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).

References

Anderson KK, V. A. (2014). The role of untreated psychosis in neurodegeneration: a review of hypothesized mechanisms of neurotoxicity in first-episode psychosis. *Can J Psychiatry*, 59(10):513-517.

AS, D. (2004). *The clinical importance of insight, Insight and Psychosis: Awareness of Illness in Schizophrenia and Related Disorders.* ew York Oxford University Press.

Christoph Aluttis, S. V. (2014). Public Health and Health Promotion Capacity at National and Regional Level: A Review of Conceptual Frameworks. *Journal of Public Health Research*, 199.

Desai, P. L. (2013). Estimating the direct and indirect costs for community-dwelling patients with schizophrenia. . *Journal of Pharmaceutical Health Services Research*, 94):187-194.

(2017). *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.* London: The Lancet.

(2017). *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.* London: The Lancet.

Hawe P, N. M. (1997). Multiplying health gains: the critical role of capacity-building within public health programs. *Health Policy*, 39:29-42.

J. Gilleen, K. G. (2011). Domains of Awareness in Schizophrenia. *Schizophrenia Bulletin*, 61–72.

Joseph B, N. J. (2015). Insight in schizophrenia: relationship to positive, negative and neurocognitive dimensions. *Indian Journal of Psychology Medicine*, 5-11.

Kulhara P, B. A. (2008). Early intervention in schizophrenia. . *Indian J Psychiatry*, 50(2):128-134.

NIMH. (2022, March 3). *Mental Health Information Schizophrenia*. Retrieved from NIMH: https://www.nimh.nih.gov/health/statistics/schizophrenia#part_2546

NIMH. (2022, March 3). *NIMH Mental Health Information Schizophrenia*. Retrieved from National Institute on Mental Health : https://www.nimh.nih.gov/health/statistics/schizophrenia#part_154881

Palmer BA, P. V. (2005). The lifetime risk of suicide in schizophrenia: a reexamination. *Arch Gen Psychiatry*, 62(3):247-53.

Theodoridou A., R. W. (2010). Disease Burden and Disability-Adjusted Life Years Due to Schizophrenia and Psychotic Disorders. In W. R. Preedy V.R., *Handbook of Disease Burdens and Quality of Life Measures.* New York, NY: Springer.

Tsai J, R. R. (2013). Psychiatric comorbidity among adults with schizophrenia: a latent class analysis. *Psychiatry Res.*, 210(1):16-20.

Walker, A., Drennan, S., Hessler, J., Chausky, J., & Gross, H. (2021). *Frederick County Local Behavioral Health Authority Jurisdictional Plan 2021.* Frederick: Frederick County Health Department Local Behavioral Health Authority.