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House Bill 1017 Frederick County – Mental Health Law –
Assisted Outpatient Treatment Pilot Program
Health and Government Operations Committee
March 9, 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 House Bill 1017.

HB 1017 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 HB 1017 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.