of Maryland who cannot protect themselves will have the opportunity for mandatory outpatient care that can stop the endless revolving cycle of hospitalizations and releases without help.

Please help save lives and families by passing this bill (SB807) thank you.

SB 807 - NAMI - SUPPORT.pdf
Uploaded by: Moira Cyphers
Position: FAV

March 7, 2022

Senate Bill 807 – Frederick County – Mental Health Law – Assisted Outpatient Treatment Pilot Program – SUPPORT

Chair Kelley, Vice Chair Feldman, and members of the Senate Finance 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.

Senate Bill 807 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

Kathryn S. Farinholt
Executive Director
National Alliance on Mental Illness, Maryland

Contact: Moira Cyphers
Compass Government Relations
MCyphers@compassadvocacy.com

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 **SB 807.**

Kathryn S. Farinholt
Executive Director
National Alliance on Mental Illness, Maryland

Contact: Moira Cyphers
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SB807_sdaniels_fav.pdf
Uploaded by: Philip Tajitsu Nash
Position: FAV

Testimony for SB807
March 8, 2022, 1:30 PM Senate Finance Committee
From: Sue Daniels, Bethesda
Position: FAVORABLE

A Once-Promising Young Life Without Hope because Maryland has no AOT

Our son had a bright future, with a job that he loved as a lead software developer at a Fortune 500 corporation. He had close friends and a steady relationship with a wonderful young woman. Entirely through his own earnings and savings, he had a nice apartment and a car. We were so happy for him. Then, suddenly, at the end of his twenties, he became ill with schizophrenia and lost everything, even his future, through no fault of his own. He lost his job, his friends, his girlfriend, all his possessions, and without the help of his parents, would have become homeless. In his psychotic state, he has unwittingly done things that were very dangerous to himself and others, and is currently facing a trial for breaking fire safety laws. He has been hospitalized repeatedly, but because Maryland has failed to pass AOT protections for people stricken with severe mental illness, he has never received the treatment he desperately needs. We have begged the doctors to treat him, but they say their hands are tied without a change in the law, and that they cannot treat him unless he consents, even though he is not capable of understanding his disease and consenting until after he is treated. It's a Catch-22.

When a person is psychotic, their thinking is confused, and usually the person doesn't realize they are ill and so they won't take the medication they urgently need. Instead, in the case of our son, he knows only that his life has become a shambles, that he is lonely and miserable, and that "I can't do the things I used to be able to do." In his despair, he has attempted suicide. Our family lives in constant fear of him killing himself before the law changes and he can get treated. Whenever he doesn't answer our text messages, we miss work, drop everything and drive to his apartment, terrified of what we may find on the other side of the door. It is ongoing hell for him and for the whole family.

Feeling alone and tormented, he is afraid to take medication that would help him wake up from this nightmare. Alas, he believes his confusion and the horrible malignant voices he hears in his head are caused by a conspiracy of evil beings who are controlling him with radio waves. His young brain, once so nimble and strong, is being ravaged year after year by the flames of psychosis. Science tells us that the sooner you treat psychosis, the more likely the person will be able to return to a more normal life. The longer this evil disease is neglected, the more it destroys the brain. Despite all our efforts to get our beloved son treated, it has now been

nearly 8 years that he has been suffering without treatment – because Maryland is one of the last three states in America that has failed to pass AOT.

As parents, we are now begging you, our lawmakers, to help our son and thousands of other afflicted young Marylanders who need and deserve help. Nearly 1% of Marylanders suffer from schizophrenia. Another 2-3% suffer from other forms of psychotic illness. This is also an issue of public safety. People who are left to suffer the ravages of psychosis without any rational intervention of compassionate antipsychotic treatment can be a danger to others. My son has struggled against evil voices for years, voices that command him to do terrible things. He screams at them to shut up and leave him alone, but they always return, sooner or later.

As the mother of a beautiful and beloved young man who has been stricken by schizophrenia, I now recognize behaviors of certain homeless people I see on the street, behaviors that I once assumed were the result of some kind of intoxication, but that I now see as the struggles of another mother's poor abandoned child, who is tormented by evil voices that won't leave them alone. We have abandoned all of them. This is not the Middle Ages, when insane people were chained to a wall and left filthy and alone in their torment. Yet today we still fail to see the humanity in our mentally afflicted children, and callously leave them chained to their illness, when medication EXISTS that could free them of their chains. AOT will help not only my son, but so many sufferers. Thousands of young people and their mothers, fathers, sisters, and brothers.

If any lawmaker thinks it is cruel and unfair to give antipsychotic medicine to a person who is so afflicted that they cannot give consent, please come and meet with me on a fact-finding mission. Come with me to my son's apartment when we rush over late at night, afraid he may be thinking of committing suicide. Meet my son, a handsome young man with a sweet demeanor, except that he has large raw unexplained scars on his legs from 3rd-degree burns, his skin is gray with grime because he no longer bathes, and if he smiles, you will see that his teeth are all rotting out, because, in his psychosis, he thinks he doesn't need to brush his teeth or go to the dentist, because when his teeth rot out, new and better ones will grow in.

If Maryland had AOT when my son got ill, this would never have happened. If AOT finally passes, my son will need to have all his rotten teeth pulled and replaced with artificial teeth. That's the least of the harms that have been done to him and others due to lack of AOT. It's the tip of the iceberg.

We have tried to get him to move to a neighboring state, because Maryland is behind the times regarding AOT and nearby states have all passed AOT laws that would help end his suffering

and ours. However, he is already struggling against suicidal thoughts and voices that tell him to do horrible things, and does not even want to talk about moving.

He tells us that when the voices return, commanding him to do bad things, he feels immense anxiety and rage. He says he has learned that if he expresses violence on an inanimate object, such as furniture or a wall, that the voices go away for a while, and he can have some peace. As a result, he has never harmed anyone, but he has been evicted from several apartments for violently banging the walls as he attempts to calm his unending torment. After his most recent eviction, he owed $2,000 in damages, having destroyed extensive areas of interior walls and two metal doors.

I was stunned when I saw he had stabbed a pair of scissors into a wall perhaps 20 times, leaving big gashes, like something out of a horror movie. I told him this looked pretty scary. He looked at me and said softly, “Mom, that shows how much I didn’t want to hurt anybody.”

Dear lawmakers, there’s a better way to banish the cruel demons of psychosis. Violence against furniture and walls is not a solution. Violence against self and others is surely not a solution. Refusing to deal with the problem is not a solution – it is heartless abandonment of our most afflicted. AOT is a rational and compassionate solution. In the name of compassion and rational government, please pass the law. FAVORABLE.

SB807_ZD_fav.pdf
Uploaded by: Philip Tajitsu Nash
Position: FAV

Testimony for SB807
March 8, 2022, 1:30pm, Senate Finance Committee
From: ZD, Bethesda, Montgomery County, MD
Position: **FAVORABLE**

AOT could have saved my son years of visits to the emergency room and now homelessness.

My 28-year old son has bipolar disorder, anxiety disorder and personality disorder. He has been ill for approximately 8 years, and has been to the emergency room and hospital many times.

In May, 2021 I petitioned for an Emergency Evaluation. He was taken to Suburban Hospital and agreed to voluntary treatment for 6 days and improved. At discharge, he agreed to cooperate in treatment, and signed a treatment contract, but after he was out he refused to go or take the prescribed medicine. He does not accept that he has a mental illness. Of course, he deteriorated.

In June we did the hardest thing a parent can do: we put him out of our house. He was angry, and destructive. Now he is homeless in Montgomery County. He has no money to eat and sleeps in the parks. He comes to us very hungry and dehydrated on hot days. The first time he came to us, he looked so bad.

I am afraid to let him come home and I am afraid to leave him out there, homeless and hungry. I am afraid of what will happen to him or what he might do.

Why we must wait for a crime to happen before we help someone who is clearly suffering serious mental illness? If AOT was available, then my son and I wouldn't be going through a such a horrible experience.

There is no question in my mind that this experience has left a permanent scar on both my son and myself. Please pass the AOT pilot bill as a first step to helping my son, myself and families like ours.

SB807_S. White_Fav.pdf
Uploaded by: Shakeemah White
Position: FAV

Testimony for SB 807 – Frederick County – MH Law – Assisted Outpatient Treatment Pilot Program
Senate Finance Committee
Date: March 8, 2022
From: Shakeemah White, Olney, Montgomery County
POSITION: Favorable

Assisted Outpatient Treatment (AOT) might have saved my mother 15 years of ongoing psychosis, physical assaults, long periods of homelessness, and ongoing psychological and physical deterioration. My mother is diagnosed with paranoid schizophrenia and has no insight into her illness. Injectable antipsychotic medication has proven successful in providing her sustained periods of relief from delusions, fear, and agitation. Sadly, she has never reliably taken oral medication. The result – my mother has been hospitalized over 15 times since we moved here in 2006. Since 2016 she has not voluntarily accepted any treatment.

She initially agreed to treatment – Haldol injections – from 2006 to 2007. I am her only child, and we were happy to all be together. But in 2007 she started refusing the injections. One weekend while my two children and I were away, my mother – believing that we were all moving back to New York – packed all our clothes, shoes, accessories, and small appliances onto a moving truck and left town with our belongings.

My mother agreed to return to Maryland in 2008 and was accepting of the Haldol injections and therapy from 2008-2013. She was stable, doing very well, and living with us. In 2013 she started refusing the medication again as she believed she no longer needed it. She predictably deteriorated, believing she had a newborn baby girl, that her ex-husband was following her, and that demon spirits were jumping out of magazines. She would squander her money. I doggedly sought treatment and a variety of services for her, but she consistently refused services and there was no way to compel her into the treatment she so desperately needed. It was difficult to keep her stable, and she went through the "revolving doors" of the mental health system, involuntarily hospitalized many times during 2014-2016.

In 2016 she again returned to NY where she was homeless, living in train stations and abandoned buildings. That year my grandmother passed away, but my mother insisted she had to stay in New York "to take care of my mother." Periodically she would call me – belligerent, cursing and screaming – but in December 2020 she stopped calling and I didn't know if she was dead or alive. Last September, after receiving a call from a good Samaritan, I went to New York and found my mother in a Brooklyn train station. She was frail, dirty, and incoherent. On the way to my hotel, she pulled down her pants and defecated along the busy street. I got her back to Maryland, and she was immediately involuntarily admitted. She has been hospitalized involuntarily three times since returning to Maryland. She continues to refuse all medication, even for her high blood pressure. In addition to her suffering from the psychosis, I worry she will have a devastating or fatal stroke.

Court monitored outpatient treatment is the compassionate choice for those who cannot be reached otherwise. She could be safe, stable, and preparing to celebrate her 67th birthday in 2 weeks. She could enjoy the years ahead. Instead, she is currently hospitalized and again, insisting that she does not need medication.

Thus, the cycle continues, needlessly wasting state resources, both human and financial. You know better than I the cost of inpatient psychiatric care and the grinding, endless strain on all parts of the mental health system. AOT would help free individuals like my mom from the domination of this devastating illness. Although neither my mother nor I line in Frederick County, others there would benefit.

We know what doesn't work. For a change, let's offer something that could. Please support this pilot program.

SB807_AmandaWoodward_FWA.pdf
Uploaded by: Amanda Woodward
Position: FWA

Testimony for SB807
March 8, 2022, 1:30 pm Senate Finance Committee
From: Amanda Woodward, 8469 Hill Street, Ellicott City, Maryland 20143.
Position: FWA

Good afternoon to members of the Senate Finance Committee. My name is Amanda Woodward, and I am a Registered Nurse with 24 years of extensive experience in acute care psychiatry, emergency medicine and the criminal justice system. Over the course of my career, I have witnessed lives wasted and families torn apart by serious mental illness (SMI). I have seen the same SMI individuals repeatedly cycling through Jails, ERs, and psych units. Had I worked with the police, I would have also seen them dead or homeless. I am convinced that had my patients had a supportive AOT program, their outcomes would have been so much better.

One argument against AOT is that it limits the individual's freedoms or choices. My response is psychotic illnesses themselves hold minds hostage by preventing full expression of personality and humanity. According to the Treatment Advocacy Center, about half of those with Bipolar 1 and Schizophrenia are affected with anosognosia. (TAC, By the Stats) This is the inability of the mind to understand it is hijacked by delusional thoughts and hallucinations. This explains why 50 percent of those with SMI live unmedicated. Would any of us take medication if we didn't think we were sick? A **quality** AOT program for these people involves caring, supportive clinicians and a wise civil court judge to monitor progress and make use of the black-robe effect, which studies have shown to keep individuals engaged in the program.

Some individuals with SMI may testify that they were maltreated in a hospital setting or by community mental health agencies. Their lived experience is valid. In the same way, some cancer patients say their treatment makes them question their choice to live longer. Still, we do not withhold their life-saving treatment. For the best outcomes, AOT programs must be formed from **high quality** models such as that of SAMHSA, which has been proven to work by many studies across the nation. Kindness, dignity, and support go a long way…

In the absence of such AOT programs, loved ones of those with SMI are left to care for their sick relative when laws and health systems fail them. These families endure unbearable stress. I have seen both the heroics and exhaustion of mothers. Approximately 1/3 of family homicides involve a person with SMI. (TAC, By the Stats) AOT like this would preserve the family peace by freeing caregivers from the clinician's role and allowing them to do what families do best.

The altruistic implementation of AOT will stop the down-stream problems we see today, making the effort worthwhile, in addition, studies have shown state expenditures on these current issues would dramatically decrease. These savings could, in turn, cover the costs for wide-spread implementation of upstream solutions.

I support SB807 with amendment.

Senate Bill 0807 in Favor.pdf
Uploaded by: Charles Richardson
Position: FWA

Testimony for the March 8, 2022 meeting of the Senate Finance Committee
Topic: SB 807 Assisted Outpatient Treatment Pilot Program with Amendment
By: Charles Richardson, MD (Address: 7662 Sweet Hours Way; Columbia, MD 21046, District 13)

I recently retired from the state of Maryland and Spring Grove Hospital where I worked as a psychiatrist for 32 years. My experience made it clear that the criminalization of mental illness in Maryland remains a major problem. The statutory authorization of evidence based Assisted Outpatient Treatment as proposed in SB0807 by Senator Hough would go far to reverse this trend.

Over 100,000 Maryland residents are afflicted by severe mental illnesses, including Schizophrenia and Bipolar Disorder. Acute episodes of these brain-based illnesses require weeks to months of sustained medication before gradually resolving. This is far longer than typical inpatient admissions, which seek only to resolve acute dangerousness. Most patients voluntarily continue their treatment as outpatients as their symptoms continue to resolve. But a small percentage will not, specifically because they lack the capacity to perceive the presence of an illness or the need for treatment. This perceptual deficit is a symptom of their brain disorder, which usually resolves at the same slow pace as their other symptoms. Maryland's mental health system does not currently provide a mechanism to ensure continued outpatient treatment for these patients until such time as they can again see the wisdom of voluntary participation in outpatient services.

This deficiency in our system of care contributes directly to the criminalization of mental illness, as the disorganized and terrified behavior of inadequately treated patients all too often leads to arrests. Patients are then literally punished for their illness-driven behavior by prolonged incarcerations in jails and state hospitals. And the legal entanglements often lengthen their court-ordered inpatient treatment well beyond clinical need, reducing the efficiency of limited state resources. Tragically, in Maryland today, the only way to ensure sustained treatment of severe mental illness is for the patient to be arrested, jailed, and court-ordered for treatment at a state facility. This is just plain cruel.

Assisted Outpatient Treatment is an evidence-based means of intensifying treatment for severe mental illness, on an outpatient basis, for those who are unable to recognize their need for treatment. It would address the need for sustained treatment so often necessary for a patient to achieve improved judgment, not merely the absence of dangerousness. It would do so without requiring the patient to reside in a locked facility. It would make families feel more secure in allowing their loved ones to reside at home. It would reassure the local police that troublesome behavior is being addressed in such a way as to ensure community safety. It would provide a mechanism for civil court-mandated treatment while reducing the use of the more punitive and costly criminal court-ordered treatment. I am respectfully asking you to support SB0807, submitted by Senator Hough, to institute this life-altering treatment.

SB0807_SponsorAmendment_483620-01
Uploaded by: Senator Hough
Position: FWA

SB0807/483620/1

AMENDMENTS PREPARED BY THE DEPT. OF LEGISLATIVE SERVICES

08 MAR 22
11:17:50

BY: Senator Hough
(To be offered in the Finance Committee)

AMENDMENTS TO SENATE BILL 807
(First Reading File Bill)

AMENDMENT NO. 1

On page 1, in line 5, after "County;" insert "requiring the Office of the Public Defender to provide representation to certain individuals in proceedings in which judicial commitment of an individual to assisted outpatient treatment under the Pilot Program may result;"; after line 6, insert:

"BY repealing and reenacting, with amendments,
Article - Criminal Procedure
Section 16–204
Annotated Code of Maryland
(2018 Replacement Volume and 2021 Supplement)";

and after line 12, insert:

"Preamble

WHEREAS, A small but persistent subset of individuals with severe mental illness struggle to voluntarily adhere to the treatment they require in order to live safely in the community, due to an inability to maintain awareness or understanding of their mental illness; and

WHEREAS, When individuals with severe mental illness remain untreated, they may suffer needlessly from homelessness, poverty, repeated hospitalizations, repeated arrests, trauma, and suicide; and

WHEREAS, Civil commitment to outpatient care combined with adequate resources for treatment and monitoring, known in many states as "assisted outpatient treatment", is a federally recognized best practice for improving treatment adherence and outcomes among individuals with histories of repeated psychiatric crises while reducing systemic costs through avoided hospitalizations; and

WHEREAS, Maryland is one of only three remaining states without statutory authority for a court to order civil commitment of an individual to outpatient care; now, therefore,".

AMENDMENT NO. 2

On page 1, after line 14, insert:

"**Article – Criminal Procedure**

16–204.

(a) Representation of an indigent individual may be provided in accordance with this title by the Public Defender or, subject to the supervision of the Public Defender, by the deputy public defender, district public defenders, assistant public defenders, or panel attorneys.

(b) (1) Indigent defendants or parties shall be provided representation under this title in:

(i) a criminal or juvenile proceeding in which a defendant or party is alleged to have committed a serious offense;

(ii) a criminal or juvenile proceeding in which an attorney is constitutionally required to be present prior to presentment being made before a commissioner or judge;

(iii) a postconviction proceeding for which the defendant has a right to an attorney under Title 7 of this article;

(iv) any other proceeding in which **[**confinement under**]** a judicial commitment of an individual **TO CONFINEMENT** in a public or private institution**, OR TO ASSISTED OUTPATIENT TREATMENT UNDER TITLE 10, SUBTITLE 6A OF THE HEALTH – GENERAL ARTICLE,** may result;

(v) a proceeding involving children in need of assistance under § 3–813 of the Courts Article; or

(vi) a family law proceeding under Title 5, Subtitle 3, Part II or Part III of the Family Law Article, including:

1. for a parent, a hearing in connection with guardianship or adoption;

2. a hearing under § 5–326 of the Family Law Article for which the parent has not waived the right to notice; and

3. an appeal.

(2) (i) Except as provided in subparagraph (ii) of this paragraph, representation shall be provided to an indigent individual in all stages of a proceeding listed in paragraph (1) of this subsection, including, in criminal proceedings, custody, interrogation, bail hearing before a District Court or circuit court judge, preliminary hearing, arraignment, trial, and appeal.

(ii) Representation is not required to be provided to an indigent individual at an initial appearance before a District Court commissioner.".

On page 4, in line 21, after the third "**THE**" insert "**TREATING**"; and in line 31, after "**BE**" insert "**ENTITLED TO BE**".

On page 5, in line 29, strike "**AT LEAST**" and substitute "**NO EARLIER THAN**".

On pages 6 and 7, strike beginning with "**, AN**" in line 33 on page 6 down through "**PLAN,**" in line 1 on page 7 and substitute "**TO OR FROM THE TREATMENT PLAN**".

On page 7, in line 12, after "**(D)**" insert "**(1)**"; and after line 15, insert:

"**(2) IF THE RESPONDENT INFORMS THE COURT THAT THE RESPONDENT AGREES TO THE PROPOSED MATERIAL CHANGE, THE COURT MAY INCORPORATE THE PROPOSED MATERIAL CHANGE WITHOUT A HEARING.**".

On page 8, in line 5, strike "**AT LEAST**" and substitute "**WITHIN**"; and strike beginning with "**A**" in line 26 down through "**PROGRAM**" in line 27 and substitute "**THE EFFECT OF ASSISTED OUTPATIENT TREATMENT, IF ANY, ON THE INCIDENCE OF HOSPITALIZATION AND CRIMINAL JUSTICE INVOLVEMENT AMONG PILOT PROGRAM PARTICIPANTS**".

SB 807 - FWA - MPS WPS.pdf
Uploaded by: Thomas Tompsett
Position: FWA

March 7, 2022

The Honorable Delores G. Kelley
Senate Finance Committee
3 East – Miller Senate Office Building
Annapolis, MD 21401

RE: Support – SB 807: Frederick County – Mental Health Law – Assisted Outpatient Treatment Pilot Program

Dear Chairman Kelley and Honorable Members of the Committee:

The Maryland Psychiatric Society (MPS) and the Washington Psychiatric Society (WPS) are state medical organizations whose physician members specialize in diagnosing, treating, and preventing mental illnesses, including substance use disorders. Formed more than sixty-five years ago to support the needs of psychiatrists and their patients, both organizations work to ensure available, accessible, and comprehensive quality mental health resources for all Maryland citizens; and strive through public education to dispel the stigma and discrimination of those suffering from a mental illness. As the district branches of the American Psychiatric Association covering the state of Maryland, MPS and WPS represent over 1000 psychiatrists and physicians currently in psychiatric training.

MPS/WPS support Senate Bill 807: Frederick County – Mental Health Law – Assisted Outpatient Treatment Pilot Program (SB 807). MPS/WPS have connected with the bill sponsors and proponents and have asked them to consider amendments, which we detail below, to better ensure the success of the assisted outpatient treatment (AOT) pilot program in Frederick County.

Throughout the U.S., there is a substantial population of persons with severe mental illness whose complex treatment and human service needs have not been met by community mental health programs. For many, their course is frequently complicated by non-adherence with treatment, and as a result, they often relapse, are hospitalized, or are incarcerated. These individuals typically interact with various human service agencies — substance use disorder treatment programs, civil and criminal courts, police, jails and prisons, emergency medical facilities, social welfare agencies, and public housing authorities. The pressing need to improve treatment adherence and community outcomes has led policymakers to focus on a range of legal mechanisms to improve treatment adherence, including AOT, which is the focus of the Frederick County pilot program under SB 807.

AOT is a civil court procedure wherein a judge orders a person with severe mental illness to adhere to an outpatient treatment plan designed to prevent relapse and dangerous deterioration. Persons appropriate for this intervention need ongoing psychiatric care owing to severe mental illness but who are unable or unwilling to engage in ongoing, voluntary, outpatient care. The goal of AOT is to mobilize appropriate treatment resources, enhance their effectiveness, and improve an individual's adherence to the treatment plan.

If systematically implemented and resourced, AOT can be a valuable tool to promote recovery through a program of intensive outpatient services designed to improve treatment adherence, reduce relapse and

re-hospitalization, and decrease the likelihood of dangerous behavior or severe deterioration among a subpopulation of patients with severe mental illness. Studies have shown that AOT is most effective when it includes a range of medication management and psychosocial services equivalent in intensity to those provided in assertive community treatment or intensive case management programs.

MPS/WPS believe that the following amendments would make the procedure leading to AOT easier to navigate and, in turn, create a stronger AOT pilot program:

Amendment 1

On page 2, in line 3 strike "UNDER THE SUPERVISION OF" and substitute "BY"

Amendment 2

On page 3, in line 3 after "ABLE" insert ", IF NECESSARY,".

On page 3, in line 22 after the semi-colon insert "AND"

On page 3, strike in their entirety lines 23 – 32 and substitute "(4) WITHIN THE PAST YEAR, RESPONDENT HAS BEEN CERTIFIED BY TWO PHYSICIANS AS MEETING CRITERIA FOR INVOLUNTARY HOSPITALIZATION BUT HAS NOT ADHERED TO INPATIENT TREATMENT RECOMMENDATIONS OR THE POST-DISCHARGE TREATMENT PLAN."

Amendment 3

On page 4, in line 21 after the third "THE" insert "TREATING".

Amendment 4

On page 8, strike beginning with "OR" in line 2 down through "TITLE" in line 3 and substitute "BUT MAY BE CONSIDERED AS EVIDENCE OF A RESPONDENT'S INABILITY TO BE TREATED IN A LESS RESTRICTIVE LEVEL OF CARE AS REQUIRED BY HEALTH GENERAL §10-617"

For all the reasons above, MPS/WPS ask the committee to adopt the amendments and give SB 807 a favorable report. If you have any questions with regard to this testimony, please feel free to contact Thomas Tompsett Jr. at tommy.tompsett@mdlobbyist.com.

Respectfully submitted,
The Maryland Psychiatric Society and the Washington Psychiatric Society
Legislative Action Committee

SB 807_Frederick County – Mental Health Law – Assi
Uploaded by: Adrienne Breidenstine
Position: UNF

Behavioral Health System Baltimore

March 8, 2022

Senate Finance Committee
TESTIMONY IN OPPOSITION
SB 807 Frederick County – Mental Health Law – Assisted Outpatient Treatment Pilot Program

Behavioral Health System Baltimore (BHSB) is a nonprofit organization that serves as the local behavioral health authority (LBHA) for Baltimore City. BHSB works to increase access to a full range of quality behavioral health (mental health and substance use) services and advocates for innovative approaches to prevention, early intervention, treatment and recovery for individuals, families, and communities. **Baltimore City represents nearly 35 percent of the public behavioral health system in Maryland, serving over 77,000 people with mental illness and substance use disorders (collectively referred to as "behavioral health") annually.**

BHSB opposes SB 807 Frederick County – Mental Health Law – Assisted Outpatient Treatment Pilot Program. This legislation would establish a preventive Assisted Outpatient Treatment (AOT) pilot program in Frederick County. The bill would allow for a court to order a Frederick County resident to adhere to an outpatient mental health treatment regimen.

Effective and responsive mental health systems preserve free choice to make medical decisions, listen carefully to consumers, and offer the type of services and support that consumers prefer. Involuntary commitment should be used judiciously, reserved only for individuals with serious mental illness that the Public Behavioral Health System (PBHS) has not engaged well in treatment. Often, these individuals end up involuntarily hospitalized or unnecessarily involved in the criminal justice system, resulting in poor overall health outcomes. For some, involuntary admission into community-based treatment can be an effective approach to engaging people into care.

Frederick County AOT Pilot Erodes Consumer Choice
Assisted Outpatient Treatment (AOT), or forced treatment, is only appropriate in the rare circumstance when there is a serious and immediate safety threat. Research shows that forced treatment, with medication has harmful side effects, and poor health outcomes for the people with mental illness. Further, AOT undermines the therapeutic alliance between the provider and consumer of mental health services. People subject to the AOT pilot proposed in this bill would lose the right to make decisions about the psychiatric medications they may be required to take, as SB 807 would implement a program that court orders a treatment plan designed solely by a mental health practitioner, not taking into account the wishes of the consumer, which goes against evidence-based best practice for treating people with mental illness.

Expand Outpatient Civil Commitment Program
In 2017, the General Assembly passed, and the Governor signed House Bill 1383: *Behavioral Health Administration—Outpatient Civil Commitment Pilot Program*. In 2018, BHSB began implementing Outpatient Civil Commitment (OCC) Pilot program in Baltimore City with approximately $370,000 in funding from the Behavioral Health Administration (BHA).

The OCC pilot program assists people who have not been well served by mental health services get connected and stay connected to care in the community. People with mental illness who are currently hospitalized, can be referred to the OCC program either involuntarily or voluntarily. Those who

participate in the OCC program receive peer support services for six months and those services will start before the individual is discharged from the hospital. A peer is an individual who has personal, lived experience with mental illness and/or substance use. They are an essential component of the OCC pilot because they are effective at providing consistent, persistent, intensive wrap-around support to help people stay connected to services in the community.

The innovative approach applied through the OCC pilot program is one that commits the services within the public behavioral health system (PBHS) to the person in the OCC program. With this person-centered approach to care, each participant in the program develops a program plan tailored to meet their unique health care needs and goals. To support the participant's program plan goals and ensure adherence to the program, peer recovery specialists meet with each participant several times a week. Regardless of the participant's level of engagement in the program, they are enrolled in OCC for the entire six months. The peer specialist will continue to make efforts to connect participants who may not be fully engaged, taking a "never give up" approach. As the local system manager, BHSB ensures that the hospital system and community-based behavioral health providers are accountable to the OCC program participant. This programmatic approach differs significantly from AOT, whereas AOT places the responsibility of treatment adherence solely on the individual and there is no accountability to ensure that the system is actually meeting that individual's needs.

Although an intentionally small program, OCC has been effective for the participant's it has served. Eighty percent (80%) of participants served by OCC have completed the six-month timeframe for the program and have remained encaged in peer services and have not been re-hospitalized. Since the OCC pilot program began, BHSB in partnership with BHA and community stakeholders have carefully expanded access to the program to gradually serve more people. This careful expansion was done intentionally, recognizing that OCC is one tool that can be used to better serve people with mental illness and is one that should be a tool of last resort. Pending MDH approval, the OCC regulations will be updated. These new regulations will expand the residency requirement to serve more people in a broader geographic area, ensure a prior admission in a state hospital does not prevent OCC eligibility, and include behavioral health emergency department visits in the eligibility criteria.

SB 807 would expand the use of involuntary commitment in fighting ways and undermine the existing OCC program that already exists in Maryland. BHSB urges the General Assembly to consider how to strengthen the existing involuntary commitment approach in Maryland and **urges the Senate Finance Committee to oppose SB 807 and provide an unfavorable report.**

Contact
Adrienne Breidenstine
Vice President, Policy & Communications
Adrienne.Breidenstine@bhsbaltimore.org
44-908-0503

MCF_Unfav_SB 807.pdf
Uploaded by: Ann Geddes
Position: UNF

SB 807 – Frederick County – Mental Health Law – Assisted Outpatient Treatment Pilot Program

Committee: Senate Finance
Date: March 8, 2022
POSITION: Oppose

The Maryland Coalition of Families: Maryland Coalition of Families (MCF) helps families who care for a loved one with behavioral health needs. Using personal experience, our staff provide one-to-one peer support and navigation services to family members with a child, youth or adult with a mental health, substance use or gambling issue.

We welcome the opportunity to testify in opposition to SB 807.

All of MCF family peer support staff have lived experience caring for a child or other loved one with mental health or substance use needs. Many family members oppose forced treatment, and value self-determination and the protection of civil liberties. What they want is for their loved one to have easy access to a broad array of quality, appealing, and readily available mental health treatments and community supports.

I also oppose forced treatment because, based on my family's personal experience, we found that it does not work.

Our son, whom we had committed a number of times as an adolescent, says that the experience of forced treatment forever turned him off from receiving mental health treatment. After turning 18 he refused all psychiatric treatment and medication. We must be aware that this aversion to receiving mental health services can frequently be the consequence of forced treatment.

Only very recently, as a 32 year old, did our son seek out mental health treatment and decide to begin to take medication. He says that the results have transformed his quality of life, and he wishes that he had engaged in treatment years ago. Forced treatment not only did not help to facilitate recovery, it impeded progress.

Assisted Outpatient Treatment is just a nice name for forced treatment. HB 1017 acknowledges that what they're really talking about is forced treatment, and anticipates that the person will not want to corporate, with the following verbiage:

"If the respondent does not consent to the examination, or has not appeared at the hearing after reasonable efforts to secure the respondent's appearance, and the court finds probable cause to believe that the allegations in the petition are true, the court may direct that the respondent be taken into custody and transported to an appropriate facility for examination by a psychiatrist."

And since you can't force a person to engage in talk therapy, essentially the main impact of the bill is to allow for forced medication. This is especially troubling since people have good reasons for refusing to take medication – extremely unpleasant side effects are common with many psychotropic medications, and some can cause life-long debilitating side effects. All individuals should have the freedom to decide what is put in their body.

Maryland has at hand good alternatives to forced treatment. Assertive Community Treatment Teams can be very effective at engaging hard-to-reach populations. In addition, there is a genuine Assisted Outpatient Treatment Program in Baltimore City, and advocates have been working for two years to improve the program by expanding the population that can be served. Unfortunately, the Maryland Department of Health and the Behavioral Health Administration have not moved on implementing new regulations, so the program continues to flounder. The legislature could do something about this, rather than vote to implement a harmful pilot program in Frederick County such as the one SB 807 is proposing.

A final point – in this COVID world the need and demand for behavioral health services is greater than ever before. There are lengthy waiting lists for people who **want** mental health treatment. Putting into place a forced treatment program will have the unintended consequence of pushing people who want treatment further to the back of the line.

There are a number of good reasons to vote against SB 807. We ask that you give the bill an unfavorable report.

Contact: Ann Geddes
Director of Public Policy
The Maryland Coalition of Families
10632 Little Patuxent Parkway, Suite 234
Columbia, Maryland 21044
Phone: 443-926-3396
ageddes@mdcoalition.org

senatetestimony.pdf
Uploaded by: April Sandi
Position: UNF

Date: March 7, 2022

ToSenator Delores G. Kelley, Chair, and
Senator Brian J. Feldman, Vice Chair
Senate Finance Committee

From: April Sandi, MSW, LMSW, Founder/CEO, Global Necessity Corporation

april@globalnecessity.org / 240-578-9411

Frederick County Maryland

Re: Senate Bill 807 – Frederick County – Mental Health Law – Assisted Outpatient Treatment (AOT) Pilot Program

Treatment (AOT) Pilot Program

Position: Against

Testimony:

Thank you, Health and Government Operations members for your dedicated service to improving access and equity in behavioral health care for all Marylanders.I am writing today to share an informational perspective on Senate Bill 807 , which would establish an “Assisted Outpatient Treatment (AOT)” outpatient civil commitment pilot program in FrederickCounty.My position on this bill is informed by my service as a trauma therapist and social workerproviding therapy to children and families in a variety of agencies, as a previous foster caresocial worker for DHS, a therapist for the Department of Juvenile Services, a substance abuse counselor, a school social worker in Baltimore City Schools and the founder of Global Necessity Corporation, a non profit organization that does street outreach to the homeless andcommunities of disparity in Frederick County, Maryland. Our website is www.globalnecessity.org.

Global Necessity Corporation is located in downtown Frederick and is

contracted to provide mental health case management to On Our Own of Frederick County, Justice Jobs, and the Asian American Center of Frederick. Not only do we provide mental health case management, also work with the Frederick County Health Department and Sheppard Pratt to refer folks to Residential Rehabilitation Programs and drug and alcohol rehabilitation. I am very concerned about the Senate Bill 807 “Assisted Outpatient Treatment Pilot Program”(AOT). As a mental health clinician who has worked with a variety of psychiatric disorders, I am concerned about the checks and balances and potential legal issues that this bill could cause. There are already procedures in place when someone is having a psychiatric emergency. I believe that the passing of this bill could impose on civil liberties and open a variety of problems to add to an already broken legal system in family courts as well as a path for folks to abuse the power that the passing of this bill could provide. I am a community mediator and work with families establishing custody in Baltimore County and can see in a variety of instances how this can be misused by folks trying to obtain full custody of their children in DHS cases and in family court. I beg of you to make absolutely certain that the appropriate checks and balances are considered for all stakeholders. Additionally, I am very concerned about providers taking advantage of this bill for financial gain. What is the vetting and oversight for providers that are making these decisions? What is the process if these decisions cause undue harm and hardship to the folks affected by this bill? Are there procedures in place to address these issues? In Summary, I ask that additional time is spent to look at the impact and the necessity of the AOT Pilot Program and examine if there can be additional adjustments to current laws so that they can be adjusted to fill in gaps in service and process instead of passing this AOT Pilot Program. I see this bill to be potentially harmful in a variety of ways that I would like to be examined. Global Necessity would be more than happy to participate in this process to insure that folks are in control of their own mental health and recovery. I implore the committee to consider these

concerns and questions.

Senate written testimony final.letterhead.pdf
Uploaded by: Carroll McCabe
Position: UNF

PAUL DEWOLFE
PUBLIC DEFENDER
KEITH LOTRIDGE
DEPUTY PUBLIC DEFENDER
MELISSA ROTHSTEIN
DIRECTOR OF POLICY AND DEVELOPMENT
KRYSTAL WILLIAMS
DIRECTOR OF GOVERNMENT RELATIONS DIVISION
ELIZABETH HILLIARD
ASSISTANT DIRECTOR OF GOVERNMENT RELATIONS DIVISION

POSITION ON PROPOSED LEGISLATION

BILL: SB 807 Frederick County – Mental Health Law – Assisted Outpatient Treatment Pilot Program

FROM: Carroll McCabe, Mental Health Division Chief Attorney, Maryland Office of the Public Defender

POSITION: Unfavorable

DATE: 3/7/2022

The Maryland Office of the Public Defender respectfully requests that the Committee issue an unfavorable report on House Bill 1017. This bill establishes a process to impose forcible outpatient treatment on individuals who do not meet the standard for involuntary hospitalization, and in doing so, violates constitutional protections and relies on ineffective measures to improve outcomes for people with mental illness.

Bodily integrity is among the most fundamental constitutional rights, and the right to refuse treatment is a tenet of our medical and mental health ethos with well-established constitutional protections. See, e.g., U.S. Const. Amends. 5, 14*; O'Connor v. Donaldson*, 422 U.S. 563 (1975); *Addington v. Texas*, 441 U.S. 418 (1979); *Vitek v. Jones*, 445 U.S. 480 (1985); *Mercer v. Thomas Finan Center*, 476 Md. 652 (2021). The limited, narrowly tailored exception to the prohibition on involuntary psychiatric treatment is if, by clear and convincing evidence, the person has a mental illness and is an immediate danger to themselves or others. Even when the standard for involuntary hospitalization is met, the additional liberty infringement of forced medication requires further protections, and both involuntary hospitalization and forced medication are subject to ongoing scrutiny to limit their duration to the shortest possible period and in the least restrictive setting.

HB1017 would authorize forced treatment without any of the necessary requirements or limitations. The criteria proposed are speculative and vague: "The Respondent, if not adherent to outpatient treatment, is likely to deteriorate to the extent that the Respondent will come to present a danger to the life or safety of the Respondent or others." No current danger need exist. Rather, it merely requires judges to speculate about future dangerousness. HB1017 also lacks sufficient due process to meet constitutional muster: the Court can order forced outpatient treatment for up to one year, and the Petitioner can request an extension at the end of the year for another year. There is no mention of any sort of hearing on the requested extension. Failure to comply can result in involuntarily commitment to a psychiatric hospital, as the statute permits a

psychiatrist to consider the Respondent's failure to comply as pertinent information in determining whether a Petition for Emergency Evaluation is warranted.

In addition to violating constitutional principles, speculative determinations about potential future dangerousness will exacerbate racial disparities. Consistent with national studies, data from my Divisions' representation at involuntary commitment hearings indicate that Black Marylanders are more likely to be retained at as compared to white peers. Studies of involuntary outpatient civil commitment programs in New York and North Carolina revealed similar racial disparities in the implementation of their programs.

Moreover, HB 1017 allows any interested party over the age of 18 to file a Petition asking the court to order forced outpatient psychiatric treatment for another individual. Vague and speculative criteria make it easier for "interested parties over the age of 18" to successfully litigate false Petitions. In the emergency petition and involuntary commitment context, we regularly see petitions that are filed for malicious purposes in domestic violence cases, divorce and custody battles, and where a family member wants to take control of another family member's money. Individuals with developmental disabilities, brain injuries, and physical disabilities are also more likely to be faced with coercive and involuntary treatment, due to stigma and the lack of adequate community support services.

Beyond the legal concerns, forced treatment simply does not work. Multiple studies provide strong evidence of the efficacy of intensive community mental health services, not coercion. Mandated treatment is not a substitute for quality services and cannot overcome inadequacies in an under resourced state mental health system. In Maryland, there are currently inadequate treatment resources to meet the needs of people willing to participate voluntarily in mental health treatment. Allocating scarce resources to provide intensive mental health services to individuals mandated to participate in outpatient civil commitment will divert resources from significant portions of the population who voluntarily seek mental health services. People who cannot access treatment are at a higher risk for inpatient hospitalization.

While HB1017 does not make clear who will fund the mandated outpatient treatment, it is a costly endeavor. The funds required here would be better spent developing robust community treatment options and making them more available to individuals in urban and rural areas. My office represents clients released from inpatient psychiatric units with a "discharge plan" that consists of a bus token and a list of shelters. Resources would be better served dedicated to a proper continuum of care for these individuals.

Deputy Public Defender Keith Lotridge has submitted separate testimony on this bill addressing in greater detail the resource infeasibility for OPD to provide the representation called for here. The Mental Health Division, which I oversee, does not have the staff to represent clients in forced outpatient civil commitment cases.

The process proposed is also unrealistic for any attorney to provide effective assistance of counsel. The hearing is to be held not later than 3 days after the Petition is received by the court, with a limited right to postponement. It is impossible to hire an expert, obtain and review the

client's inpatient and outpatient medical records and interview collateral sources within that time frame.

The Bazelon Center for Mental Health Law has described involuntary outpatient services as "a dangerous formalization of coercion within the community mental health system." It diverts resources away from effective services, undermines the treatment provider-consumer relationship, and with the threat of forced medication with harmful side effects can deter people from voluntarily seeking treatment.

For these reasons, the Maryland Office of the Public Defender urges this Committee to issue an unfavorable report on HB 1017.

Submitted by: Government Relations Division of the Maryland Office of the Public Defender.
Authored by: Carroll McCabe, Director of Mental Health Division, carroll.mccabe1@maryland.gov, 410-767-9853.

SB0807 AOT pilot.pdf
Uploaded by: Dan Martin
Position: UNF

mhamd
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Senate Bill 807 Frederick County – Mental Health Law –
Assisted Outpatient Treatment Pilot Program
Finance Committee
March 8, 2022
Position: OPPOSE

The Mental Health Association of Maryland is a nonprofit education and advocacy organization that brings together consumers, families, clinicians, advocates and concerned citizens for unified action in all aspects of mental health and substance use disorders (collectively referred to as behavioral health). We appreciate the opportunity to provide this testimony in opposition to Senate Bill 807.

SB 807 would establish a preventive Assisted Outpatient Treatment (AOT) pilot program in Frederick County. The bill would allow for a court to order a Frederick County resident to adhere to an outpatient mental health treatment regimen.

AOT is a form of mandatory community treatment. These types of programs are known by a variety of titles that are frequently used interchangeably, including "Assisted Outpatient Treatment," "Outpatient Civil Commitment," "Involuntary Outpatient Treatment," and "Compulsory Treatment Orders." These titles, however, do not convey the criteria or requirements of particular laws that have been enacted across the country, which fall under one of three categories:

(1) *Less Restrictive Alternative to Inpatient Admission* – Over 30 states permit a court or administrative hearing officer to order an individual to adhere to community treatment *in lieu of* involuntary inpatient admission. This type of outpatient civil commitment is restricted to situations in which it has already been proven by clear and convincing evidence that the individual meets the inpatient commitment criteria, i.e., they are a danger to self or others.

(2) *Conditional Release from Inpatient Hospitalization* – At least 40 states permit mandated community treatment as a condition of discharge for persons who have been involuntarily admitted on an inpatient basis.

(3) *Preventive Outpatient Commitment* – Less than half the states[1] permit mandated community treatment for individuals who do not currently meet the inpatient commitment criteria but are believed to need mental health treatment to prevent 'likely' future hospitalizations.

[1] Grading the States: An Analysis of Involuntary Psychiatric Treatment Laws. Treatment Advocacy Center. September 2020.

Prevalence of AOT

Proponents of AOT assert repeatedly that Maryland is one of just a few states without the program. However, what those proponents fail to disclose is that – of the states that have 'AOT' – a minority of those states have laws that actually authorize mandatory community treatment for individuals who do not meet inpatient commitment criteria. The vast majority of states only authorize mandatory outpatient commitment *for individuals who already meet the inpatient commitment criteria*, making it a truly less restrictive alternative to inpatient hospital care.

Cost and Effect on Voluntary Services

Regardless of the specific type of outpatient civil commitment law, however, few states use it widely. It appears that only New York has developed a comprehensive program to implement its law. Undoubtedly, cost is a major factor in states' decision not to use the program. On top of $30+ million per year in administrative support costs, New York spends approximately $125+ million annually in additional funding for enhanced community services to serve those on AOT as well as those seeking services voluntarily. Yet despite this annual influx of funding, New York experienced a 50% reduction in the availability of voluntary intensive case management and assertive community treatment (ACT) services statewide during the first three years of implementation.[2] Without significant additional funding attached to any AOT proposal, it will either be rarely used or it will result in "queue jumping," in which people court-ordered to treatment will be prioritized for intensive services at the expense of those who seek such services voluntarily.

Disparities in Implementation

There is also evidence of racial disparities in the implementation of New York's AOT law, with racial minorities finding themselves at a much higher risk for being court-ordered into treatment:

	Race/Ethnicity of Individuals Subject to NY AOT Orders[3]	New York Total Population Race/Ethnicity Data[4]
Black	38%	18%
Hispanic	26%	19%
White	31%	55%

These disparities mirror national disparities related to mental health diagnosis and inpatient commitment. Black individuals are up to four times more likely than whites to receive a schizophrenia diagnosis – even after controlling for all other demographic variables[5] – and more than twice as likely to be involuntarily committed to state psychiatric hospitals.[6]

[2] Swartz, M., Swanson, J., Steadman, H., Robbins, P., Monahan, J., New York State Assisted Outpatient Treatment Program Evaluation (June 30, 2009), p. 48.
[3] New York State Office of Mental Health, Assisted Outpatient Treatment Reports, Program Statistics, current through March 1, 2022.
[4] United States Census Bureau. https://www.census.gov/quickfacts/NY
[5] Barnes, A., Race, schizophrenia, and admission to state psychiatric hospitals (2004), Administration and Policy in Mental Health, Vol.31, No.3; Barnes, A., Race and Hospital Diagnosis of schizophrenia and mood disorders (2008), Social Work, Volume 53, Number 1.
[6] Lewis, A., Davis, K., Zhang, N., Admissions of African Americans to state psychiatric hospitals, International Journal of Public Policy (2010). Volume 6, Number 3-4, pp. 219-236; Lawson, W.B., Heplar, H., Holladay,J., Cuffel, B. (1994) Race as a factor in

Medication Limitations

People subject to AOT lose the right to make decisions about the psychiatric medications they may be required to take. This is of particular concern given the potential short- and long-term side effects and the often-limited effectiveness of currently available treatments. Substantial treatment progress occurred in the 1980s to 1990s as a dizzying number of new medications appeared on the market, but a cure for mental illness remains elusive and the pipeline of new medications has gone dry. There is growing acknowledgement of the limited effectiveness of many existing medications, a slowly rising chorus of concern about the long-term impact of psychotropic medications, and renewed attention to alternative treatment approaches. It is unconscionable that people under AOT could be forced to take medications that may ultimately do more harm than good.

Anosognosia and Refusal of Treatment

AOT proponents argue that some individuals lack the capacity to understand their illness and must be forced into treatment. They claim this is due to a neurological condition known as anosognosia. Aside from the fact that this assertion effectively discredits in a single word any legitimate and informed concerns the person may have, there is no way to test for anosognosia so there is no way to target this population for mandatory treatment.

No Evidence of AOT Effectiveness

Lastly, there is slim evidence that AOT is as effective as its proponents' claim. Six independent systematic reviews of the body of involuntary outpatient commitment research found little to no evidence that people court ordered to community treatment have better outcomes than those receiving services voluntarily. The reviews found that, (1) outpatient commitment orders did not result in a greater reduction in hospital admissions[7]; (2) outpatient commitment orders have no significant effect on hospitalization or community service use[8]; (3) there is very little evidence to suggest outpatient commitment orders are associated with any positive outcomes[9]; (4) evidence that outpatient commitment reduces admissions or bed days is very limited[10]; (5) there is no significant difference in service use, social functioning or quality of life compared to standard care[11]; and (6) it is not proven that coerced treatment works better than voluntary treatment.[12]

For the reasons outlined above, MHAMD opposes SB 807 and urges an unfavorable report.

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inpatient and outpatient admissions and diagnosis. Hospital and community psychiatricy, 45, 72-74; Lindsey, K.P.& Paul, G.L. (1989) Involuntary commitments to public mental institutions: (2010), Davis (2010).

[7] Kisely SR, Hall K, Community Health Systems: An updated meta-analysis of randomized controlled evidence for the effectiveness of community treatment orders (March 2014). Canadian Psychiatric Association.

[8] Maughan D, Molodynski A, Rugkåsa J, Burns T. A systematic review of the effect of community treatment orders on service use. Soc Psychiatry Psychiatr Epidemiol. 2014

[9] Churchill, Rachel & Owen, Gareth & Singh, Swaran & Hotopf, Matthew. (2007). International Experience of Using Community Treatment Orders.

[10] Kisely, S.R, Campbell, L.A, Scott, A (2007). Randomised and non-randomised evidence for the effect of compulsory community and involuntary outpatient treatment on mental health service use. Psychol Med 37(1), 3-14.

[11] Kisely S.R, Campbell L.A, Preston N.J. Compulsory community and involuntary outpatient treatment for people with severe mental disorders. Cochrane Database Syst. Rev. 3:CL004408. The review was updated in 2011. Cochrane Database Syst. Rev. 2.

[12] Ridgely, M. Susan, John Borum, and John Petrila, The Effectiveness of Involuntary Outpatient Treatment: Empirical Evidence and the Experience of Eight States. Santa Monica, CA: RAND Corporation, 2001.

SB807 and HB1017 written testimony-Roskes.2.pdf
Uploaded by: Erik Roskes
Position: UNF

March 6, 2022

To: Senate Finance Committee
House Health and Government Operations Committee

Re: SB807
HB1017

There is so much wrong with these cross-filed bills, it is hard to know where to start.

Civil commitment in Maryland operates under administrative law, but this bill would place involuntary outpatient commitment, a purportedly less-restrictive intervention, into the realm of the judiciary. This disjunction sets up obvious procedural problems. Unlike the pilot in Baltimore City, the proposed model in Frederick County would be completely divorced from other involuntary mental health interventions.

There is no defined standard to be applied, nor a time horizon for the prediction that a person will become dangerous, in 10-6A-05(4). Predictions of dangerous are notoriously difficult, especially over periods longer than a few days, and should not be the basis of a year-long commitment.

Similarly, in 10-6A-05(5), there is no definition of "recent" history. In states that use involuntary outpatient commitment, there is generally a timeframe during which a respondent must demonstrate their unwillingness to engage in voluntary treatment.

In 10-6A-06(B)(1), it is unclear why a person under guardianship should ever need involuntary outpatient treatment, when the guardian is able to consent to treatment even over his/her ward's objection. In fact, involuntarily treating a ward over the guardian's objection would appear to gut guardianship law and the role of the guardian in making decisions in the ward's best interest. Similarly, in the next paragraph, involuntarily treating someone in a manner inconsistent with their previously executed advance directive renders that advance directive valueless and will cause individuals to be less likely to execute such advance directives.

I have numerous concerns about the timeframes in 10-6A-07. First, in (A)(2) there are real practical limitations of getting into court within 3 business days. Even involuntary outpatient commitment allows for 10 days for a hearing. But of more concern to me is that the various postponements could result in a haring not occurring until as long as 30 days after the initial petition – at which point any prediction of risk is of low value and validity.

In 10-6A-07(D)(3)(I), it is not clear what would constitute "reasonable efforts" or what an "appropriate facility" is. I have great concerns that individuals will be placed in jails, especially concerning as patients in need of inpatient treatment have trouble accessing inpatient beds. Given that these individuals do NOT require inpatient treatment (otherwise, they would be in the inpatient commitment pipeline), there are resource issues here, as well as potential federal or state constitutional issues attendant to such a detention.

Involuntary outpatient commitment is not a solution needed in Maryland. What is needed is a well-funded, broad based community mental health system that offers high quality treatment and rehabilitative services at varying levels of intensity that are accessible and attractive to patients.

Thank you for considering my comments. Please note that while I am a member of the Maryland Psychiatric Society, and an employee of the MSDE, these opinions are my own and may not reflect the views of these or any other organizations with which I am affiliated.

Respectfully,

Erik Roskes, MD
General and Forensic Psychiatrist

SB807_DRM_unf.pdf
Uploaded by: Karen Foxman
Position: UNF

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 Bill 807-Frederick County- Mental Health Law-Assisted Outpatient Treatment Pilot Program
Finance Committee
March 8, 2022
Position: Unfavorable

Disability Rights Maryland (DRM) is Maryland's designated Protection & Advocacy agency, and is federally mandated to defend and advance the civil rights of individuals with disabilities. In particular, DRM supports the rights of individuals with disabilities to receive appropriate supports and services to live safe, meaningful, and productive lives in their communities. DRM supports the rights of individuals with disabilities to actively participate in their treatment care plan. DRM opposes Senate Bill 807, which will establish an Assisted Outpatient Treatment (AOT) pilot program in Frederick County, and would allow a court to order Frederick County residents to adhere to an outpatient mental health treatment regimen based on the individual's likelihood of "deterioration," thereby forcing treatment, violating the civil rights of those with psychiatric disabilities, and creating disparities in treatment that will impact people of color.

Mandating involuntary outpatient commitment is an infringement on an individual's constitutional rights. Aspects of SB 807 are particularly concerning. SB 807 would force an individual living in the community to submit to a psychological examination. While the proposed bill requires "clear and convincing evidence" for the court to mandate that an individual adhere to the AOT, the bill requires only "probable cause" for an individual to be "taken into custody and transported to an appropriate facility to be examined by a psychiatrist if they fail to show up for the psychological examination that is required for the AOT." This standard could potentially violate the civil rights of individuals with psychiatric disabilities, and will increase disparate treatment and harm to people of color.

The process in SB 807 for creating the individual's mandated treatment plan is equally concerning. SB 807 states that the respondent "shall be given a reasonable opportunity to participate in the development of the treatment plan," but fails to provide a meaningful way for the affected individual to contribute to the plan. SB 807 further states that "types of medication to be taken shall be identified, although the specific medication or doses need not be identified." This assumption of medication as a course of treatment is alarming, given an individual's right to choose medication or refuse medication, including type and dosage, considering the long-lasting and permanent harmful side effects of many psychiatric medications. Pursuant to the Due Process Clause of the Fourteenth Amendment, an individual has a constitutionally protected liberty interest in being free from forced administration of psychiatric medication. SB 807 raises significant constitutional questions regarding coercive medication under an AOT program, since an individual could be subject to an Emergency Petition solely for failing to follow the court-ordered treatment plan, including any medication specified by such plan.

SB 807 also permits an individual's mental health advance directive to be disregarded. The bill proscribes that an individual's advanced directive "shall be honored… unless considered contrary to the best interest of the respondent by the psychiatrist." This bill could take away an individual's ability to have a say in their psychiatric care that is already guaranteed in Maryland law, through forced participation in the AOT. This right should not be abridged solely because a person is diagnosed with a mental health disability.

In his State of the Union address last week, President Biden called for parity between mental health and physical health. SB 807 only exacerbates the lack of parity by forcing treatment for those with psychiatric disabilities in the community.

The legislature must also consider at what point an individual living in the community with a psychiatric disability will be free from submitting to the AOT and forced treatment. SB 807 as drafted exposes a person living in the community with a psychiatric disability, who is not a danger to themselves or others, to the constant risk of being subjected to forced treatment and continual commitment to this program.

Research and data on outpatient commitment show it confers no additional benefit beyond access to effective community services. The threat of forced treatment, with medication that has harmful side effects, often deters individuals from voluntarily seeking treatment. A recent study involving individuals with schizophrenia in mandatory community programs, published in European Psychiatry, concluded that patients who are more engaged in their treatment decisions exhibit improved treatment outcomes, that patient participation includes being involved in decision making or expressing attitudes about different treatment options and that an increased emphasis on collaborative care has the potential to increase the participation of patients in their own treatment and improve their autonomy.[1] Finally, as stated throughout this testimony, mandating treatment in the community without imminent health and safety concerns raises serious constitutional concerns.

Instead of passing legislation that would expand coercive treatment in Maryland, we urge you to prioritize developing and funding additional community mental health and behavioral support services, establishing treatment alternatives that are trauma-informed, culturally appropriate, and which utilize peers and evidence-based treatment modalities to meet individuals where they are. While targeting individuals with mental health disabilities, in practice this bill would also negatively impact individuals with developmental disabilities, those with traumatic brain injuries, and others with physical and behavioral health disabilities, as these individuals might find themselves targeted by this bill.

DRM encourages the Committee to consider the negative impact of this bill on the disability community in Maryland. **Disability Rights Maryland opposes Senate Bill 807and urges an unfavorable report.** For more information, please contact Karen Foxman, Esq., at (410) 727-6352 ext. 2477 or KarenF@DisabilityRightsMD.org.

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[1] Joanne E. Plahouras et al., Experiences with legally mandated treatment in patients with schizophrenia: A systematic review of qualitative studies, 63 European Psychiatry e39 (2020), available at https://www.cambridge.org/core/journals/european-psychiatry/article/experiences-with-legally-mandated-treatment-in-patients-with-schizophrenia-a-systematic-review-of-qualitative-studies/98603E48CF32F7B2DF0CE9C082EB6155

OOOMD - 2022 SB807 - Frederick AOT Pilot - Written

Uploaded by: Katie Rouse

Position: UNF

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WRITTEN TESTIMONY IN OPPOSITION OF
Senate Bill 807: Frederick County – Mental Health Law – Assisted Outpatient Treatment Pilot Program
Finance Committee, Senate
March 8, 2022

Thank you Chair Kelley, Vice-Chair Feldman, and committee members for your dedication to improving the quality and accessibility of healthcare services for all Marylanders. On Our Own of Maryland is a statewide behavioral health (BH) education and advocacy organization, operating for 30 years by and for people with lived experience of mental health and substance use challenges. Our network of 20+ affiliated, peer-operated Wellness & Recovery Centers provide free, voluntary behavioral health recovery support services to 5,000+ community members across Maryland.

On Our Own of Maryland strongly opposes SB807, which would establish an "Assisted Outpatient Treatment (AOT)" preventive outpatient civil commitment pilot program in Frederick County. While not the intent of the bill or its sponsors, the model proposed ignores the reality of current gaps and barriers in our BH system, would injure people with behavioral health challenges, and may impede the expansion of effective, evidence-based BH practices such as Assertive Community Treatment, Mobile Crisis Teams, and Peer Support that are already working well in our state.

We need services, not sentences: There is a dire need to increase access and decrease barriers to services for Marylanders living with BH challenges, as recognized in several other bills currently under consideration.[1] Introducing a judicial process not only does nothing to create appropriate and accessible services out of thin air, but adds serious consequences for non-compliance. AOT's unspoken expectations are that the individual, with or without a dedicated supporter, will follow complex rules and requirements even if they are effectively absent from the decision-making process; have time, transportation, and financial resources for multiple service appointments and hearings; and somehow successfully navigate into programs despite well-established BH service network inadequacies. Especially for individuals reliant on public services, added administrative burdens for overworked case managers are likely to result in poorly managed care and increased stigma against individuals enrolled in AOT.

We need to be heard, not handcuffed: Far from a 'lack of insight', individuals have legitimate and rational reasons for not wanting to participate in certain behavioral health services, often based on prior experiences: intense negative side effects from medications, disrespectful or unhelpful treatment by providers, or dehumanizing restraint, seclusion, or even assault during crisis or hospitalizations. Involuntary interventions create fear and distrust, and the significant stigma and trauma of forced treatment has serious long-term consequences for individuals' health and wellbeing:

- "I was Emergency Petitioned at 19 years old because I refused to take medication [that caused troubling side effects]. I did not scream, curse, or be disrespectful; I did not threaten to do anything to myself or anyone else. The therapist claimed I would become a 'danger to myself and others,' even though my mood was good for once. The police slammed me into the car door and handcuffed me as tight as possible, groped and laughed at me, as I heard my mother's sobbing and begging behind me. In the hospital, I experienced assault, seclusion, and humiliation. I still have flashbacks, nightmares, and horrible, intrusive memories… it will likely haunt me for the rest of my life. I have become scared of the police, wary of my neighbors, lost trust in my friends, and I isolate much more now."
- "I've been receiving psychiatric care since I was 17. There were always times when my ability to make decisions was disregarded. There were multiple occasions where I was forced to remove my clothing in front of male guards and be forcibly medicated, without my consent or my knowledge of what the medication was. [During one hospitalization] they wanted to put me on lithium. I have a pre-existing thyroid condition and my psychiatrist had never prescribed it to me because of this. I declined and reminded them that I was not supposed to take Lithium…staff informed me that my options were to take Lithium or to do electroshock

[1] Such as 2022 Senate Bills 12, 94, 241, 275, 323, 394, 398, 407, 440, 460, 559, 637, 659, 707, and others

treatment. I was exhausted…and agreed to take the Lithium. After release, my psychiatrist immediately took me off it because of how it would affect my thyroid."

- "The police came to my house [for a wellness check after speaking about suicide to a friend]. They handcuffed me roughly. I had no shoes on when they took me outside to the car. At the hospital, they put me in a small room with two other handcuffed men. I was afraid. The staff ignored us. They strapped me to a stretcher and took me to another hospital. I was in restraints for at least 24, maybe 32 hours. They treated me like I was a criminal or a wild animal. It was horrible and embarrassing."

The absence of the individual's voice in their own treatment decisions under this proposed AOT program is counterproductive and unethical. Self-report of effects and experiences are crucial for safety and quality of care, and require a trusting relationship between the peer and their provider(s). Not only does this bill not include any assessment or accountability mechanism regarding the personal experiences or outcomes of those enrolled, it codifies multiple opportunities for disregarding the input of the individual, up to and including their literal absence. Ignoring Psychiatric Advance Directives is particularly troubling, as PADs are often used to communicate prior negative experiences with specific medications or provider institutions, as well as effective self-help strategies.

We need what helps, not what harms: At least 6 large systematic research literature reviews show very limited to no evidence that mandating outpatient treatment reduces hospital readmissions[2,3] or improves social functioning or psychiatric symptoms.[4,5,6] In fact, over a 12-month period, there was no difference in hospital readmission rates for those who were mandated into treatment when compared to those who received it voluntarily.[7]

It is the availability of appropriate, accessible services – not a loved one's concern, a psychiatrist's prediction, or a judge's order – that determines who receives care in the community, institutionalization, incarceration, or nothing.

What helps people enter recovery is being seen, heard, respected, trusted, and supported. Community-based, person-centered, trauma-informed services like Assertive Community Treatment (ACT), Mobile Crisis Teams, and Peer Support have been shown to improve outcomes in individuals living with severe mental health challenges. ACT teams in particular, which meet people where they are in the community, have been shown to help reduce hospital readmissions and length of stay,[8,9] and improve psychiatric symptoms.[10] The On Our Own affiliated network has demonstrated for decades that collaborative, choice-based peer support works for people with serious BH challenges. All of these services are available, albeit limited, in Frederick County; their enhancement and expansion would likely result in a far greater increase of the types of positive outcomes this AOT program seeks to achieve.

Forced treatment is inherently harmful, and should only be used as the very last resort in situations with significant safety concerns. Maryland has well-established criteria and protocols for involuntary interventions, but the AOT program described by this bill would proactively harm and unnecessarily infringe on the civil rights of people with BH challenges without just cause. **We strongly urge an unfavorable report on SB 807. Thank you for hearing us.**

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[2] Maughan, Daniel & Molodynski, Andrew & Rugkåsa, Jorun & Burns, Tom. (2013). A systematic review of the effect of community treatment orders on service use. Social psychiatry and psychiatric epidemiology. 49. 10.1007/s00127-013-0781-0.

[3] Kisely, S.R, Campbell, L.A, Scott, A (2007). Randomized and non-randomised evidence for the effect of compulsory community and involuntary outpatient treatment on mental health service use. Psychol Med 37(1), 3-14.

[4] Kisely SR, Hall K, Community Health Systems: An updated meta-analysis of randomized controlled evidence for the effectiveness of community treatment orders (March 2014). Canadian Psychiatric Association.

[5] Kisely S.R, Campbell L.A, Preston N.J. Compulsory community and involuntary outpatient treatment for people with severe mental disorders. Cochrane Database Syst. Rev. 3:CL004408. The review was updated in 2011. Cochrane Database Syst. Rev. 2.

[6] Ridgely, M. Susan, John Borum, and John Petrila, The Effectiveness of Involuntary Outpatient Treatment: Empirical Evidence and the Experience of Eight States. Santa Monica, CA: RAND Corporation, 2001. https://www.rand.org/pubs/monograph_reports/MR1340.html.

[7] Ibid

[8] Vijverberg R, Ferdinand R, Beekman A, van Meijel B. The effect of youth assertive community treatment: a systematic PRISMA review. BMC Psychiatry. 2017 Aug;17(1):284. DOI: 10.1186/s12888-017-1446-4. PMID: 28768492; PMCID: PMC5541424.

[9] Ponka D, Agbata E, Kendall C, Stergiopoulos V, Mendonca O, et al. (2020) The effectiveness of case management interventions for the homeless, vulnerably housed and persons with lived experience: A systematic review. PLOS ONE 15(4): e0230896.

[10] Ibid

OPD Unfavorable SB 807-- Lotridge.pdf
Uploaded by: Keith Lotridge
Position: UNF

PAUL DEWOLFE
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KEITH LOTRIDGE
DEPUTY PUBLIC DEFENDER
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KRYSTAL WILLIAMS
DIRECTOR OF GOVERNMENT RELATIONS DIVISION
ELIZABETH HILLIARD
ASSISTANT DIRECTOR OF GOVERNMENT RELATIONS DIVISION

POSITION ON PROPOSED LEGISLATION

BILL: SB 807 Frederick County – Mental Health Law – Assisted Outpatient Treatment Pilot Program

FROM: Keith Lotridge, Deputy Public Defender, Maryland Office of the Public Defender

POSITION: Unfavorable

DATE: 3/7/2022

The Maryland Office of the Public Defender respectfully requests that the Committee issue an unfavorable report on Senate Bill 807.

OPD's Mental Health division Chief, Carroll McCabe, has provided separate testimony to detail the significant substantive concerns that we have with this bill. The constitutional violations she identified on their own would make it impossible for us to represent individuals in these proceedings in the manner intended by the drafters. Putting that aside, however, my testimony will focus on the cost impact of the bill, particularly with respect to the reliance on public defenders for challenging involuntary treatment orders for people who cannot afford a private lawyer.

On February 22, 2022, an amendment to SB 807 was prepared that amends the authorizing statute for public defender services to include representation of individuals for whom a judicial order to involuntary outpatient services may be issued. There is no discussion in the bill for how these services will be funded, and our fiscal note information predates this amendment. For our office alone, additional attorneys, experts, social workers and support staff would be required, costing hundreds of thousands of dollars.

OPD is already facing a significant gap in needed resources, and this bill will further overburden our already overworked Mental Health Division (MHD). MHD attorneys currently maintain caseloads well above recommended standards. Last year, eight attorneys represented clients in 9,600 involuntary civil commitment cases as well as hearings held at least once per week in approximately 33 hospitals around the State. Our current resources simply cannot take on this additional work.

A similar pilot project was established in Baltimore City in 2017, without including public defenders or seeking to amend our authorizing statute. That program highlights the high cost for little to no benefit for involuntary outpatient services. A recent briefing provided that, since it began approximately 3 years ago, the Baltimore City program has served approximately 14 clients, eleven of whom joined the program voluntarily. No information was provided to indicate whether the 3 involuntary patients successfully completed the program. A significant sum of money was spent to provide the participants with two full-time peer specialists, one part-time clinical supervisor, a consumer quality team, attorney representation for participants, and one monitor to oversee participants' engagement in services. Additional investment is needed to develop and maintain this level of infrastructure, particularly if it intends to grow to statewide.

Maryland taxpayers would get more "bang for their buck" if that money was spent on providing substantive mental health treatment in the community. There is a real need for robust community treatment options, and the funds proposed to be spent here would be better utilized by developing robust treatment options, ensuring that they are accessible to residents seeking services, and providing comprehensive discharge plans for people released from inpatient psychiatric units.

For these reasons, the Maryland Office of the Public Defender urges this Committee to issue an unfavorable report on SB 807.

Submitted by: Government Relations Division of the Maryland Office of the Public Defender.
Authored by: Keith Lotridge, Deputy Public Defender, keith.lotridge@maryland.gov, 410-767-8708.

2022-SB807 (AOT) - Oppose - Mary Buckley (Written)

Uploaded by: Mary Buckley

Position: UNF

PERSONAL WRITTEN TESTIMONY IN OPPOSITION OF
SB 807: Frederick County – Mental Health Law –
Assisted Outpatient Treatment Pilot Program
Finance Committee, Senate
March 8, 2022

Thank you committee members for giving me the opportunity to share my story with you today. My name is Mary Buckley and I am a Frederick resident. I am here to share my experiences with involuntary commitment.

I am **strongly opposed to Senate Bill 807** because I have experienced forced treatment in my own life. It was traumatic, unhelpful, and damaging.

When I was 32 years old, my first hospitalization took place simply because I was experiencing extreme insomnia and my family interpreted my related behavior as odd. All I needed was sleeping pills. I was too exhausted to find a way to get them and needed someone to help me obtain them.

My family came to "help" at my house knowing I was deteriorating. I was languishing in bed upstairs alone, with little support. At this time, my sister was helping to care for my 2 young children. One night, my family member pinned me to the floor and brought me to an institution that was very abusive. I was put in four point restraints, and later secluded, with no explanation of why or for how long, due to hallucinations that began after they took me away.

During my hospitalization, I was forcibly medicated and my psychiatric advance directive, detailing which medications I was not to take, was completely ignored. When discharged, I was provided with no resources for where to receive help next. I was so traumatized by this experience that my mental health worsened significantly, leading me to be in and out of psych wards for almost 25 years. The hospitalizations only made things worse.

At first, I was diagnosed with postpartum psychosis by a psychiatrist hired by my family. In a family meeting, when asked to explain the behaviors that proved it, my family was speechless. My next "diagnosis" was bipolar disorder when in reality I believe I was experiencing trauma-induced depression and anxiety.

But there was one place that helped me feel better: a respite house. I had gone to many times before and after being hospitalized, to cope with the anxiety and depression from being in the hospital.

I was able to heal there. It was safe, supportive, and had an atmosphere that fostered community and trust. The program was the perfect balance between structure and freedom. I had my own room, and there were people there that I could genuinely connect with, including staff. We even ate dinner as a family. There was a backyard, and we were provided transportation to doctor visits. I finally found peace and healing. I can't say enough good things

about the place. My depression and anxiety are slowly improving and I have finally found the right combination of meds.

I urge you to listen to my story, and understand the harm that forced treatment does to someone and to our service system. It's dehumanizing, disempowering and retraumatizing. It instills the belief that individuals with serious mental health issues are unable to make treatment decisions on their own. Choice-based recovery services such as the respite house I went to, provided me with a safe, comfortable space to heal and begin to recover. To create a more recovery focused behavioral health system, we need to listen to voices of people like me, who receive these services. **I urge you to vote against SB 807**.

Thank you,
Mary Buckley
buckleymarysharon@yahoo.com

MelindaMorgan Testimonial SB807.pdf
Uploaded by: Melinda Morgan
Position: UNF

Date: March 7, 2022

To: Senator Delores G. Kelley, Chair, and

Senator Brian J. Feldman, Vice-Chair

Senate Finance Committee

From: Melinda Morgan, LCSW-C (licensed clinical social worker)

Mindy.morgan@yahoo.com / 301-331-5007

Re: Senate Bill 807 – Frederick County – Mental Health Law- Assisted Outpatient Treatment (AOT) Pilot Program

Position: Opposed

Testimony:

Thank you, Finance, Committee members for your dedicated service to improving access and equity in behavioral health care for all Marylanders. I am writing today to share my **opposition to Bill 807**, which would establish an "Assisted Outpatient Treatment (AOT)" outpatient civil commitment program in Frederick County.

My position on this bill is informed by my experience working as a licensed clinical social worker serving patients in the state of Maryland, as well as my personal experience as a person with a diagnosed mental illness of bipolar disorder.

My first concern lies with "interested parties" as vague language within the bill. In my experience, many people involved, even at a distance from those with a mental illness have a tendency to call themselves "interested" and in this situation would have the ability to attempt a commitment under this bill. Frustrated neighbors, disgruntled ex-partners, former co-workers… any of these have the capacity to pull a person into the court system by the mere fact that they were diagnosed with a mental health condition. This is discriminatory and there is great potential for abuse.

Additionally, we have an emergency petitioning system in place that allows for qualified professionals to force a person to be evaluated. This preserves safety until a hospital can determine the presence of imminent danger and intervene if needed. To take away someone's rights has always been a serious and dire, last resort decision to preserve life and limb. Due to the fact that imminent danger is not something that can legitimately persist for up to a year, this bill is saying that people with mental illness would not be afforded the same rights as others by virtue of their illness. Those committed under this program would have done nothing wrong. They are ill and exercising their right to autonomy in making medical decisions as every other American with a medical condition is allowed the freedom to do.

It is a challenge to access mental health care as it is. I am fortunate enough to afford my mental health care and the mental health care for one of my children. I pay hundreds of dollars a month for medication,

therapy and psychiatry… with insurance. Cost is an issue, access is an issue, and stigma is an issue. A program like this is well intentioned but money would be far better spent increasing access to peer programs like On Our Own and assertive treatment models like ACT that meet people in whatever stage of change they are in. These programs encourage people along the way to create their own wellness plans, such as WRAP (Wellness Recovery Action Plans), to help people plan and engage with their own treatment. Funding for these proven programs needs to be increased, as I can vouch that every ACT referral I've seen sent in the last 3 years has sat on a wait list.

I want to conclude by saying that as a person living with bipolar disorder, I know this bill is an attempt to help, but forcing people into treatment is not the answer. I have sat in a hospital where I was being told what I "had" to do. I couldn't get out until I was "well enough" to exit. It was the most traumatizing experience of my entire treatment history. I learned to look better on the outside to get by while I was ultimately worse on the inside. It was frightening, damaging, and disempowering and I still feel afraid to ask for help to this day for fear that it might happen again. This is the experience I have heard from many others I have worked with as well. True change does not come from forcing people. It comes from walking alongside them.

For these reasons, I strongly oppose Bill 807 and urge an unfavorable report by the Committee.

Sign on letter on HB 1160 and HB 1017-SB 807_final
Uploaded by: Rodney Coster
Position: UNF

Senate Bill 807: Frederick County – Mental Health Law – Assisted Outpatient Treatment Pilot Program

Senate Finance Committee

March 8, 2022

Position: Unfavorable

Dear Chairwomen Kelly and Pendergrass and Members of the Senate Finance and House Government and Operations Committees:

The undersigned organizations **strongly oppose House Bill 1017 and Senate Bill 807, as amended, and HB 1160,** which together would significantly expand when and how Marylanders with mental illness can be subjected to involuntary inpatient and outpatient psychiatric treatment. By removing the decision to engage in treatment from the individual receiving services, even absent imminent health and safety concerns, these bills raise serious constitutional issues, will increase existing racial and ethnic disparities in the receipt of involuntary treatment, and will surely exacerbate the long wait times for receipt of mental health services, prioritizing those who do not want treatment over those who do. Combined, these bills will also overrun hospital psychiatric inpatient units with people on Emergency Petitions.

Research shows that the vast majority of individuals with mental illness are better served by access to appropriate behavioral health services in the community. Forced treatment is only appropriate in the rare circumstance when there is a serious and immediate safety threat. Not only is forced treatment a serious rights violation, it is often counterproductive. Fear of being deprived of autonomy discourages people from seeking care. Coercion undermines therapeutic relationships and long-term treatment. The reliance on forced treatment may also confirm false stereotypes about people with mental illnesses being inherently dangerous. Moreover, the experience of forced treatment is traumatic and humiliating, often exacerbating a person's mental health condition. For individuals with developmental and behavioral health disabilities, inpatient psychiatric treatment is rarely the most appropriate clinical intervention, and is often not medically necessary – rather, access to appropriate community services is essential. It is important to note that there is already a wait for psychiatric inpatient beds in Maryland hospitals, due to the lack of sufficient community mental health and behavioral support services for persons with mental health and developmental disabilities. Making it easier to involuntarily commit individuals with mental illness will put added pressure on an already overburdened system.

Data on involuntary commitment collected by the Maryland Office of the Public Defender indicates that Black Marylanders are more likely to be retained at hearing as compared to white peers. This disparity mirrors national disparities related to mental health diagnosis and inpatient commitment. Black individuals on average are up to four times more likely than whites to receive a schizophrenia diagnosis – even after controlling for all other demographic variables, and more than twice as likely to be involuntarily committed to state psychiatric hospitals. Any revision to Maryland's involuntary commitment process must take these disparities into consideration, and changes must be made with an eye toward reducing inequities in how the process is applied.

HB 1017/SB 807 would create an outpatient commitment program in Frederick County that would authorize a court to order an individual with a mental health disability to involuntary outpatient treatment of potentially unlimited duration, upon a finding that an individual is likely to deteriorate to the point where they pose a danger to the life or safety of themselves or others and is unlikely to

adequately adhere to treatment on a voluntary basis. Data on outpatient commitment show it confers no additional benefit above access to effective community services. The threat of forced treatment, with medication that has harmful side effects, often deters individuals from voluntarily seeking treatment. Further, outpatient commitment undermines the therapeutic alliance between the provider and consumer of mental health services.

Similarly, HB 1160, would expand involuntary commitment in frightening ways. The bill would define as "dangerous" those individuals at risk of psychiatric deterioration and broaden commitment to include individuals who are "reasonably expected, if not hospitalized" to present a danger to self or others. However, just because an individual's mental health symptoms may be worsening does not necessarily make them a danger, nor does it mean involuntary hospitalization is the clinically appropriate level of care. And predictions of future dangerousness are notoriously unreliable, with studies consistently finding clinical assessments of future dangerousness to be "accurate in no more than one out of three predictions"[1] and only "slightly more reliable than chance."[2]

The goal of emergency involuntary commitment should be to protect the safety of the individual in crisis, as well as the safety of others. As a clinical tool, it should only be used only as a last resort. We support the use of other treatment services, include ACT team services and peer supports as critical to addressing mental health crises and promoting recovery. In our experience, individuals will be less likely to engage in treatment and will turn away from mental health services if they are coerced into participating into programs or treatment that they do not choose for themselves.

Effective and responsive mental health systems preserve free choice to make medical decisions, listen carefully to consumers, and offer the type of services and support that consumers prefer. Such systems do not simply respond to crises but develop plans in partnership with the individuals they serve to avert crises. Shared responsibility promotes "buy-in" and results in better treatment outcomes. In the long run, the best way to secure "treatment compliance" is to respect consumer choice.

Instead of passing legislation that would expand coercive treatment in Maryland, we urge you to prioritize developing and funding additional community mental health and behavioral support services, establishing treatment alternatives that are trauma-informed, culturally appropriate, and which utilize peers and evidence-based treatment modalities to meet individuals where they are. While these bills appear to target individuals with mental health disabilities, in practice they would also negatively impact on individuals with developmental disabilities, those with traumatic brain injuries, and others with physical and behavioral health disabilities.

Thank you for your careful consideration of these bills. For all of the reasons set forth, we ask the Senate Finance and House Health and Government Operations Committees to give these bills an unfavorable report.

Signed,

Accessible Resources for Independence, 1406B Crain Hwy S #206, Glen Burnie, MD 21061

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[1] Monahan, J., Structured Risk Assessment of Violence, *Textbook of Violence Assessment and Management* 17, 20-21 (Simon and Tardiff eds., 2008).

[2] *See, e.g., In re the Detention of D.W., et. al. v. the Department of Social and Health Services*, No. 90110-4 (Supreme Court of Washington, August 7, 2014)

The Arc of Maryland, 8601 Robert Fulton Dr Suite 140, Columbia, MD 21046

Behavioral Health System Baltimore, Tower II, 100 S Charles St 8th floor, Baltimore, MD 21201

B'More Clubhouse, 831 N Calvert St, Baltimore, MD 21202

Disability Rights Maryland, 1500 Union Ave., Ste. 2000, Baltimore, MD 21211

The Freedom Center, 202 Perry Pkwy #5, Gaithersburg, MD 20877

IMAGE Center of Maryland, 300 E Joppa Rd #312, Towson, MD 21286

Independence Now, 12301 Old Columbia Pike # 101, Silver Spring, MD 20904

Maryland Coalition of Families, 10632 Little Patuxent Pkwy, Columbia, MD 21044

Mental Health Association of Maryland, 1301 York Rd, Lutherville-Timonium, MD 21093

Office of the Public Defender, Mental Health Division, 200 Washington Avenue, Suite 303
Towson, MD 21204

On Our Own of Maryland, Mailbox 14, 7310 Esquire Ct, Elkridge, MD 21075

Peer Wellness and Recovery Services, Inc., 9909 Lorain Ave, Silver Spring, Maryland, 20901

Public Justice Center, Inc., 201 N Charles St Suite 1200, Baltimore, MD 21201

sb807.pdf
Uploaded by: Sara Elalamy
Position: UNF

MARYLAND JUDICIAL CONFERENCE
GOVERNMENT RELATIONS AND PUBLIC AFFAIRS

Hon. Joseph M. Getty
Chief Judge

187 Harry S. Truman Parkway
Annapolis, MD 21401

MEMORANDUM

TO:	Senate Finance Committee
FROM:	Legislative Committee Suzanne D. Pelz, Esq. 410-260-1523
RE:	Senate Bill 807 Frederick County – Mental Health Law – Assisted Outpatient Treatment Program
DATE:	March 2, 2022 (3/8)
POSITION:	Oppose

The Maryland Judiciary opposes Senate Bill 807. This legislation would establish a pilot "Assisted Outpatient Treatment Pilot Program" in Frederick County. It would permit certain individuals to petition the court to request an order for the respondent to receive assisted outpatient mental health treatment.

These bills establish the Assisted Outpatient Treatment Pilot Program in Frederick County. The bills set requirements for a pilot program including requirements regarding eligibility, hearings, and treatment which seems very well intended, but needs procedural work to be logistically implemented, at a minimum. The times outlined in this bill seem unrealistic and there are due process considerations. The entire process hinges on a report from a psychiatrist who will be required to appear in court on short notice and it is not indicated how the psychiatrist will be compensated. Also, the respondent is entitled to counsel at the hearing which is not outlined in the bill how counsel will be assigned or retained. In addition, there is no mechanism for enforcement of any court-ordered treatment should a respondent fail to comply with the treatment regimen.

Further, the bill, at Health - General Article § 10-6A-05(4), presents a vague standard in requiring courts to determine whether a respondent "is likely to deteriorate to the extent that the respondent will come to present a danger to the life or safety of the respondent or others[.]" By contrast, existing law on involuntary admissions asks courts to determine whether a respondent "presents a danger to the life or safety of the [respondent] or of others." Health - General Article § 10-623(b). This bill needs more clarity to explain to courts how to determine if someone is "likely to deteriorate" in the future such that they will eventually present a danger the life or safety of themselves or others.

The Judiciary did want to express that even though the bill, as written, may embody procedural and logistical challenges, the overarching purpose and intention are favorable.

cc. Hon. Michael Hough
Judicial Council
Legislative Committee
Kelley O'Connor

2022- SB 807 (AOT) - Oppose - Sharon MacDougall (W

Uploaded by: Sharon MacDougall

Position: UNF

PERSONAL WRITTEN TESTIMONY IN OPPOSITION OF
Senate Bill 807: Frederick County – Mental Health Law –
Assisted Outpatient Treatment Pilot Program

Finance Committee, Senate
March 8, 2022

Hello Distinguished Committee Members:

My name is Sharon MacDougall, and I am a resident of Frederick County, MD. I am writing in opposition to HB 1017, which would establish an Assisted Outpatient Treatment Pilot Program in Frederick County.

I have 30 years of experience working in various capacities within Maryland's behavioral health system. I have served as a provider of both traditional mental health services and peer support services, delivered by persons with lived experience of behavioral health challenges. I worked for about 10 years for the Local Behavioral Health Authority in Frederick County. Most importantly, I am a person with lived mental health experience, and the sister of someone currently receiving intensive level services from a psychiatric rehabilitation program here in Frederick.

I strongly oppose this bill because I see how it could really hurt people, especially people I know and care about.

My primary opposition to the bill is that it goes against the very principles and values that are supposed to be considered first and foremost in everything we do. Providers express pride that their care is self-directed and person-centered, with a focus on trauma-informed treatment. This bill proposes treating those in significant distress in a way that entirely disregards the individual and what they want. This approach takes away their right to freedom of choice regarding what happens with their body and mind (i.e. forced psychiatric medications). This is definitely not self-directed care, and for many would be another traumatizing experience that compounds the significant trauma they have already experienced in their lives.

The bill also does not take into consideration the following:

- There is no determination of competency before the restrictions of AOT are enacted. There is a presumption of competency unless determined otherwise but it is not mentioned in the bill. It requires that a psychiatrist state the clinical basis for the determination and that the person meets criteria. These can be made without even seeing the individual.
- The bill also does not address the requirement that all medical care be provided after a person has given informed consent. This can only be waived if a person has been declared incompetent (see paragraph above).

- There are many parts of the bill where actions are taken to place a person in AOT based on criteria that are not defined and subject to interpretation. What does “deteriorate” mean? What are “reasonable efforts?” This decision to force a person to take medication or other treatment is based on criteria that are subjective and open to interpretation by the individuals ordering the treatment.

There are many better alternatives to AOT. Residential crisis services are very effective for people in crisis, but not determined to be in need of hospitalization. Peer support is key in reaching people in crisis who are resistant to treatment. I have witnessed the transformation take place when someone is at first adamant about not getting into treatment but is met with BH care and support, such as peers, that is grounded in trust, choice, mutuality, and shared-decision making.

Peer supporters approach individuals in crisis by showing the person respect, validating their thoughts and feelings about the situation, and working together to identify the next steps that work for them. When individuals are able to build a trusting relationship that is non-threatening and sensitive to a person’s trauma history, defenses can come down and fear can lessen. Once trust is developed and there is a recognition that choice will be honored, people often feel more supported and become more empowered to agree to treatment that they think will be helpful.

Peer supporters work with them throughout this entire process and follow up to ensure they continue to receive the support they need. Trauma can be avoided and the person can engage in treatment with a mindset that allows them to truly benefit. This is an example of how a person who would be under consideration for AOT could instead enter into treatment that is self-directed, offers hope, and empowers an individual to choose and engage in the services that work best for them. I used this approach recently with a person in serious distress who could’ve been hospitalized. However, because she was connected with a non-threatening person who could relate with personal experience, and a supportive housing situation, she is healing and able to function independently again.

Frederick County has many wonderful behavioral health providers and services that do understand what it means to provide person-centered and trauma-informed care, and who are supporting people into recovery and greater wellness every day. We need more funding and recognition for these types of services. I strongly encourage the Committee to choose to build on the strengths of our community and evidence-based practices like Assertive Community Treatment and Peer Support, and to give an unfavorable report on this forced treatment bill.

Sincerely,

Sharon MacDougall
301.712.6778
shmacdoug@gmail.com

SB807_Andrea Walker_Info.pdf
Uploaded by: Andrea Walker
Position: INFO

Andrea Walker, MA, MPH
Frederick County Health Department
Local Behavioral Health Authority
350 Montevue Lane
Frederick, MD 21702
Email: awalker@frederickcountymd.gov

RE: HB1017/SB0807 Frederick County – Mental Health Law – Assisted Outpatient Treatment Pilot Program

Position: Informational Only

As the Director of Behavioral Health Services Division, Frederick County Health Department, and the Local Behavioral Health Authority, I am working to build an accessible, responsive, and culturally sensitive 24/7 system of behavioral health care for Frederick County. The system includes traditional levels of care according to the American Society of Addiction Medicine (ASAM) including, all levels of residential, Intensive Outpatient, and Outpatient services for substance use disorders. The system also includes Outpatient Mental Health Clinics, Psychiatric Residential Rehabilitation, Psychiatric Rehabilitation Day Program, Vocational Programs, Targeted Case Management Services, and Assertive Community Outreach (ACT). We provide school based support services for children and adolescents living in homes with substance use and/or mental health issues. Our crisis services include Residential Crisis, Walk In Behavioral Health Services, 211 call center, 24/7 Mobile Crisis, Frederick County Community Outreach And Support Team, and Frederick County Crisis Response Team. We also employ a robust peer support team with 17 certified peer recovery specialists embedded in multiple agencies who provide support and systems navigation for those with mental illness and substance use disorders. These agencies include Frederick Health Hospital, Division of Parole and Probation, Drug Treatment Court, Sheppard Pratt Mobile Crisis, Mental Health Association Walk In Center, Frederick County Adult Detention Center, Mobile Harm Reduction Services, Community Action Agency, Department of Fire and Rescue Services, On The Mark Adolescent Club House, and Street Based Outreach. We have a strong system of care with an emphasis on client-centered services and self-directed care. We also run a recovery and wellness center known as CORE. This program was the first of its kind in Maryland, launched with a grant from the Substance Abuse and Mental Health Services Administration (one of 11 in the nation). Our jurisdiction prides itself on launching innovative programming and has several nationally recognized; award winning programs, (Walker, Drennan, Hessler, Chausky, & Gross, 2021).

Frederick County works collaboratively with all sectors, public and private, to ensure residents of Frederick County have equal access to a comprehensive and responsive continuum of behavioral health care. *Despite having a significant mix of traditional and nontraditional services, there is still a gap in care for those with severe and persistent mental illness who lack the capacity to direct their own care.* Those with untreated severe and persistent mental illness, such as schizophrenia, may lack the ability to know they are ill. Lack of awareness of illness and symptoms is a common characteristic of those with schizophrenia, with up to 80% failing to acknowledge having mental illness, (J. Gilleen, 2011). Lack of insight and low awareness of the condition leads to poor treatment outcomes, and even poorer prognosis, (AS, 2004). This lack of insight, also known as “anosognosia,” exists irrespective of cultural variations of patients, (Joseph B, 2015). At times, this lack of insight may lead to the inability to consistently participate in clinical and support services, and engagement in unsafe behaviors. These individuals may be evaluated under emergency petitions, or arrested for petty crimes. Upon discharge from the emergency department, hospital or detention center, even with appropriate planning and coordination, the individuals may not engage in follow up care.

According to the National Institutes on Mental Health, the prevalence of schizophrenia and related psychotic disorders in the U.S. range between 0.25% and 0.64%. Despite its relatively low prevalence, "schizophrenia is associated with significant health, social, and economic concerns, (NIMH, 2022)." In fact, schizophrenia is one of the top fifteen leading causes of disability worldwide, (GBD: Global, regional, and national incidence, prevalence, and years lived with disability for 328 diseases and injuries for 195 countries, 1990-2016: a systematic analysis for the Global Burden of Disease Study 2016., 2017).

Early intervention to prevent relapse is critical to preventing chronic disabilities, (Kulhara P, 2008). Psychotic illnesses, if left untreated, may lead to chronic and difficult to treat illness and disability, (Kulhara P, 2008). Research indicates that the duration of untreated psychosis (DUP) may have a neurotoxic effect on the brain structure, (Anderson KK, 2014). The mechanism by which this occurs is extremely complex but "doperminergic hyperactivity and prolonged HPA activation have been hypothesized as potential mechanisms to explain these associations, (Anderson KK, 2014)." The longer a person goes without effective treatment during psychosis, the more difficult it becomes to treat and the more severe the symptoms.

Individuals with severe and persistent mental illness, particularly schizophrenia, have an increased risk of premature mortality compared to the general population. Research shows that these individuals die on average 28.5 years earlier than their neurotypical counterparts do, (NIMH, 2022). Additionally, this population is at far greater risk of suicide compared to the general population, as an estimated 4.9% of people with this diagnosis die by suicide, (Palmer BA, 2005). Approximately half of this population have a co-occurring disorder and/or behavioral health disorder, (Tsai J, 2013). The financial costs associated with schizophrenia are disproportionately high when compared to other chronic mental and physical health conditions. These costs reflect both direct costs of treatment and indirect costs such as lost productivity, criminal justice involvement, social service needs, and other factors, (Desai, 2013). Schizophrenia is one of the most burdensome and costly illnesses worldwide, because of onset, course and rate of disabilities, (Theodoridou A., 2010). Family relationships suffer when the burden of care shifts to families. Caregiver time off work also affects the workforce and leads to economic loss. According to the Global Burden of Disease Study, schizophrenia causes a high degree of disability, which accounts for 1.1% of the total DALYs (disability-adjusted life years) and 2.8% of YLDs (years lived with disability), (Theodoridou A., 2010). Schizophrenia is listed as the eighth leading cause of DALYs worldwide in the age group 15–44 years, according to the WHO World Health Report: New understanding, new hope, 2001, Geneva.

The Frederick County Local Behavioral Health Authority invests a significant amount of time and support in coordinating care with other local agencies and providers. Often this requires significant negotiation to repair "burned bridges" as these individuals frequently violate rules of housing programs and shelters. This population is often transient, requiring coordination with other Counties within the State. Assisted Outpatient Treatment may fill the gap in care for this population who has not found success in any other voluntary traditional and/or intensive level services.

The Local Behavioral Health Authority of the Frederick County Health Department conducts a three-phase process for evaluating and creating programs. The first phase is feasibility. During this phase, research is conducted regarding the technical, legal, operational, economic/financial, managerial, schedule and political aspects of the program. Currently, legislation is required for an Assisted Outpatient Treatment (AOT) program to be considered for pilot implementation.

Should the bill pass, a workgroup will be established to start the next phases of capacity building and launch. Capacity building requires the development and/or coordination of existing organizational structures and resources while ensuring a commitment to health improvement, (Christoph Aluttis, 2014). This process ensures that the conditions are in place to achieve positive health outcomes and ensure that the program can be sustained over time, independent of external events, (Hawe P, 1997).

The workgroup will engage agency and community partners, including those with lived experience, to create policy and procedure, refine eligibility criteria, and create safeguards for the client and guidelines to prevent and/or screen out inappropriate referrals. Referrals may come from a variety of sources, but will be subject to vetting, and require the referral source to demonstrate the client has not been successful in less restrictive voluntary programs (such as Assertive Community Treatment) and environments (psychiatric residential rehabilitation).

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OOOFC Testimony for Senate Bill 807.pdf
Uploaded by: Christy Kehlbeck
Position: INFO

Date: March 7, 2022

To: Senator Delores G. Kelley, Chair, and
Senator Brian J. Feldman, Vice Chair
Senate Finance Committee

From: Christy Kehlbeck, Board President, On Our Own of Frederick County, Inc.
chkehlbeck@comcast.net / 240-344-5839
Frederick County Maryland

Re: Senate Bill 807 – Frederick County – Mental Health Law – Assisted Outpatient Treatment (AOT) Pilot Program

Position: Informational Only

Testimony:
Thank you, Finance Committee members for your dedicated service to improving access and equity in behavioral health care for all Marylanders.

I am writing today to share an **informational perspective on Bill 807,** which would establish an "Assisted Outpatient Treatment (AOT)" outpatient civil commitment pilot program in Frederick County.

My position on this bill is informed by my service as Board President of On Our Own of Frederick County, Inc. (OOOFC), a non-profit organization that offers services to people who live with mental health challenges / substance use disorder to recover and be connected to society. Website is www.onourownfrederick.org.

The OOOFC Wellness & Recovery Center is located in downtown Frederick. Our staff are "Peers" with similar "lived experiences" providing people one-on-one peer support, support groups, trainings, social activities, and daily "Warm-line" phone support. Since July 1, 2021, OOOFC has served over 450 unduplicated people, had over 175 "One-on-One" peer support sessions, held over 300 facilitated peer Support Group sessions, helped 22 peers find housing, helped 26 peers find employment and helped 5 peers to enter voluntary inpatient treatment.

We appreciate that the intent of Senate Bill 807 "Assisted Outpatient Treatment Pilot Program" (AOT) is to provide services to those with mental health challenges and we support the spirit in which it was proposed. However, without careful review and revision, the proposed framework in its current state could result in circumventing existing checks and balances, imposing undue restrictions on individual liberties and could lead to potential fraud and abuse. We have concerns about the effectiveness of treatment when it is administered under duress. The end result of implementing this proposed legislation, could, in fact, be detrimental to those it is intended to serve, which

we are sure was not the original intent. We have a few questions and concerns to share with the Committee.

Checks and Balances: We have confidence in the current "Emergency Petition" procedures in place, along with the proven checks and balances and the appeals opportunities. At first glance, this AOT pilot program appears to circumvent the current procedures and safeguards to protect all impacted stakeholders.

Respondents and Petitioners: This bill could have the unintended effect of empowering any disaffected petitioner with a "legitimate interest" to lodge a complaint against a respondent who is "likely to deteriorate" and result in that individual being forced into the judicial process and treatment at taxpayer expense. Who determines the "legitimate interest" of a respondent and how will we determine who is "likely to deteriorate" in this instance?

Oversight: What is the vetting and oversight process for providers and psychiatrists? Under the proposed legislation, is it possible that an individual or organization could recommend someone for this program and then profit from keeping an individual assigned to one of these programs? Who will determine any potential conflict of interest between the recommending psychiatrist and the provider?

Outcomes: As a program focused on the treatment of mental health, we would expect to see outcomes and measures that go beyond those indicated in the Bill (i.e., number of people treated, number in compliance with mandated plans, and cost savings). These quantitative measures do not necessarily speak to the quality or efficacy of the proposed treatment on the individual, only that it occurred and it saved money. How will cost savings and return on investment be calculated? What is the baseline for cost against which this program will be measured and who determines that?

We are concerned that without appropriate outcomes and measures, this might be used by businesses and individuals to push those with mental health challenges out of the public eye rather than shining a light on their challenges and providing an appropriate, outcome-focused response for all impacted stakeholders.

Summary: We would highly recommend additional time be invested to examine the necessity and impact of this AOT Pilot Program on our community and residents to determine appropriate outcomes for individuals, and to ensure proper checks and balances to mitigate against potential fraud and abuse.

OOOFC would be happy to participate in this vetting process and to share outcomes resulting from our unique peer support services and educational trainings. We would also welcome expanded stakeholder engagement and participating in crafting this legislation for the betterment of our community.

I strongly urge the committee to consider these concerns and questions.