SB480 - Johns Hopkins - Support.pdf
Uploaded by: Annie Coble
Position: FAV

JOHNS HOPKINS
UNIVERSITY & MEDICINE
Government and Community Affairs

SB480
Favorable

TO: The Honorable Melony Griffith, Chair
Senate Finance Committee

FROM: Annie Coble
Assistant Director, State Affairs

DATE: February 28, 2023

RE: SB480 MENTAL HEALTH LAW – ASSISTED OUTPATIENT TREATMENT PROGRAMS

Johns Hopkins **supports SB480 Mental Health Law – Assisted Outpatient Treatment Programs**. This bill authorizes a county to establish an assisted outpatient treatment program (AOT). AOT helps guarantee outpatient treatment for a mental health disorder to which an individual is ordered by the court to adhere.

Johns Hopkins has significant expertise in research and treatment of behavioral health disorders, offering a broad range of intensities of services and modalities of care. Our Department of Psychiatry is consistently ranked among the very top programs in the United States for clinical care according to U.S. News and World Report. Across The Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center, we experience over 275,000 inpatient and outpatient visits annually. As one of the largest behavioral health providers in the State, we witness firsthand the devastating impact these disorders have on individuals. Which is why we support Maryland making a real investment into the complete behavioral health care system through this tool.

The Johns Hopkins Community Psychiatry Program offers a wide range of outpatient mental health and related serves. The outpatient services are designed to serve young adults to elderly persons with clinics, mobile treatment and outreach programs, as well as specialized programs to reach specific groups within the community. AOT is a vital tool for ensuring patients attend the program to receive the services they need to improve and avoid rehospitalization.

For these reasons and more, Johns Hopkins urges a **favorable** report on **SB480**.

Abila Tazanu_SB480 Support Testimony.pdf
Uploaded by: Ashlee Reyes
Position: FAV

SB 480

Abila Tazanu, M.D., and Director of Spectrum of Hope- Health, Wellness and Community Services

Position: SUPPORT

As a mother and pediatrician this support would have a tremendous impact on those living with severe mental illness.

Sincerely,

Aila Tazanu, M.D.

Margaret Go_SB480 Support Testimony (1).pdf
Uploaded by: Ashlee Reyes
Position: FAV

SB 480 - Assisted Outpatient Treatment Programs
Testimony by Margaret Go
Montgomery County
Position: SUPPORT

My eldest child suffered from mental illness. Since his death, I have read about the terrible state of our mental health care. Those with serious mental illness who cycle in and out of the carceral system are not getting the help they need. Prisons are not conducive to mental health. Continually cycling through the system is an injustice to them and to our communities state-wide.

For this reason, I am writing to urge you to strongly support Senator Lewis Young's SB 480 to authorize assisted outpatient treatment (AOT) programs in Maryland.

Sincerely,
Margaret Go

Olivia Longus_SB480 Support Testimony.pdf
Uploaded by: Ashlee Reyes
Position: FAV

SB 480
Testimony by Olivia Longus
Montgomery County
Position: SUPPORT

I am an intern at Help in the Home a private organization that assists individuals suffering from severe mental illnesses and gets them to a point where they can live independently. This can be done for these individuals but with the extra support that would come from Assisted Outpatient Treatment (AOT) individuals can improve their health faster.

Barbara is an individual at Help in the Home who would benefit from AOT. She is someone who refuses to attend follow up treatment. She is a woman in her late 50s who has lived a life of psychiatric torment. Barbara is hospitalized on a very frequent basis for suicidality and medical issues that arise from self-neglect. Because she does not follow up with treatment after discharge. Barbara's periods of time out of the hospital grow shorter and shorter as her symptoms grow more severe with age.

I believe Barbara is an example of how AOT will save the state money by decreasing the time she spends in the hospital.

Sincerely,

Olivia Longus
Intern
Help in the Home LLC

SB480 Support_RayettaMichael (1).pdf
Uploaded by: Ashlee Reyes
Position: FAV

SB 480, Mental Health Law -Assisted Outpatient Treatment Programs
Rayetta Michael
Montgomery County
Position: SUPPORT

I am the Co-Owner of Help in the Home LLC. Our agency provides support to people with severe and persistent mental illness.Services range from coordinating the care outlined by various treatment providers to daily support with med monitoring, meal prep household chores etc. Treatment compliance is key to the stabilization and recovery.

AOT has been shown to improve treatment compliance: 90% of AOT recipients interviewed said AOT made them more likely to keep appointments and take medication. AOT has been shown to reduce hospitalizations, arrests, incarcerations, homelessness, violence, and victimization in states where it is practiced. Finally, AOT improves quality of life: 81% of patients in New York's program said AOT helped them to get and stay well; 75% said it helped them gain control over their lives.

I am aware of two individuals who would currently benefit from the passing of this bill. The first is a young man who has walked away from every treatment center his parents have found for him. He refuses to meet with psychiatrist therapist or participate in treatment. Currently, he is living with his girlfriend losing weight and increasing in social isolation. We are doing our best to monitor his condition for the development of physical/psychiatric conditions that meet criteria for an emergency petition. This is a painfully slow process that merely hopes we will be able to identify this BEFORE a fatal tragedy occurs.

Our only hope of getting treatment for Sam is through an emergency petition. However without the passing of this AOT bill the emergency petition will allow for little real progress as it is likely that once he is stable enough to be discharged (i.e. no longer an immediate danger to himself or others, he will be discharged to repeat the same cycle of refusing to go to appointments and decompensating until hospitalization is once again needed. With AOT Sam would be much more likely to follow up with aftercare treatment thereby increasing his prognosis for stabilization and recovery.

Barbara is the second person I know who refuses to attend follow-up treatment. She is a woman in her late 50s who has lived a life of psychiatric torment. Barbara is hospitalized on a very frequent basis for suicidality and medical issues that arise from self-neglect. Because she does not follow up with treatment after discharge, Barbara's periods of time out of the hospital grow shorter and shorter as her symptoms grow more severe with age. I believe Barbara is an example of how AOT will save the state money by decreasing the time she spends in the hospital.

Sincerely,

Rayetta Michael
Co-Owner, Help in the Home LLC

J. Robinson testimony 2023-02-28.pdf
Uploaded by: Carolyn Knight
Position: FAV

Testimony for SB 480 - Mental Health Law – Assisted Outpatient Treatment Programs

Senate Finance Committee
Chair: Melony Griffith
Date: February 28, 2023, 1:00pm
From: Jackie Robinson, Waldorf, MD

POSITION: SUPPORT

My name is Jackie Robinson I am asking for your support of the AOT bill. It is desperately needed to save lives and improve the quality of life for mentally ill people like my daughter and their families.

Jasmine first developed psychotic symptoms in 2014 when she was just 16. She had nightmares, severe anxiety, paranoia, and hallucinations. She would scream and run from the creatures/demons chasing her. During hospitalization at Children's National Hospital, she was awake for days before becoming catatonic. The cause was thought to be lupus cerebritis – the neuropsychiatric manifestation of lupus – when lupus antibodies were found in her cerebrospinal fluid. She as discharged on her lupus medication and Abilify for her psychotic symptoms. On this treatment regimen, Jasmine did well in high school and was accepted at the Wentworth Institute of Technology in Boston. In 2020 she graduated with a Bachelor's degree in engineering.

November 2020: On Thanksgiving we were in Massachusetts with family when her psychosis returned. She became manic and paranoid. After brief treatment at a hospital in New Bedford we brought her back to Maryland where she was admitted to Medstar Washington Hospital Center. The workup showed no signs of lupus effecting the brain and she was diagnosed with schizophrenia for the first time, beginning our journey of serious mental illness. The catatonia is part of her schizophrenia but it is particularly dangerous because of her lupus. After discharge she saw a psychiatrist but refused the treatment she recommended. Jasmine was now 22 years old and we had legally lost the ability to protect her despite her complete lack of insight.

July 2021: Jasmine was hospitalized in the Medstar Southern Maryland Hospital Center. She refused any treatment and they could not hold her and she was not a threat to herself or others. She was discharged in a manic state and hallucinating. She refused the psychiatric appt made.

October 2021: While in Massachusetts living with her father, we were able to achieve a 6-week court ordered admission. She had been starving herself and the doctor feared that she would die without intervention. Jasmine began monthly antipsychotic injections and was doing well when released – the closest to her baseline she had been since her schizophrenia diagnosis in 2020. But a few months after discharge, she refused the monthly injections and any offered oral alternative.

August 2022: Jasmine was again hospitalized in Massachusetts. After a 3-week stay she was discharged on a bi-monthly injections and daily oral medication. She returned to Maryland with me and remains on this regimen, but it is a daily struggle trying to get her to take it. I fear that she will soon hurt me over this conflict.

January 26: Jasmine began, crying, screaming, and cussing me out when I tried to get her to take her medication. She said, "I want you dead. You need to die. I am going to kill you. You are an evil person. You give me medicine that causes cancer and takes away my super powers. I am not sick. There is nothing wrong with me. I have superpowers that no one can understand – especially the doctors. Doctors can't understand engineers."

January 31: While getting ready to fly to Boston to visit family and for her bi-monthly injection in Brockton, she became irate, repeating all the insults and threats. Only the threat of seeking involuntary hospitalization got her to be cooperative and on the plane.

February 5: Jasmine returned to live with us and we were able to find a new doctor at Alliance Behavioral Health. She continues to take medication but not the optimal combination recommended. I fear she will at some point refuse to take any medication and end up back in the hospital. I also fear that either she or I will end up injured or dead.

My smart daughter – who was my best friend – has never had any real insight into her illness and there is no hope that will change without the right medication, support, and care that could be provided by court supervised Assisted Outpatient Treatment. Please help her and patients like her in this state.

SB480_ClaireWilk.pdf
Uploaded by: claire wilk
Position: FAV

Date of Hearing: 2/28/2023
Claire Wilk
District 14

TESTIMONY ON SB480- POSITION: FAVORABLE

Mental Health Law - Assisted Outpatient Treatment Programs

TO: Chair Griffith, Vice Chair Klausmeier, and members of the Finance Committee

FROM: Claire Wilk

OPENING: **My name is Claire FitzGerald Wilk. I am a resident of District (14). I am submitting this testimony in support of SB480.**

I am a recently retired MCPS Elementary School Reading teacher, very active member of NAMI Montgomery, and the mother of two mentally ill children. I deeply care about this bill. I only have one living child now with mental illness. The other child, James Wilk, lost his life to suicide due to his mental illness. With James, we tried so hard to help him. I called the crisis center several times, but they never really helped. They would basically let me know that if he wasn't trying to take his life when I called, then there was nothing that they could do. They were "So sorry…" Right now, my other mentally ill son is not getting the best help for his mental illness. He is given some psychiatric prescriptions, but they just aren't really helping him. He needs more treatment. Now, he has turned to hard drugs to help medicate himself. If SB480 passes, my husband and I will be able to help our son get the best treatment. It really is a life and death situation. My son is bright, with an honors college degree, and he has a caring personality. He has the ability to contribute to our world, once he is mentally stable and free of addiction. Please help him, and help us by passing this bill.

Bill SB480 will greatly improve the lives of the people in Maryland. Families will be able to get the help that they need to treat their loved ones with mental illness and drug addictions. If SB480 was in place when my son, James, was alive, I think that we could have saved his life. James had a very promising future, but his illness cut his life off before it could even get started.

I am very much in favor of Bill SB480. The bill will help families, like mine, who are trying desperately to help their suffering loved ones, to get the services that they need.

I respectfully urge this committee to return a favorable report on SB480.

Dailey testimony SB 480.pdf
Uploaded by: Clara Keane
Position: FAV

Testimony by Lisa Dailey, Executive Director of Treatment Advocacy Center
Submitted to Senate Finance Committee
Hearing regarding SB 480: February 28, 2023
POSITION: STRONG SUPPORT

Thank you for the opportunity to submit written testimony. I am writing as the executive director for Treatment Advocacy Center, a national nonprofit focused on eliminating barriers to treatment for those with severe mental illness. I am also writing as the sibling of someone who has benefited greatly from and is probably alive today because of her enrollment in assisted outpatient treatment (hereafter AOT) in a state that has made this treatment tool available for decades as part of its regular treatment continuum (Wisconsin).

I am certain that many will provide testimony about the need for AOT to address resistance to treatment on the part of individuals with severe mental illness. I am writing about the need for AOT to prevent treatment systems from simply opting to ignore the most difficult cases. My sister never refused medication. Without support from a treatment team, however, she could not maintain stability and her county of residence did not want to work with her because she could be difficult and combative. Without a court order there was no accountability for failing to even attempt to find the right medication or to check on her welfare periodically.

Her combativeness and volatility were of course directly due to her unmanaged symptoms, but without a court order there was nothing preventing her treatment team from dropping her. They could then wait for her to become so chaotic and dangerous that she would eventually be admitted to inpatient treatment in another county, usually in the back of a police car after a dangerous and traumatic encounter. They could wash their hands of any responsibility for her wellbeing or for the safety of our family or the community. I realize this is not the case in all places but where it *is* an issue, court involvement is the only remedy.

What finally made the difference for our family was an AOT order that did not allow her to be dropped when she was the most symptomatic. During court hearings, she liked the involvement of a neutral judge to ensure that there was accountability if the county failed to provide what was required in her treatment order. She knew that while under court order she needed to refrain from using drugs and alcohol and *actually did so.* This period of supervised treatment led to her finally being stabilized on the right medication for her after more than a decade of only partial relief from her symptoms. She needed that structured time to stabilize, and that only happened under the supervision of a judge preventing a reluctant treatment team from washing its hands of her.

She is now stable in the community, not under a court order of any kind, and has maintained her treatment on her own. There is no question that if she lived in Maryland instead of Wisconsin she would almost certainly not have recovered enough to find the right medication to get her life back, and she agrees with this. She wishes that the intervention had happened sooner to prevent some truly awful experiences that she lived through when in psychosis. I ask that you pass SB 480 from the committee and extend this same chance to Marylanders affected by severe mental illness, who deserve to recover just as much as she did.

Respectfully,

Judge Burke SB 480.pdf
Uploaded by: Clara Keane
Position: FAV

SB 480
Judge Stephanie Pearce Burke
Position: Support

Chair Melony Griffith and the members of the Senate Finance Committee:

I write in support of SB 480 because Maryland judges should have options for court-ordered treatment which are less restrictive than hospitalization or incarceration. I was not always a believer in assisted outpatient treatment (AOT), but through my experience, I have come to see AOT as an invaluable tool which creates a meaningful partnership between the court, the community mental health care provider and SMI adults living in our communities who have historically fallen through the cracks.

The Kentucky General Assembly passed AOT in 2017 over the strong objection of the Kentucky District Judges Association and the Kentucky Department of Public Advocacy. I testified against the bill on behalf of Kentucky's 115 District Court judges. As a state District Court Judge in Louisville, Jefferson County, Kentucky, I initially shared the same objections that you are no doubt hearing in Maryland, the same objections that state legislators always hear regarding AOT—objections rooted in a fundamental misunderstanding of AOT's intent and compassionate approach to saving lives through court-ordered outpatient care.

Surprisingly, court-ordered assisted outpatient treatment is effective because it is not wielded with a heavy-hand, but with a patient-centered focus, and it provides an alternative that is less restrictive than involuntary hospitalization or incarceration. The "least restrictive alternative" language in SB 480 means that, for people who are in need of clinical treatment, AOT can keep them living in the community instead of a psychiatric inpatient facility. The express lack of contempt power also means that courts will have to work with the respondent and their treatment team to ensure adherence to the treatment plan.

As President of the Kentucky District Judges Association, I can say that our judges now strongly support the implementation of AOT across Kentucky. AOT is working in Kentucky and will work in Maryland if the legislature will give the counties that want to implement it a chance. Furthermore, Kentucky is taking advantage of federal grant funding to start AOT programs and Maryland can too if the General Assembly passes enabling legislation. I ask you to vote favorably in committee for SB 480. AOT can save the lives of Marylanders who have not had sufficient community-based services with court support.

Judge Stephanie Pearce Burke

President, Kentucky District Judges Association

JEFFERSON DISTRICT COURT
LOUIS D. BRANDEIS HALL OF JUSTICE
600 West Jefferson Street
Louisville, Kentucky 40202
Direct: (502)641-0895

Lindsey Hoggle_SB480 Support Testimony.pdf
Uploaded by: Clara Keane
Position: FAV

SB 480
Testimony by Lindsey Hoggle
Montgomery County
Position: SUPPORT

My story is unfortunately a very public one - I am the maternal grandmother of Sarah and Jacob Hoggle, two toddlers who have been missing from Maryland since September 2014. My daughter, Catherine Hoggle, remains at Clifton T. Perkins Hospital, as she is charged with their disappearance. While many of the facts are not public in this case, her plans were to escape with her 3 children as her present situation had her feeling "punished" for having mental Illness. Catherine had been diagnosed with Schizophrenia in years prior.

In spite of our family's determined plans to support her, she, like most individuals with SMI, received mental health services that did not sustain her willingness to continue treatment. Her medications also caused side effects that made their continuation a challenge. My family's devastation from this situation is palpable, yet I remain hopeful for others who could benefit from access to an evidence-based treatment program like assisted outpatient treatment programs.

We have navigated both the mental health system and the legal system in this case and still do not have answers we want nor an established treatment plan that incorporates a proven treatment regimen for someone in her condition.

It is possible for individuals with SMI to live a meaningful life. There are reasons to be hopeful when there are programs like AOT.

Sincerely,

Lindsey Hoggle

Mary Virginia Smith_SB480 Support Testimony.pdf
Uploaded by: Clara Keane
Position: FAV

SB 480
Mary Virginia Smith, Ph.D.
Position: SUPPORT

My son, now 46, suffers from ASD and PDD with co-occuring Bipolar Disorder NOS and Schizoaffective Disorder Bipolar Type.

He has been homeless.

He has been hospitalized seven times on emergency crisis intervention criteria - dangerously staying over 18 hours in ER rooms waiting for nearly non-existent mental health division beds, costing the already poorly funded mental health care system exorbitant amounts of public funds, and disrupting his life and that of his family over and over and over and over and over and over and over (that's seven, isn't it?).

As his Social Security Representative Payee and life-time family case manager, I can testify that his homelessness and all hospitalizations could have been averted were AOT assisted outpatient treatment programs available to us in Maryland (and Virginia) during these horrific decades.

For this reason, I am writing urgently and strongly to support Senator Lewis Young's SB 480 for immediate authorization of assisted outpatient treatment (AOT) programs in Maryland.

AOT serves those with severe mental illness, such as schizophrenia, bipolar disorder and other serious mental illnesses, who as a result of the illness itself, are unwilling or unable to consistently engage in voluntary treatment.

Maryland ignominiously is one of only three U. S. states that does not authorize 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. AOT also reduces cost and strain to treatment systems struggling to serve individuals "caught in the revolving door" of repeat hospitalizations, homelessness and incarcerations.

My son and I are living testaments of the requirement to pass SB 480 for immediate authorization of assisted outpatient treatment (AOT) programs in Maryland.

My son and I trust you as our elected official to support authorization of SB 480.

Sincerely,

Mary Virginia Smith, Ph.D.
1615C Piccard Dr Apt. 1404
Rockville, MD 20850

SB 480_Dr. Michael Knable.pdf
Uploaded by: Clara Keane
Position: FAV

ClearView
COMMUNITIES

Regarding SB 480
Testimony by Dr. Michael Knable
Submitted to Senate Finance Committee
Hearing, February 28, 2023
POSITION: STRONG SUPPORT

Thank you for the opportunity to submit my testimony for your consideration today. I am a resident of Chevy Chase, Maryland and I have worked as a psychiatrist in Maryland for more than 30 years. I am currently the Medical Director of Clearview Communities, a long-term residential treatment center for young adults with severe mental illnesses that is in Frederick, MD.

I have also served on the District of Columbia Commission on Mental Health since 2007. The Commission is a division of the D.C. Superior Court and as commissioner, I assist a magistrate judge in making inpatient and outpatient civil commitment determinations. Assisted outpatient treatment (AOT) is a long-standing component of the District of Columbia system of care for individuals with mental illnesses. This less restrictive form of civil commitment allows people to continue to receive needed treatment but to do so on an outpatient basis, when they are ready, with the help of their community support systems.

I can attest that AOT is no more difficult or complicated to implement than any other form of court-ordered treatment and it has the added benefit of encouraging communication between hospitals, outpatient treatment providers and the courts to ensure that a person receives well-coordinated care. Since research demonstrates that it does decrease the likelihood that a person will be re-hospitalized, incarcerated, or unhoused while enrolled, it is unfathomable to me that this tool is not available for residents of Maryland.

I ask the Senate Finance Committee to move SB 480 forward and help to complete our continuum of care in Maryland for the those who need and will benefit from AOT.

MBKnable

Michael Knable, DO
Medical Director
Direct Line: 301-360-5728

Stacy Derrick_SB480 Support Testimony.pdf
Uploaded by: Clara Keane
Position: FAV

SB 480
Testimony by Stacy Derrick, Co-Owner of Help in the Home LLC

Position: SUPPORT

I am the Co-Owner of Help in the Home LLC. Our agency provides support to people with severe and persistent mental illness. Services range from coordinating the care outlined by various treatment providers to daily support with med monitoring, meal prep household chores etc. We provide support to people who need treatment in order to live a meaningful life that is filled with purpose and dignity.

The current Involuntary Treatment Law allows these clients to refuse treatment and live a marginal life, often in reprehensible conditions defined by isolation fear and inability to care for basic physical needs. We have seen people with mental illness suffer tremendously as their families stand by helpless waiting until their loved one is dangerous enough to be hospitalized and praying that irreparable health consequences violence and death can be avoided.

I would like to describe a young man who would currently benefit from the passing of this bill. He has walked away from every treatment center his parents have found for him. He refuses to meet with psychiatrist, therapist or participate in treatment. At this time, he is living with his girlfriend, losing weight and increasing in social isolation. We are doing our best to monitor his condition for the development of physical/psychiatric conditions that meet criteria for an emergency petition.

Because the standard for hospitalization is immediate danger, we can merely hope we will be able to intervene BEFORE a fatal tragedy occurs.

Sincerely,

Stacey Derrick
Co-Owner
Help in the Home LLC
Montgomery County

SB480 Cynthia Lewis Support.pdf
Uploaded by: Cynthia Lewis
Position: FAV

February 23, 2023

SB480 Testimony

Cynthia Major Lewis, MD
Assistant Professor
Director Adult Emergency Psychiatric Services
The Johns Hopkins University
1800 Orleans Street
Baltimore, MD 21287

Position: Support

To The Finance Committee:

My name is Dr. Cynthia Major Lewis, and I am a Board-Certified Psychiatrist who is currently the Director of Adult Psychiatric Emergency Services at the Johns Hopkins Hospital in Baltimore, MD. **The views in this letter are my own and are not representing Johns Hopkins.** I am writing this letter in support of Senate Bill 480 to enable the establishment of Assisted Outpatient Treatment (AOT) Programs in Maryland.

Assisted Outpatient Treatment (AOT) is court ordered mental health treatment for individuals with severe mental illness who have a history of noncompliance with treatment. This lack of compliance often leads to repeat emergency department visits, inpatient hospitalizations, arrest, incarceration, homelessness, victimization, suicide and violence.

A substantial body of research has established the effectiveness of Assisted Outpatient Treatment programs in improving treatment outcomes in patients with severe mental illness. Some studies have shown an 87% reduction in incarceration, 70% reduction in inpatient hospitalizations, 83% fewer arrests and an 87% decrease in homelessness. Assisted Outpatient Treatment Programs have been shown to increase treatment compliance and ease the strain placed on family members and caregivers.

Although research is limited, cost-effectiveness research studies and anecdotal evidence have reported government cost savings, shifting dollars being spent on countless emergency room visits and inpatient hospitalizations to lower cost outpatient treatment. There has been evidence of further cost savings because of the decreased interaction with police and the criminal justice system.

I completed my psychiatric residency program at Johns Hopkins in 2001. I was able to treat a diverse patient population, patients who come from all walks of life and have had the fortune of treating patients in various community settings. My passion lies in treating patients with severe mental illness, those who are often disenfranchised and most vulnerable.

After my residency training, I served three years in a rural health physician shortage area on the Eastern Shore of Maryland. I worked in underserved community mental health clinics, providing mental health treatment to patients who were accepting of care. After my service obligation, I returned to Johns Hopkins and worked primarily in our Community Mental Health Clinic on our East Baltimore campus. I also started a very small private practice.

I worked as an Attending psychiatrist in the Johns Hopkins Community Psychiatry clinic for sixteen years. I was able to form an alliance and develop a healthy patient/physician relationship with the majority of my patients. I treated a significant amount of patients who had Severe Mental Illness (SMI). These patients often carried diagnosis of Schizophrenia, Schizoaffective Disorder, Bipolar Affective Disorder and Severe forms of Depression. Our clinic had case managers, social workers, therapists, nurses, psychiatrists and many wrap around services that allowed us to keep most of our patients healthy, safe and out of the hospital. Patients who struggled in this setting

were often referred to a higher level of care like an ACT team or Capitation Program. Patients in these programs received more intensive treatment with the goal of keeping them well, supported and out of the hospital. We lost a small percentage of patients to noncompliance. Patients with psychotic and severe mental illness often have a lack of insight; which is a lack of ability to appreciate that they have a psychiatric illness that needs treatment. This lack of insight is a significant contributor to refusal to comply with treatment.

It was not until I was asked to Direct the Adult Psychiatric Emergency Services at Johns Hopkins, that I began to get a sense that something was broken in Maryland's mental health system. My position allows me to spend 100% of my clinical time in the Emergency Department. Our emergency department is located in inner city Baltimore. We see many patients who have comorbid substance abuse and chronic medical problems along with severe mental illness.

While being embedded in the emergency department, I began to notice that I would often see the same patients, several times a month and often several times a week. These patients were coming into the Emergency Department on their own, often in need of food/shelter/rest or they were brought on an Emergency Petition; which requires them to be handcuffed by the police and brought to the Emergency Department; against their will for evaluation, if an interested person believes they have a mental illness that is causing them to be a danger to themselves or others. Once evaluated, a determination is made regarding appropriate disposition. Patients who require inpatient admission can sign a voluntary form and come into the hospital voluntarily or what is often the case, they can be placed on involuntary certificates if it is determined that they present a danger to themselves or others.
With the help of a safe therapeutic environment, therapy and medication management, patients with severe mental illness often get better when hospitalized and become safe for discharge back to the community.

I became increasingly alarmed when I would see these same patients back in the emergency department within days, weeks or months of their previous presentation or hospitalization. A frequent pattern is that soon after discharge, patients in this population stop their medication and fail to follow up with outpatient care. Their symptoms of psychosis, mania or depression return. They become unable to care for themselves or a danger to themselves and others. They find themselves with exhausted and burned -out family members who are no longer able to care for them. This leads to insecure housing and homelessness. They re-present to the Emergency Department either on their own or via Emergency Petition, only to repeat the cycle above.

As I continued to watch this cycle repeat itself, I began to question why is this happening? I was asked to provide a Grand Rounds lecture to my Department and focused my presentation on Maryland's current mental health system and questioned if there was a need to rethink State Hospitalization. I went back and looked at the history of mental illness, State Hospitalization and De-institutionalization. It was while doing this research that I realized that Maryland did not need to reconstruct State Hospitals. I learned that Maryland was one of only three states that does not have Assisted Outpatient Treatment Programs. I learned that these programs, when managed successfully, are designed to help patients with severe mental illness, who through no fault of their own and because of symptoms that are part of their clinical disease process, find themselves lacking the insight or ability to appreciate that they have an illness that is treatable and worthy of treatment. Maryland's lack of an Assisted Outpatient Treatment has led to a population of patients with severe mental illness who are falling through the cracks. These patients are being denied the ability to receive life-saving, evidence- based treatment that can help them lead safe, healthy and dignified lives.

Mental illness are mental disorders that cause significant changes in thinking, emotions or behavior, causing problems in occupational, social and interpersonal functioning. One in five adults, or 19% of the US population, has mental illness. One in twenty or 4% of those with mental illness suffer from Severe Mental Illness (SMI); which causes significant functional impairment in one or more major life activities. It is 1% of patients with severe mental illness that are falling through the cracks of our mental health system and have become our "revolving door" of patients circulating in and out of our emergency departments, inpatient units and jails. It is this group that would benefit from Assisted Outpatient Treatment.

Our patients deserve better than what Maryland is currently offering. Patients with severe mental illness are at increased risk of dying by suicide. They are patients whose rights are being impacted when they are emergency petitioned and brought to the emergency department or involuntarily hospitalized against their will. These are patients who have family members and loved ones who have had to estrange themselves or send them to other states that have Assisted Outpatient Treatment programs.

Our patients deserve to have voices at the table who are advocating for them because they can't advocate for themselves. They deserve to live in a state that is going to roll up its sleeves and figure out how we balance their well-deserved rights for autonomy and self-care with the right to life altering and lifesaving care. Our patients deserve an Assisted Outpatient Treatment Program in the state they call home.

Continuing to allow Maryland's mental health system to function in its current form is unacceptable. Our patients deserve better. Our exhausted medical and mental health providers deserve better. Our communities deserve better. Our taxpayers deserve better. I humbly ask for a favorable report on House Bill 480.

If you have any questions or concerns regarding this testimony, please do not hesitate to contact me at cmajor@jhmi.edu.

Respectfully submitted,

Cynthia Major Lewis, MD
Assistant Professor
Director Johns Hopkins Adult Psychiatric Emergency Services

SB480_DamianWilk_FAV.pdf
Uploaded by: Damian Wilk
Position: FAV

Date of Hearing: 2/28/2023
Damian Wilk
District 14

TESTIMONY ON SB480- POSITION: FAVORABLE

Mental Health Law - Assisted Outpatient Treatment Programs

TO: Chair Griffith, Vice Chair Klausmeier, and members of the Finance Committee

FROM: Damian Wilk

OPENING: **My name is Damian Wilk. I am a resident of District 14. I am submitting this testimony in support of SB480.**

My name is Damian Wilk. I am a longtime resident of Montgomery County. I am very familiar with the entire mental health system. While trying to assist my relatives, I have experienced multiple hospitals, emergency rooms, mental health facilities, and mental health professionals. I have also sought help from a crisis center, mobile crisis teams, police, and a residential rehabilitation program. I am also a volunteer with the National Alliance on Mental Illness – Montgomery County (NAMI-MC). I am an instructor for NAMI's Family to Family course. Pre-COVID, I was a volunteer with NAMI in the Lobby.

I had a son that persistently struggled to voluntarily adhere to mental health treatment. We tried a wide variety of methods to get him help. We were consistently told that unless he said he was suicidal, there was nothing they could do for him. Once I was able to have him agree to go to an emergency room for treatment. At the last moment, he did not go in, and had a friend pick him up. Due to his untreated mental illness, he died of suicide. If Senate Bill 480 had been in place, he would still be alive today.

I have another mentally ill relative that also persistently struggles to adhere to voluntarily treatment. Due to unsuccessful mental health treatment, he self-medicated and became drug addicted. Everything we have done to help him has failed and I believe he will die if he does not receive proper treatment. SB480 is our last hope for getting them treatment.

The current mental health system has failed both my relatives. The provisions of SB480 would make it possible for the mental health system to help those that cannot voluntarily adhere to mental health and drug treatment. Nothing can be done to help my relative that died by suicide, but my relative currently suffering from mental illness and drug addiction can be saved. He is smart, well educated, and caring. He has the potential to be a great asset to his community. **I respectfully urge this committee to return a favorable report on SB480.**

2.27.23 - Debra Bennett Support SB480 Testimony.pd

Uploaded by: Debra Bennett

Position: FAV

SB480 Testimony

Debra Bennett
1217 Adeline Way
Capitol Heights, MD 20743

Position: Favorable

February 27, 2023

My name is Debra Bennett. I am a concerned family member and caregiver of a loved one with a severe mental illness (SMI), a NAMI member, and a volunteer Maryland Ambassador with Treatment Advocacy Center.

My 34-year-old son is diagnosed with a SMI, substance use disorder, and a severe hearing impairment. He has been unstable for almost two years now -- revolving through homelessness, hospitalizations, victimization, and incarceration. Since 2021, he has been hospitalized 16 times – eight in 2021, seven in 2022, and once already this year and it is only February. The cost of his hospitalizations must now range between $500,000 to a million dollars!

My son has tried to use literally all outpatient **voluntary** services in three Maryland counties (Anne Arundel, Frederick, Baltimore) and Baltimore City to obtain stability-- **unsuccessfully**. Maryland only offers **voluntary** outpatient services but they do not work for everyone with a SMI.

Last year, out of 12 months he was hospitalized for nine and only in the community for three in a **voluntary** residential program in Baltimore City. Because his illness affects his insight about his need for consistent treatment and housing, he left the program and became homeless in June. Later in June and July he was hospitalized. In one encounter, the crises team said, he was hearing auditory hallucinations and running nude in a public park. In another, he was harassing people and seen beating his head on the side-walk. He told the responder, “I don't have control of my life anymore, I need medicine." In addition to medication, my son needs an AOT program to ensure he takes the medicine, stays in treatment, and housing. All of these are needed for him to remain stable in the community.

Last August, after being discharged from the Baltimore City hospital to the **voluntary** crisis resident in Anne Arundel County, he left after 10 days. He was homeless and still unstable. He was assaulted and taken to the ER but he left. Only days later he was arrested for trespassing. My son did not need handcuffs, he needed an AOT program. The court committed him to a Maryland state forensic psychiatric hospital for five months.

On January 30, after five months confinement and psychiatric treatment, my son was discharged to a different **voluntary** residential program in Baltimore City. While I was very hopeful about the new program, I also asked myself what would be different this time? Absolutely **nothing** changed for him! Within less than two weeks, he was back in the hospital. On February 22, he was discharged and returned to the program. I wish I could be optimistic this time but without an AOT program, I do not see how the cycle will end.

For almost two years, my family has not seen our loved one outside of a treatment setting. My son used to say that I was his best friend, but now he says “I’m not his mother.”

AOT could save my son’s life. AOT could restore our family. I urge you to support SB 480. Thank you.

SB480_EricSmith-fav.pdf
Uploaded by: Eric Smith
Position: FAV

SB480 Testimony
Eric Smith
Position: SUPPORT

Hello. My name is Eric Smith, and assisted outpatient treatment (AOT) saved my life. Before AOT, I had a terrible quality of life. Shortly before entering into AOT, I wouldn't eat anything other than butter because voices in my head told me everything else was poison. I also thought I was an asset working with the FBI…and since the reality I was living was no reality at all, I was arrested not long after that because I was trespassing, going places the voices in my head told me to go.

At that time, I did not voluntarily seek out nor remain engaged in any type of treatment for severe mental illness because of anosognosia. Anosognosia, a brain based impairment that is common for people like me, stole my ability to understand I was ill and prevented me from making rational choices. No matter what anyone told me, I believed I was a codebreaker for the US government.

I do not want to be psychotic, but when I was psychotic that isn't something I could understand due to anosognosia. When I was psychotic, I told numerous treatment providers and my family to leave me alone and that I didn't want treatment. The AOT team understood my voiced opposition to treatment was not the real me talking…it was me being held hostage by my own psychotic mind and anosognosia, not a personal choice.

My life was saved by an AOT judge and treatment team that recognized I needed rescuing from my illness…and the only way that was going to happen based on my history and presenting symptoms was by involuntarily stabilizing me as an inpatient and then immediately stepping me down into AOT as soon as I no longer met criteria to remain a psychiatric inpatient.

Without AOT, I would have continued on my path of not seeking out or trusting treatment providers…without the judge and 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.

After more than 10 years of counseling, psychiatry, and voluntary treatment failing me, I lost faith in treatment providers. Since the AOT program I was in relied on a judge playing an active role in communication about my treatment plan, I was able to place trust back into treatment providers because the judge's authority resonated with me in a way that no treatment provider could up to that point.

I support disability rights and civil rights groups. That said, some people from these groups oppose AOT, and they are good people operating on misconceptions or misplaced fear about AOT. The truth is simple: Anosognosia and my illness robbed me of the ability to be free and live life for many years…AOT restored my ability to be free and live life, and it can do so for others.

Despite being a high school dropout with severe mental illness, thanks to AOT I graduated *magna cum laude* with a BA in psychology, and then earned a master's degree with a 4.0 GPA.

Please support AOT as a recognition that a population of people exists (including me) who need AOT, and are failed in the absence of it…and have faith in the wonderful treatment providers and judges of Maryland to make AOT work for people like me who need it.

47 of our 50 states have created AOT laws, and it is time for Maryland to join them.

I look forward to answering any questions you may have. Thank you for your time and consideration.

SB480_Burton_FAV.pdf
Uploaded by: Evelyn Burton
Position: FAV

SB480 Mental Health Law-Assisted Outpatient Treatment Programs
From: Evelyn Burton, Maryland Advocacy Chair, Schizophrenia & Psychosis Action Alliance evelyn.burton@sczACTION.org 301-404-0680
POSITION: FAVORABLE

In One year

12 psychiatric hospitalizations
18 Emergency Department visits for psychiatric evaluation
4 Crisis Center visits for psychiatric evaluation.

Total Charges: **$509,000.00**

My relative, whom I will call John, has a form of schizophrenia. One of his symptoms is anosognosia, which occurs in some individuals with this illness. It is a neurological deficit causing diminished awareness of the need for treatment caused by the illness itself. The result was he did not think that he needed to adhere, as an outpatient, to the treatment and medication prescribed in the hospital. Each time he was released from the hospital he would quickly relapse, becoming psychotic (out of touch with reality) with delusions and suicidal ideation, necessitating rehospitalization to save his life.

What the numbers above do not tell you is the unimaginable suffering and trauma experienced by my loved one and his family, because Maryland does not have Assisted Outpatient Treatment, the only evidence-based method offering a path to treatment and stabilization for those like my relative, who are unable to adhere to voluntary outpatient treatment.

My loved one was **terrified** each time he saw a policeman in Columbia Maryland because he **knew the officer was really a praying mantis, which could devour him alive.** John was confused and afraid wandering in a large parking lot, without any ID, not knowing how he got there and unable to remember his name, where he lived, or anything about himself. He was tormented with thoughts and plans of suicide.

What I do not have to image is the suffering of his family. I can tell you the pain I felt in the pit of my stomach each time he called saying he wanted to kill himself and he had a suicide plan. Would I be able to get him to the hospital in time? I can tell you of the sleepless nights and anxiety I felt when he was missing, wondering if he was in the hospital or jail, alive or dead. I can tell you of the desperation and feeling helpless to break the cycle and get him into treatment before tragedy.

The opponents of AOT said that the solution is Assertive Community Treatment (ACT) Teams and peer support persons. I applied for the Howard County ACT team. They went to his apartment to interview him and he slammed the door in their face. He did not think he needed their services. I hired at certified peer support person to live with him 24/7 and help persuade him to see a psychiatrist and take prescribed medicine but John refused, became delusional, became afraid of the peer support person and accused him of being a NAZI.

After my loved one became homeless and almost got arrested, I gave up on Maryland and sent him to Arizona. There he was quickly put in an AOT program. Since then, he has complied with injectable medication, routine psychiatrist visits, and case manager appointments, and this week will be starting a day program and vocational counseling. There is nothing coercive about the program. His treatment team encourages him and takes his concerns and goals into account. He views them as his best friends. He takes the medicine out of respect for the judge's order and his relationship with his treatment team.

My heart still breaks when he calls and begs to come back to Maryland where his friends and family are. I tell him he cannot because he is under a court AOT order. What I do not tell him is this: I will not bring him back and risk him suffering, being incarcerated, and have brain damage from untreated psychosis, if he once again stops his medicine due to lack of insight; not until Maryland has AOT program to provide treatment to those who are unable through no fault of their own to adhere to voluntary treatment.

I know of at least 2 other families that sent their loved ones to another state to get the benefits of AOT. Unfortunately I work with many more who cannot afford to do this and their loved ones suffer the consequences of denial of treatment: homelessness, incarceraton, hospitalization, victimization, and suicide.

It is time for Maryland to join the 47 other states and the District of Columbia and enable AOT. Please give a favorable recommendation to SB480 and save lives.

SB480_Burgholzer_FAV.pdf
Uploaded by: Janet Edelman
Position: FAV

SB480 Testimony, Senate Finance Committee, February 28, 2023
Jill Burgholzer, DNP
112 Saint Claire Place
Suite 202
Stevensville, MD 21666
Position: **SUPPORT**

I'm writing in support of state legislation (SB480) to enable the establishment of Assisted Outpatient Treatment (AOT) programs in Maryland which will provide a path to treatment for the high-risk subset of those with serious mental illness (SMI) which our current system is incapable of treating.

As a psychiatric nurse practitioner working in emergency departments and acute inpatient psychiatric units in multiple hospitals in the Baltimore area I wholeheartedly believe the addition of AOT programs would make a significant difference in reducing the suffering of our state's vulnerable citizens who are suffering from serious, chronic mental health disorders. I have reviewed data from other states that have been successful with an AOT program and urge your favorable vote.

Kind regards,

Jill Burgholzer, DNP

SB480_CarmenA_FAV.pdf
Uploaded by: Janet Edelman
Position: FAV

SB480 Testimony
Finance Committee, Feb. 28, 2023
Carmen A, Montgomery County
POSITION: FAVORABLE

I have a very close family member who suffers from serious mental illness. She has a long history of hospitalizations - **about 25 hospitalizations to no avail**.

She would be discharged after a very short time, at the most one week, with no follow-up services and often not continue her medication.

My family member has been **homeless** for about 3 years, after being discharged from several hospital stays. It became a pattern: hospital, shelter, shelter, hospital. When in shelters, there was no proper follow-up amid unsanitary conditions, and she was even **victimized by care takers and other shelter users. All outpatient treatments have proven a failure.** Meanwhile, she **lost insight of her illness and need of treatment.** She was thrown out of the shelter she was in due to behavior resulting from lack of treatment, **was out in the streets** for a week, and in a total state of psychosis, she was accused of committing a felony and immediately incarcerated. **After two years between jail and forensic hospitalization,** it would seem that the felony charge will be dropped for lack of evidence, but a second degree assault would remain. All efforts and gains on the part of her Public Defender are still in the air and the defendant kept waiting in a devastating situation of uncertainty and injustice.
I believe there must be a more human, effective, and less costly way of taking care of our population with mental illness. One step in a good direction would be to establish in Maryland, an **Assisted Outpatient Treatment** as developed by SAMHSA and the Treatment Advocacy Center which has proven results in reducing homelessness and incarceration.

I request that the Committee give a favorable report to SB480.
Thank you for working towards the improvement of a broken, inhuman, and costly system.

SB480_Cooper_FAV.pdf
Uploaded by: Janet Edelman
Position: FAV

Testimony for SB 480
Chair: Senator Melony Griffith
Date: February 28, 2023
Lisa Bass Cooper emediapro@gmail.com Montgomery County, MD
Position: SUPPORT

Madame Chair Griffith and Members of the Senate Finance Committee, thank you for this opportunity to testify to support SB 480 to create assisted outreach treatment programs under mental health law.

My name is Lisa Bass Cooper. My daughter receives mental health services in Silver Spring, Maryland, where she suffered a relapse at the end of January 2022. I am a member of NAMI Montgomery County, part of the country's largest grassroots mental health organization, the National Alliance on Mental Illness, and recently joined the group Treatment Advocates Coalition.

My daughter, who will be discharged from Sheppard Pratt Hospital this week to a new HOC-subsidized rental apartment with a live-in aide, developed schizoaffective disorder 19 years ago. Nearly two years later, my son showed signs of bipolar disorder, but was never adequately diagnosed. Confronted with a court hearing for seeking to use a stolen vehicle to commit vehicular suicide, he used my car instead the day before his hearing to commit vehicular suicide. He was 19. If an AOT program existed, he might have been able to get adequate treatment and counseling after his discharge from the hospital, only a week prior to his death.

For nearly 10 years after his suicide, my daughter was medication-compliant until she turned 30 and wanted to get married and bear children. She secretly stopped taking her medication and relapsed into a rapid cycling mania that was only calmed by introducing ECT at Sheppard Pratt Hospital. She relapsed again and she landed in a hospital that not only allowed her to refuse antipsychotic medications, but had her arrested from the hospital for injuring a male nurse who was in her room in the wee hours of the morning. Her father and I filed a complaint with authorities, but my daughter, who had never been arrested or in jail, served 75 days in Montgomery County’s psychiatric lockup, still being allowed to refuse medication. Upon her release, I rented an apartment for her so she could comply with orders to remain in Montgomery County and go to Mental Health Court to have her record expunged. She achieved that goal and graduated. Her future looked bright.

But within 48 hours, she announced she was not taking medication because of the threat of tardive dyskinesia, a side effect of some psychotic medications. My hands were tied for five months until she became very manic and went through a revolving door of rapid cycling mania and delusions about having children. Eventually, after nine hospitalizations over a 15-month period at a government cost topping $1 million, she is on an ECT regimen that appears to be working. However, at any point, she may lose insight into her illness, and will need a law like the one before you today to maintain some equilibrium and purpose in her life.

Senators, I hope you will join 47 other states that understand the need to modernize mental illness laws and services. Poor implementation and lack of foresight of the deinstitutionalization laws covering people living with mental illness are wreaking havoc in families and our society at-large. This is not about civil liberties. It’s about recognizing a problem and fixing it. Passing SB 480 is a step in the right direction.

SB480_Edelman_FAV.pdf
Uploaded by: Janet Edelman
Position: FAV

SB480 Testimony, Senate Finance Committee, February 28, 2023
Janet Edelman
12038 White Cord Way
Columbia, MD 21044
Position: **SUPPORT**

My name is Janet Edelman. I live in Columbia and have been an advocate for people living with a mental illness for over forty years. I am currently vice-chair of the Howard County Behavioral Health Advisory Board, but I am testifying as an individual.

I ask for your support for SB480 to authorize the establishment of an evidence based Assisted Outpatient Treatment program in Maryland. Assisted Outpatient Treatment (AOT) is the practice of delivering outpatient treatment under a civil court order to a small, high-risk subset 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, and is monitored by the local mental health system. This allows time for lasting stabilization on medication and treatment.

Unless AOT legislation passes this year, Maryland will not be eligible for the new round of SAMHSA grants which will be given out this year, to start new AOT programs. These grants are generally only given out every 4 years.

I will be addressing some of the objections presented by those who are opposed to AOT.

Opponents claim that AOT should not be available since there is currently a shortage of mental health services and those services should go to those who voluntarily agree to and can comply with service requirements. They are correct that there are insufficient services in Maryland. However, Maryland does have a broad range and a significant number of services available, including mental health clinics, intensive case management, residential rehabilitation programs, psychiatric rehabilitation programs and assertive community treatment teams. We have vastly more services than most of the 31 other states with active AOT programs. For people who would qualify for AOT, the consequences of non-treatment are severe: suicide, victimization, criminalization, and homelessness. Standard medical triage practice requires that those most at risk of severe outcomes be given priority. Therefore, AOT participants should be given priority to services. It is also a mischaracterization of AOT to view those who would benefit from it as refusing voluntary services, because they generally are not capable of making a rational choice because they cannot understand that they have an illness that needs treatment. Research shows that AOT programs result in very significant cost savings even in the first year, which can be applied to expanding services for all.[1]

Opponents say that AOT is not needed because the Baltimore Outpatient Civil Commitment (OCC) addresses the same need and could be expanded statewide. The OCC pilot has failed the

[1] Jeffrey Swanson et. al. "The cost of assisted outpatient treatment: can it save states money?" *American Journal of Psychiatry* 170 (2013): 1423–1432.

sickest individuals since they will not join the program voluntarily. The Baltimore OCC pilot in five years has failed to successfully show that it can routinely provide outpatient treatment to those who cannot or will not engage in voluntary treatment, reporting enrolling only 3. It also has failed to report any important outcome measures, such as reduced hospitalization, incarceration or homelessness. The Baltimore pilot does not ever order actual treatment, only meetings with a peer. It is not dealing with the sickest individuals, leaving them to cycle in and out of hospitals, jails, and the streets.

Opponents claim AOT may be applied to many people inappropriately, e.g. non-dangerous individuals, any individual who refuses medication or shelter, individuals without a mental illness who act out with severe tempers or by damaging property, and those who need assistance in the community. In order to address this concern, the 2023 Maryland legislation has more specific criteria than the 2022 bill. Assisted Outpatient Treatment is intended to be limited to a very small group of individuals with serious mental illness, who meet narrow and specific criteria, such as a recent lack of compliance with treatment that resulted in serious violence, repeated hospitalizations or arrest, and are unlikely to adhere to voluntary outpatient treatment to the extent that they will come to present a danger to the life or safety of themselves or others. Opponents often forget that not just one, but all of the criteria must be met. In addition, AOT must be the least restrictive alternative appropriate to maintain the health and safety of the individual.

A common claim by opponents is that AOT is forced treatment and permits involuntary medication administration of outpatients. This is a misunderstanding and not true. No AOT program in the country or SB480 permits involuntary medication administration. In Maryland, medication over objection can only be done in a hospital after an involuntary commitment hearing before an administrative law judge and review by a medical panel of experts.

Opponents argue that expanded, well-funded voluntary community services are an alternative to Assisted Outpatient Treatment. This ignores the well documented finding that some people with severe mental illness have anosognosia, the inability to recognize their own illness and need for treatment and who therefore reject all voluntary services. Anosognosia can cause an individual not to engage at all with voluntary services or to be noncompliant with voluntary treatment. Without the option of AOT, they repeatedly suffer the consequences of non-treatment: repeat hospitalizations, homelessness, victimization, suicide, criminalization, and violence.

Opponents like to quote a study showing a higher percentage of people of color in the NY AOT program than in the general population. They ignore the conclusion of the very thorough follow-up research finding no discrimination within the AOT program. The research concludes the disproportionate representation is due to discrimination prior to entering the AOT program. AOT offers a path to treatment to address previous harm caused by discrimination.

Janet Edelman
12038 White Cord Way
Columbia, MD 21044
Position: **SUPPORT**

Opponents claim that AOT requires significant new funding. They ignore the research studies showing how AOT can be successfully implemented using existing services and without additional funding.

In conclusion, the AOT program in SB480 addresses an unmet need in Maryland in caring for some of the sickest individuals. The arguments against AOT are filled with inaccuracies and present a case for maintaining the status quo which has failed this group of individuals for decades. Other states have made progress on this issue while we in Maryland, in an attempt to satisfy all advocates, have not implemented an evidence based practice. Maryland has completely neglected the needs of those who are the sickest and who, without AOT, continue to require costly services in the hospitals, jails, prisons and homeless shelters. Please pass SB480.

SB480_Gieser_FAV.pdf
Uploaded by: Janet Edelman
Position: FAV

SB480 Testimony

Nancy Gieser
February 25, 2023

Position: SUPPORT

Passing AOT is a personal matter to me. I have family members who have or are suffering from severe mental illness and have tried to help my loved ones for decades. I have watched as family members go to the hospital (because of being a danger to themselves and possibly others), only to be discharged the same day, or after a few days, even a week, and return with little or no improvement in outcome.

AOT would help those who suffer from severe mental illness and their families get much needed and effective community resources. AOT would reach out to people who experience symptoms (such as delusions, hallucinations, paranoia, anxiety, hearing voices, or extreme mood changes) and often have no insight into their illness or the need for treatment. They often refuse treatment or are unwilling to access treatment.

AOT would help family members who have tried to help, but are overwhelmed by a system that lacks sufficient pathways to get help. Often crises emerge that lead to hospitalization, but such stays are short and patients are discharged after several days with only a prescription and follow-up suggestions to seek treatment. AOT could help to get treatment before hospitalization and to reduce hospital visits.

The societal benefits of AOT would include reducing the number of police responses in the community, the number of hospital visits (in an already overwhelmed system), the number of inpatient stays, and the number of arrests and incarcerations. Studies have found that AOT is effective, and that it reduces costs of treatment. Providing AOT and resources for treatment teams would be a benefit to many in Maryland.

I urge that the committee prepare a favorable report on AOT.

SB480_Rolfes-FAV.pdf
Uploaded by: Janet Edelman
Position: FAV

SB480 Testimony

Kristina Rolfes
13021 Gent Rd.
Reisterstown, MD 21136
Baltimore County
Position: SUPPORT

My name is Kristina Rolfes, and I am a family member of a person with severe mental illness. My brother was at various times locked up, homeless, beaten, and suffering without help from a debilitating mental illness because Maryland does not offer Assisted Outpatient Treatment.

My family was unable to get treatment for my brother with schizophrenia because he had a lack of insight into his own illness, known as anosognosia, which is the most common reason people with serious mental illness do not accept treatment. Because we could not get him treatment, he deteriorated and suffered from terrifying delusions, auditory hallucinations, personality changes, and an inability to have relationships, hold a job, or even to perceive reality. For my brother and so many others like him, the only way in Maryland to receive effective treatment is after a tragedy occurs, and that's exactly what happened in his case. His delusions caused him to attack my father, who suffered a traumatic brain injury as a result. As for my brother, he was jailed and later locked up in a state hospital, horrified at what he'd done as a result of his delusions.

The only bright side to this horrible story is that because he received treatment while in the forensic hospital, he regained insight and stopped suffering from delusions and hallucinations. After discharge, he continued treatment on an outpatient basis and became a productive member of society, volunteering for NAMI and serving on the board of directors and working as a peer in assertive community treatment for people in crisis. He also was able to marry and have a son. However, it should not have taken this extraordinary tragedy in order to get him treatment.

AOT could have provided the treatment my brother needed, and would have prevented enormous unnecessary suffering and trauma for him and our entire family. I support AOT because it provides a path to treatment for the most vulnerable, prevents the criminalization of mental illness, and because it is compassionate care that saves lives. I ask the committee for a favorable report on SB480.

SB480_Van Remmen_FAV.pdf
Uploaded by: Janet Edelman
Position: FAV

SB480 Testimony
Dr. Sarah Van Remmen, MD
Position: SUPPORT

I am an emergency psychiatrist and associated medical director of psychiatric emergency services for one of the largest hospitals in Baltimore. I am also an inpatient attending psychiatrist who cares for patients with severe mental illness. Every month my team in the psychiatric emergency room learns that another one of our patients has died or been incarcerated because they did not have the opportunity for assisted outpatient treatment.

D- young person with living with schizophrenia who was murdered while attempting to find food and a warm place to sleep.

J- a young person living with schizophrenia and traumatic brain injury who was incarcerated for exposing themself in public. Later that same year they were resuscitated after accidental overdose and was hypothermic due to homelessness.

D- a young person living with schizoaffective disorder who was just released from state hospital where she was sent after assaulting one of our psychiatrists. They have already become homeless again and are no longer taking medications.

J- a young person living with schizophrenia who went missing for weeks before being brought to our hospital as a Doe by police. They were so catatonic that they couldn't tell us their own name. Their family was terrified that they had been killed.

I have more stories than it is possible to tell in a single page testimony. And they all have the same theme- these people were directly harmed because their illness prevented them from receiving outpatient psychiatric treatment. Their inability to recognize their own need for treatment has led to direct harm.

I feel very strongly that AOT is necessary to help this small group of vulnerable individuals. Under the current system, these people are held captive by illness. Being able to provide them with adequate treatment allows them to regain autonomy over their own lives again. It is heartbreaking to see the patients we care for being harmed while we are powerless to intervene until after it's too late.

Until after they're assaulted their psychiatrist again.

Until after they're found in an alley frozen again.

Until after their family files a missing persons report again.

Until another is murdered.

We have the ability to treat these individuals, Please vote in favor of SB480 so that we can. My patients cannot keep waiting to be treated with the dignity and respect that they inherently deserve.

SB480_Villani_FAV.pdf
Uploaded by: Janet Edelman
Position: FAV

SB480
V. Susan Villani, M.D.
103 Longwood Rd.
Baltimore, MD 21210
Position: SUPPORT

When our daughter was a young child she was delightfully creative, played soccer, took piano lessons, and on Mother's Day made me cards telling me how much she loved me. She became moody as an adolescent, worried about her weight, and anxious about her relationships with peers. We thought she was going through a tough developmental phase and sought help for her through the best child and adolescent psychiatrist we could find. Her father and I being both being child and adolescent psychiatrists, although concerned about what her symptoms possibly meant, were confident that with the help of professionals, she would learn to manage her moods, and build a happy adult life.

We were wrong. At the age of 37 this past summer our daughter fell down the steps of the boarding house where she was living and died. Her mental illness got worse and worse through her adolescence and young adult years. She had residential treatment out of state in a well-regarded treatment facility which probably saved her life, however, when she returned to Maryland she had aged out of transition to adult-life programs and went into the adult system of care. Again, my husband and I thought that certainly with all our professional knowledge and connections within the mental health system, she would surely get back on track, learn a trade or skill to be able to construct a life and be able to move forward.

Again we were wrong. She bounced in and out of hospitals with over 50 hospitalizations, multiple medication trials, and ECT. She would get better only to be discharged and be unable to take care of herself. Living with us was untenable due to her wanderings at night, inability to comply with basic requirements of living with others, and a developing hostility towards us and her younger sister. She was inconsistent with taking her medications, would sleep all day, and refuse to be involved with recommended therapy, be it individual or group. She was becoming severely and persistently chronically mentally ill before our eyes, but as an adult she was allowed this as her choice. It did not matter that her brain was deteriorating. We could see her loosing cognitive abilities, but she could not be forced to take her medications or be in any meaningful treatment.

As time went on, she became increasingly paranoid, argumentative, and hostile towards us. This would get better when she was taking her medications, but she did not like them and unfortunately saw little connection between taking them and the positive effects. She denied that they helped and saw us as interfering parents trying to control her. She could not give a reliable history when she showed up in ER's, and those caring for her were fearful of violating her confidentiality so did not seek information from us. Being knowledgeable health care professionals we understood that our giving information was in fact not a violation of HIPPA and so we often used this knowledge to work our way into being involved with her care.

But our love and our persistence was not enough to save her. She needed a system of mental health care that provided beyond what parents can do. She needed a treatment system that surrounded her, made sure she took her medications, and worked through her paranoia and self-sabotaging behaviors. During her last year of life my husband and I each found her in

her apartment near death. She was hospitalized over and over, each time discharged back to the apartment near our house that we helped fund, even though we told the inpatient teams she could not manage there. We finally had to say she could not go back there. After one prolonged hospital stay at Johns Hopkins, she was less paranoid and seemed to be developing some insight to needing to take her medications. But without AOT within a few weeks she began to deteriorate once again. A group home with medication supervision was the best there was to offer. But she had the right to refuse her medications and her participation in other treatment was optional as well. She was her own worst enemy and there was nothing we could do.

I am convinced that if Maryland had AOT our daughter would be alive. There would have been another tool in the toolbox to help us help her with her struggles. At our daughter's memorial service I spoke about her struggles and mentioned that 47 other states have AOT and Maryland does not. Many in attendance were shocked to hear this and shook their heads in disbelief. It is my hope that the legislature will move forward to adopt and sign into law AOT for the citizens of Maryland who suffer with serious and persistent mental illness. I do not want anyone else to unnecessarily lose a loved one because the state has refused add this service to the mental health care system.

V. Susan Villani, M.D.
Board Certified Child and Adolescent Psychiatrist
February 26, 2023

SB480_Woodward_FAV.pdf
Uploaded by: Janet Edelman
Position: FAV

Testimony for SB480
February 28, 2023, Senate Finance Committee
From: Amanda Woodward, 8469 Hill Street, Ellicott City, Maryland 20143.
Position: SUPPORT

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 SB480.

SB480_ZD_FAV.pdf
Uploaded by: Janet Edelman
Position: FAV

SB480
From ZD, Bethesda, Montgomery County, MD
Position: **FAVORABLE**

AOT could have saved my son years of visits to the emergency room and 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 because he does not adhere to treatment after discharge. Because of the illness itself, he lacks insight into his need for treatment.

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. Then he was homeless in Montgomery County. He had no money to eat and slept in the parks. He came 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 was 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 after being released from the hospital.

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.

Sheppard Pratt written testimony SB480 : HB823 Ass
Uploaded by: Jeffrey Grossi
Position: FAV

Sheppard Pratt

Written Testimony

Senate Finance Committee
House Health and Government
Operations Committee

SB480 / HB823 Mental Health Law - Assisted Outpatient Treatment Programs

February 23, 2023

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 SB480 / HB823 Mental Health Law - Assisted Outpatient Treatment Programs**. 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 and 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 over 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.

As a society, and as health care providers, we must strive for autonomy in the health care decision making process. However, there are exceptional circumstances for a very small subset of the community who do not have the cognitive functions to make such decisions. AOT is designed for this subset of our community with SMI – those caught in the mental (and general) health system revolving door who are unwilling or unable to voluntarily engage with treatment.

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

There is considerable evidence that AOT has been of great benefit to those that suffer from mental illness and the community they reside in. Less time in the hospital, fewer visits to emergency departments, and fewer incidences of violence and arrests are clearly a benefit to everyone. It is imperative that implementation of an AOT is done with the input of patients, providers, government funders, courts, and law enforcement in order to fully realize the benefits.

Sheppard Pratt urges you to vote a favorable report on **SB480 / HB823 Mental Health Law - Assisted Outpatient Treatment Programs.**

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

SB480 AOT 2023 Cover Letter.pdf
Uploaded by: Karen Lewis Young
Position: FAV

KAREN LEWIS YOUNG
Legislative District 3
Frederick County

Committee on Education, Energy, and the Environment

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Karen.Young@senate.state.md.us

THE SENATE OF MARYLAND
ANNAPOLIS, MARYLAND 21401

February 27, 2023
Support of SB 480 – Mental Health Law - Assisted Outpatient Treatment Programs
The Honorable Melony Griffith
Finance Committee
Maryland Senate
11 Bladen Street, Room 302
Annapolis, MD 21401

Chair Griffith, Vice-Chair Klausmeier, and Esteemed Members of the Finance Committee,

Assisted Outpatient Treatment (AOT) is the delivery of outpatient treatment under a civil court order to a small, vulnerable subset of individuals with severe mental illness (SMI), who are too often caught in a cycle of repeat ER and hospital stays, homelessness, and incarcerations. AOT is designed for those individuals with an existing mental health diagnosis, such as schizophrenia or bipolar disorder, who have a history of inconsistent or no engagement with outpatient treatment. The inconsistency or lack of treatment among these populations is often due to diminished awareness of the need for treatment, a condition directly related to their illness itself. Participants in this AOT program must show a pattern of hospitalizations, be likely to deteriorate and potentially become a danger to the life or safety of themselves or others.

While there are a variety of programs that already exist to assist those with SMI, the existing programs do not reach everyone. Some of the most at-risk continue to be invisible to our treatment system. In Maryland, our preference for voluntary engagement has left a percentage of people with SMI, who are not able to always understand or appreciate the nature of their own illness as a direct result of their condition, out in the cold, both figuratively and literally. This program is a chance for Maryland to invest in an evidence-based practice that exists in all but three U.S. States. The program is crafted to help individuals whose needs are not currently being served and deserve the benefits of a program designed to prevent hospitalization, incarceration, and deterioration on the street.

AOT provides an outpatient treatment option when it is the least restrictive way to maintain health and safety. 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. For some of the most vulnerable among us, this means that engagement is

supervised and a person cannot simply fall through the cracks. Our news headlines are rife with examples of people who have left a hospital, still ill, and have had tragic outcomes. AOT is a powerful tool to empower those enrolled to continue their stabilization after discharge, and to keep and build on the gains they earned while in the hospital. AOT allows the individual and their treatment team to take what is often a brief window of opportunity to intervene and provide needed support to end the revolving-door of treatment and strike out on a new, more successful path.

Under this program, a person in AOT will receive an individualized treatment plan, designed with their input and collaboration, for one year. During this time, they will receive concentrated support with the goal of working together toward success. This is treatment, and treatment is not punishment. Criminal contempt is not part of this program, nor is jail. If the current treatment program is not working, this program does not allow forced medication, rather the program requires everyone to come back to the Court to troubleshoot. The program requires collaborative effort and all successes are shared, an important element of the program. Should the individual's condition deteriorate, the treatment team will have the services in place and the lines of communication open, so they can get the individual back on track. With everyone invested in the individual's success, a win for one is a win for the treatment team.

This is what's missing in Maryland – an acknowledgement that the path to success is harder for some than others. Placing the onus on individuals who are struggling with symptoms of untreated severe mental illness to be solely responsible for their own success within a complicated system, sets them up to fail and causes needless suffering. This program will be a game-changer for anyone who in the past would have been discharged into nothing.

This program is not reinventing the wheel – AOT has existed for decades in most states and there is significant data demonstrating its effectiveness. AOT has been shown to significantly reduce hospitalizations, arrests, incarceration, homelessness, violence, and victimization in states where it is practiced. A five-year report[1] comparing recipients' outcomes under AOT to their prior results under voluntary treatment found:

- 77 percent fewer experience psychiatric hospitalizations;
- 83 percent fewer experienced arrest;
- 87 percent fewer experienced incarceration;
- 74 percent fewer experienced homelessness.

AOT has also proven to be extremely popular for those enrolled in other mental health programs, with 90% of AOT recipients interviewed reporting that it made them more likely to keep appointments and take medication.[2] 81% said AOT helped them to get and stay well. In a

[1] Kendra's Law: Final Report on the Status of Assisted Outpatient Treatment (New York: Office of Mental Health, March 2005)
[2] Id.

recent survey of those enrolled in SAMHSA's federal pilot program, a whopping 92% of participants either agreed or strongly agreed with the statement "I liked the services I received here."[3]

Beyond the humanitarian reasons to consider AOT, there are the financial savings to consider. Implementation of AOT in other states has resulted in cost savings for both the health and criminal justice systems. In New York City, where AOT is widely practiced, the net costs per person declined 43% in the first year of AOT and an additional 13% in the second year (about $50,000 total/person). Other areas of the state saw even greater savings.[4]

This bill was heard during the 2022 legislative session and significant changes have been made in order to address stakeholder concerns. I urge you to support this legislation which will assist the severely mentally ill in obtaining treatment.

Sincerely,

Senator Karen Lewis Young

[3] Id.
[4] Swanson, Jeffrey W, Ph Dl, et al, "The Cost of Assisted Outpatient Treatment: Can it Save States Money? Am J Psychiatry 2013.

AOT WES MOORE.pdf
Uploaded by: Laura Shears Coates
Position: FAV

January 10, 2022

Dear Governor Elect Wes Moore,

I am excited for the new change that you will help bring to our dear state of Maryland that deeply needs it. I am reaching out to you today in desperation to help change Maryland's approach to handling mental health crisis from those who do not present imminent threat to others.

My days and nights are consumed with the same fears each day. Is today going to be the day I get the call that my brother killed my mom when he was detached from reality in a psychosis state? Is today going to be the day the police protect themselves and in doing so kill my brother? Is today the day that an EMT will need to take a permanent leave for an injury he sustained at a home he responds to more then 2x a week since there are so many emergencies that go on at that address?

First to help you understand better let me introduce my only brother Joshua. In 2016, Joshua was t-boned by a drunk driver that resulted in a TBI, epilepsy, substance abuse addiction, schizophrenia and postcoital psychosis. Joshua can't explain to you how he feels to identify that how he feels isn't safe for himself or others. Joshua has paranoia about taking medication and it is terribly difficult to get him to comply with his medication regimen. Joshua has had over 220 hospital admissions since his accident, and it continues due to loopholes in Maryland law that prevent him from getting his needed medical care.

My brother is so sick he cannot even recognize it nor know that his lack of addressing it is causing further damage to his brain. My brother's condition is deteriorating to a point where he does not have quality of life. He has no friends or associates outside of his immediate family and at times he doesn't even know who we are even though we've been part of his entire life.

My brother has been approved for long term skilled nursing for his medical conditions only to be denied due to his mental health status. Mental health treatment isn't even a thing for him. The therapists say that since he has cognitive decline, he doesn't benefit by learning skills as he can't retain what he is learning. Even chemical restraints are no longer working. You know since he was given them 3 to 4 times weekly and they eventually became something his body got used to. I can't admit how many times I played out if assisting suicide would be the best way to help my brother because every other effort, I have tried hasn't gotten us anywhere.

Doctors always give me the same speal which goes something like "we feel so terribly sorry for what your brother and family is going through but Joshua said he isn't going to hurt himself or others and we can be liable if we force him to get treatment against his cooperation and we are going to have to discharge him". Thankfully, I don't have to tell EMT, police or hospital his name anymore. He is the most frequent return guest with over 500 calls for service to 911 and over 300 trips to the hospital. Yet still the cycle continues for us.

What is even sadder is we aren't the only family fighting this battle. I have met so many wonderful people through my fight for advocacy for my brothers need for treatment that have lost loved ones at the hands of mental illness of another loved one and I am begging you to help stop that statistic now.

There are some very simple changes to Maryland Law that can help get Joshua and others like him the help they deserve and need even when they are too sick to recognize it. For example, Assisted

Outpatient Treatment (AOT) which is court ordered outpatient treatment for those who are unwilling to engage or commit in treatment by own free will. This will help Joshua and others like him with severe and persistent mental illness from deteriorating further from mental decline, reduce ER visits for return Eps and mental health crisis, reduce family deaths by those with severe mental illness, prevent crime and less burn out to care takers and family members.

I am trying to make this as short as possible in hopes you read it all the way through, but the truth is I could go on and on for days on how traumatic this has been for our family. We need your help and are depending on you not to leave our loved one and others who suffer severe and mental illness behind.

Warmest Regards,

Laura Shears Coates

AOT_Support_Testimony for SB 480.pdf
Uploaded by: Lisa Bass Cooper
Position: FAV

Testimony for SB 480 - Mental Health Law - Assisted Outpatient Treatment Programs
Senate Finance Committee
Chair: Senator Melony Griffith
Date: February 28, 2023

Lisa Bass Cooper
emediapro@gmail.com
30629 Steelman Court
Fenwick Island, DE 19975

Position: SUPPORT

Hello, my name is Lisa Bass Cooper, and I am testifying to support SB 480 on behalf of my daughter, a resident of Montgomery County, Md.

My daughter developed schizoaffective disorder 19 years ago. Nearly two years later, my son showed signs of bipolar disorder, but was never adequately diagnosed. He took the keys to my car one Sunday morning and committed vehicular suicide. He was 19. If an AOT program existed at the time, he might have been able to get adequate treatment and counseling after his discharge from the hospital, only a week prior.

For nearly 10 years after his death, my daughter was medication-compliant until she turned 30 and wanted to get married and bear children. She secretly stopped taking her medication and relapsed into a rapid cycling mania that was only calmed by introducing ECT at Sheppard Pratt Hospital. She relapsed again and landed in a hospital that not only allowed her to refuse antipsychotic medications but had her arrested from the hospital for injuring a male nurse who was in her room in the wee hours of the morning. We filed a complaint with authorities on her behalf, but never received a response. My daughter, who had never been arrested or in jail, served 75 days in Montgomery County's psychiatric lockup, still being allowed to refuse medication until a competency hearing. During Covid-19 restrictions, I was unable to see her. Upon her release, I rented an apartment for her so she could be compliant with Mental Health Court and have her record expunged. She achieved that goal and graduated. Her future looked bright.

But within 48 hours, she announced she was not taking medication because of the threat of developing tardive dyskinesia. She went unmedicated for five months, until she became very ill and went through a revolving door of rapid cycling mania and delusions about having children. Eventually, after nine (9) hospitalizations over a 15-month period, she is on an ECT regimen that appears to be working. I'm pleased today that she has been discharged into a decent apartment in Silver Spring, Maryland, where she will have support of a live-in aide and a HOC-subsidized voucher she applied for nearly three years ago. However, at any point, she may lose insight into her illness, and will need a law like the one before you today to maintain some equilibrium and purpose in her life.

Senators, I hope that you will join many other states that understand mental illness and pass this important legislation, SB 480. Thank you for listening.

2023 2 27 SB480 Support Eichenberger pdf.pdf

Uploaded by: marianne eichenberger

Position: FAV

SB480 Testimony
Marianne Eichenberger
Position: SUPPORT
Date: February 27, 2023

I am an advanced practice mental health nurse of over 40 years living in Howard County in District 12. I am here testifying as an individual in support of bill SB480 Assisted Outpatient Treatment (AOT).

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. It is critical to get these individuals whose judgment, reasoning and/or inability to control their behaviors into treatment so they (the clients) can make informed decisions regarding their future treatment.

AOT Nationwide for mentally ill individuals that spent 1 or more nights in a prison decreased from 12.7% to 7.1%. AOT decreased homelessness for those that spent 1 or more nights homeless from 13.6% to 7%. States using AOT are showing significant cost declines for mental health services for those on AOT (New York 50% in the first year, Ohio 40% in Summit County).

I have worked with numerous seriously mentally ill clients that described the horrors of being homeless, searching for food in garbage cans or begging for food, not understanding that the voices they hear were not real or the erroneous beliefs that they were experiencing were incorrect. These clients have been assaulted/rapped on the streets and have had numerous hospitalizations (over 5 and many as high as 10/15) before committing a crime and being hospitalized in a forensic mental health hospital. As an outpatient therapist I have had the privilege of seeing these clients successfully move into group homes/independent living, manage their finances, reconnect with family/friends, get jobs, and get their first pet (the happiness in the client's face will be something I will never forget). AOT would have begun the treatment process at a time when these clients judgment and ability to reason were seriously impaired. It would have been much more cost effective, safer for the clients, 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 SB480 KSmith Final.pdf
Uploaded by: Marilyn Martin
Position: FAV

Testimony for- Establishment of Assisted Outpatient Treatment (AOT)
Senate Finance Committee
Date: February 23, 2023, 1:00pm
From: Kathleen Smith, Waldorf, MD, Charles County
Position: SUPPORT

My name is Kathleen Smith; I am a resident of Charles County Md. I am a Member of Southern Maryland NAMI and the mother of an adult son who has severe mental illness as well as developmental disabilities. If AOT had been in place, I believe that my son's incarceration in a Maryland prison for 20 years, with sixty years suspended, would have not been his outcome. My son was sentenced to 80 years with 60 years suspended; so, he was to serve 20. He served 10, but we had to obtain guardianship during his incarceration. Then he was conditionally released. He now lives with us and is on multiple injectable and oral medications.

As Paul grew older, his mental illness worsened, and his behaviors deteriorated at an alarming rate. His inability to control his actions and his rising level of oddness, suicidal tendencies, and destructive behaviors towards himself, his family, and society became hard to manage.

Since 2001, I have contacted many state agencies, legislators and limited private agencies about my son, pleading for help, guidance and explaining the difficulties with obtaining care for him. My son was placed in a residential treatment facility and was discharged per our insurance company's instructions, disregarding the facility's recommendation for his staying longer to be stabilized. He was discharged, and our insurance coverage for him was exhausted for the fiscal year. Within months from his discharge, my son deteriorated, and immediate services were not available as he needed residential treatment again. At this time, my son was a school age teenager. The Calvert County LCC held a meeting and recommended that if we had him arrested as a teen that then the Dept. of Juvenile Justice would be able to create a paper trail to prove that he needed treatment and could get him treatment. This was the worst and most devastating chain of events to my son's mental health. This action worsened his paranoia, broke the parent-child trust bond, and introduced him to worse criminal behaviors within the walls of a juvenile detention center while waiting over six months or more for an available bed. The Dept. of Juvenile Justice felt this was appropriate, but I didn't feel it was an appropriate placement due to his coexisting developmental disabilities.

Once he was released from Dept. of Juvenile Justice at the age of 18, my son knew that he had the right to refuse medication and treatment because no judge was mandating that he adhere to either.

If AOT had been in place for Paul as a teen into adulthood, it would have spared him a felony conviction. Not having AOT has further damaged his future and impacted ours as older parents. He can barely find a job, and nobody will rent him housing or accept him into an RRP housing program. So, as elderly parents, we now are burdened with the ramifications of MD not having AOT.

AOT SB480 SKneller Final.pdf
Uploaded by: Marilyn Martin
Position: FAV

Testimony for SB480 – Mental Hygiene Law – Assisted Outpatient Treatment
Senate Finance Committee
Date: February 28, 2023, 1:00 pm
From: Susan Kneller, Rockville, MD, Montgomery County
Position: SUPPORT

I am Susan Kneller, the parent of a 51-year-old son diagnosed with Schizophrenia and a NAMI Montgomery County Helpline Representative for the past 22 years. The function of the Helpline is to try to put callers in touch with resources that will help them.

Many callers tell us their relatives have been hospitalized repeatedly but refuse to follow any recommended outpatient treatment, resulting in the cycle starting all over again. These callers live in hell dealing with what is often horribly bizarre behaviors that cause dysfunction to whole families. We cannot offer them any solution since Maryland does not have an Assisted Outpatient Treatment law.

There are some opponents to AOT who say that if people are engaged appropriately, they will accept treatment and services. My experience is that it is impossible to voluntarily engage people who have untreated horrifically distorted psychotic thinking. My son lost his beloved Psychiatrist of 13 years, Dr.Wayne Fenton, Deputy Director of Schizophrenia Research at NIMH, when he was **MURDERED**, trying to engage another patient who was very ill and refusing medications.

Some who oppose SB480 and AOT in general say it is a violation of the person's civil liberties; but when the cost of that idea is murder and mayhem in our society, we need to rethink our ideas of civil liberties. Dr. Fenton lost not just his civil liberties but his **life.** An individual who is psychotic has no civil liberties. They have been stolen by the illness that took away rational thought. Providing treatment through Assisted Outpatient Treatment, to those with severe illness who cannot understand they are ill, can restore their rational thoughts and abilities to exercise their civil rights. This is the only humane path to follow.

AOT Testimony Joanne Connors.pdf
Uploaded by: Marilyn Martin
Position: FAV

SB480 Testimony

Finance Committee, Feb. 28, 2023

Joanne Connors, Montgomery County

POSITION: FAVORABLE

I live with a serious mental illness. 20 years ago, I lived through numerous hospitalizations due to my lack of insight into my illness. I initially voluntarily went on the meds. But for some reason I stopped taking my medicine believing I no longer needed it.

Assisted Outpatient Treatment would have been so helpful for me. It would have given me the support and structure for staying on my meds and keeping me out of the hospital so many times.

AOT might have saved me from being homeless and spending all my savings to survive without a job. It might have saved my son from being abandoned by his mother.

AOT could only have had positive effects on my life and I wish it had been available 20 years ago when I struggled.

Please give SB480 a favorable report. **I would very much like it to be available if I ever need it in the future.**

SB480 Dr.Richardson-Final.pdf
Uploaded by: Marilyn Martin
Position: FAV

SB480 Testimony for February 28, 2023
Senate Finance Committee
Assisted Outpatient Treatment Programs
Charles Richardson, MD
Address: 7662 Sweet Hours Way; Columbia, MD 21046
Position: Support

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 (AOT) as proposed in SB480 would help to reverse this trend.

Over 60,000 Maryland residents suffer from the neurobiological illness we call schizophrenia. Many of these patients lack the capacity to perceive the presence of an illness or the need for treatment. This cognitive deficit is a symptom of their brain disorder, and it undermines their capacity to make informed treatment decisions. Assisted Outpatient Treatment aims to increase adherence to outpatient treatment, for those patients who are unable to recognize their need for treatment, and who have demonstrated adverse consequences as a result. The absence of AOT, and a civil path to sustained treatment, leaves these patients at the mercy of their illness and contributes to the fact that virtually 100% of state hospital patients are admitted with criminal charges.

Over the past 20 years, several outcome studies have been conducted in states with active AOT programs. These have consistently shown that patients assigned to AOT subsequently demonstrate reduced risk of suicide and violence, reduced in-patient admissions, and better social functioning. A 2011 study conducted by researchers at Columbia University's School of Public Health found that the risk of any arrest was nearly three times higher and arrest for violent behavior was over eight times higher among outpatients prior to AOT assignment than during AOT.

It is important to recognize that the liberty restrictions created by AOT are modest, going no farther than to increase the likelihood of civil commitment to a community hospital for patients who have a history of non-adherence associated harm to self or others. Compare this to the draconian criminal court-ordered treatment used in Maryland today. Patients adjudicated Not Criminally Responsible for even minor offenses can spend years in the hospital before being granted a Conditional Release, which then requires compliance with all medications, controls where a patient can live and what his daily activities will be, lasts for five years, and can be renewed without a hearing. Failure to comply leads to court-ordered readmission to a state facility, regardless of clinical need. All too often, the Release is revoked, and the patient must start over from square one.

One can view AOT as a means to protect the public from untreated patients. But I see it as a means to protect patients from arrest. The trauma and punishment psychotic patients suffer as a result of an arrest and its consequences are extreme, and arguably cruel. Essentially, they are punished for their illness, and for far longer than you or I would be for the same charge. AOT would provide a less restrictive alternative to achieve successful outpatient treatment with far fewer restrictions in the patient's daily life compared to criminal court-ordered treatment, while avoiding the horrors of arrest.

SB480 MJM written.pdf
Uploaded by: Marilyn Martin
Position: FAV

Testimony for SB480
Senate Finance Committee
February 28, 2023, 1 p.m.
From: Marilyn Martin, Solomons, MD
Position: FAVORABLE

My adult son has lived with schizophrenia for years and was finally 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 requires a 15-year waiting period before any expungement can be attempted. I hope that I am still alive 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.

SB480_Kelley_FAV-2.pdf
Uploaded by: Marilyn Martin
Position: FAV

Testimony for SB480 Mental Health Law - Assisted Outpatient Treatment Programs
Edward Kelley, Howard County
POSITION: SUPPORT

My son passed away last year—he was homeless and found in the woods. My son suffered from a horrific illness called paranoid Schizophrenia. **For over 20 years, my son was in and out of hospitals all across Maryland. In addition, he was arrested several times and appeared in court numerous times.** At times he boarded up our windows from the inside; slept fully dressed with a knife and baseball bat under the covers; searched for his US Marshall badge and communicated through telepathy. And there was nothing we could do to help him.

Often times my wife and I asked each other why Maryland has not adopted an AOT program. There is a serious shortage of long term beds for those requiring treatment in a secure setting. And - since there is no AOT program - the person suffering from a severe mental illness often finds themselves homeless, incarcerated or worse. Our Judges are handcuffed, as they cannot order persons needing help to comply with treatment outside of the hospital, as it is against the law. My wife and I have sat in the courtroom and been told point blank by the Judge that the courts cannot require our son to accept treatment in the community. Accordingly, the person with a lack of insight into their condition is subject to incarceration if they get in trouble again. (Howard County did not have a criminal mental health court, which would still require voluntary agreement.)

We had a wonderful ACT team in our community- Way Station of Howard County. The staff are caring professionals who truly want to help our son. On more than one occasion, they expressed frustration in their attempts to help our son - as more times than not, he rejected their efforts, as he did not believe he was ill. **Maryland could spend billions to have the best voluntary community based treatment programs on the planet, but they matter not if a seriously mental ill person refuses to participate in the prescribed treatment.**

Community based treatment is far preferred over hospitalization, especially given our State's use of our long term facilities for forensic purposes. AOT can be used to prevent hospitalizations in the first place, which affects everyone in so many ways, including financially. Our son's last hospitalization in Maryland lasted 36 days, and his bill was $47,000! In addition, each time our son got released from the hospital, he was dropped back into society without an appropriate step-down program that he MUST adhere to - so his deterioration starts within days of his release.

If providers of care try to pressure a person to adhere to needed treatment, it significantly damages their relationship with the patient, and the effectiveness of the team. With an AOT court ordered system, the provider can focus on helping the person avoid the inevitable return to hospitalization due to lack of compliance with needed treatment. ***Which of these best protects the person, family and community?***

Homelessness, costly incarceration, hospitalization and/or personal tragedy

vs.

Court ordered - community based - treatment that can prevent deterioration - lessen the stigma - and provide a safe process for returning to the community if hospitalization is ever necessary.

Severe mental illness is not a voluntary illness. Our forensic system already uses court ordered community treatment when needed - so why do we have a system where the best hope for community based treatment for our severely mentally ill is to be arrested?

SB480_Parker_FAV.pdf
Uploaded by: Marilyn Martin
Position: FAV

Testimony for SB480

Senate Finance Committee

February 28, 2023

Position: FAVORABLE

I am Dhyana Parker, on August 14, 1994 I lost my little brother to Suicide. During that time the stigma in the black community on mental illness and suicide was something we never discussed. Unfortunately, in our community we were raised with the understanding that Suicide was a White person's disease. After my brother's death, I went into a deep depression. I was afraid to get the necessary help that I needed because of the stigma and the thought of losing my job. The stigma against Mental Illness and Suicide need to change and I feel that AOT will help rid us of that stigma and allow people to get the help that they need and not have to worry about negative repercussions.

In the last 3 years, I've had several family members fighting the system because of their Mental status. Some lost their homes and jobs and it stems from the fact that the voluntary only resources available are not helping our society. The fact that Maryland is one of the states that has not supported the AOT program, is unacceptable. It seems that you don't care about your Maryland residents. It's allowing that stigma against Mental Illness to remain.

In the last few days, I've met a daughter whose mom is dealing with Suicidal Ideation, and I received a message from a father who's daughter is dealing with Suicidal Ideations as well. The AOT program can give these families some sort of hope that people really do care about them and their wellbeing. Our system is broken when dealing with Mental Illness. It's easier to get a stadium built than it is for us to get the necessary support for Mental Illness. I will continue to fight in honor of my brother who's no longer here and for those that are still here and fighting everyday just to get out of bed. I will be their voice. It's sad that we have to come here today to fight for something that's affects us all in some form.

Please give a favorable report to SB480 and help prevent suicide.

Dhyana R. Parker, President/Founder
Mental Health Advocate/Speaker
The Rock for Life Foundation, Inc
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501(c)3 EIN# 83-3980245
www.rockforlifefoundation.org

Transitional Age Youth, Family Peer Facilitator for NAMI PG
www.namipgc.org
https://www.facebook.com/namiprincegeorges/
https://twitter.com/NAMI_PGC

Testimony for SB480 LPogliano.pdf
Uploaded by: Marilyn Martin
Position: FAV

Testimony for SB480
Senate Finance Committee
February 28, 2023
From: Laura Pogliano, Baltimore
Position: FAVORABLE

In early April of 2012, my son announced he was crippled and went to bed in the middle of the day. His ankle was pulverized. He had a brain tumor. His back was broken in three places. He promised to get up when he healed. I asked him, When will that be? He said that he wasn't sure, but probably not soon. I left his bedroom and closed his door.

In the next two weeks, he quit eating and drinking. He couldn't trust anyone to bring him food. He saw poison being pumped into the water supply. He could only use the rest room with assistance. He smelled; his clothes were turning black. His lips were crusted and cracked; his hair matted. I sat by his bed, putting ice chips in his mouth and wiping his face, begging him to make a good decision for himself and see a doctor.

Two weeks later, police crept up the stairs to his room and helped him, shaking, weak, and filthy, into a squad car to go to the hospital.

If you think that's an odd series of events, it's because I left something important out. My son is severely mentally ill. He has schizophrenia, a thought disorder that includes hallucinations, delusions, and paranoia. Before the April events, he had quit taking a medicine called Clozapine, used for hard-to-treat cases. Between February and March, he quit bathing and changing his clothes. He became disorganized and missed work, then got fired. He began sitting in the living room all day, not speaking, and staring at a television that wasn't turned on. He made no phone calls, saw no friends, made no attempts to engage in any activity. He couldn't answer questions, even when they were direct.

He was sicker than he'd ever been. He really, really needed to get to a hospital.

In early April, I phoned Crisis Intervention teams, both county and city, three times, but no one would come. Finally, I went to the local courthouse and begged a judge for an emergency petition. In Maryland, it's a legal remedy to bring a person who is a danger to himself or others in for an evaluation. The police served it the next morning. He was taken to Hopkins where he refused medication.

On April 16th, he lost a hearing on his competency. He was still in a wheelchair, still in his same clothes, and unmedicated. A week later, he lost a medical panel convened to decide if medication was warranted. He was still in a wheelchair, in the same filthy clothes, but was now mute and catatonic. After a 48-hour appeal process, he finally received an injection of an antipsychotic. This was his 9th hospitalization in four years. He was unmedicated overall approximately three months and lost forty pounds. That was a result of waiting until he was a danger to himself to be able to seek care.

He was discharged from the hospital nearly two months after he was admitted. He walked his sister down the aisle at her wedding on July 28th.

I want to ask you: What should I have done as a mother, when my son went to bed and tried to starve himself to death? One of the absurdities of our situation is that if my son had any other brain dysfunction, I would be legally negligent and abusive in not seeking medical help, but with the same injured brain, in a different disability, I am "supporting a choice" he makes to starve himself while delusional. I'm sure he was not sorry that I violated his rights, or fought to give him his life back.

SB 480 AOT.pdf
Uploaded by: Mary Moran
Position: FAV

SB 480, Mental Health Law - Assisted Outpatient Treatment Programs
Senate Finance Committee
Date: February 28, 2023
From: Mary Ellen Moran, Bowie, Maryland 20716 (District 23)
Position: SUPPORT

As an individual with bipolar disorder, I am pleased to support SB 480. This Bill would ensure that I receive treatment in the least restrictive setting in the event I stop taking medication as required and begin relapsing.

SB 480 ensures a treatment plan that is comprehensive and considers all aspects of living successfully in the community. The Bill also allows for an emergency evaluation of whether I need involuntary admission to a hospital. All aspects of what is in my best interests are covered by this bill and it ensures that I get the treatment I need.

It is critical that I receive treatment as soon as possible when I need it and am unable to make a rational and informed decision to seek it. Therefore, I respectfully request that you give SB 480 a favorable report.

SB480 AOT.pdf
Uploaded by: Morgan Mills
Position: FAV

NAMI Maryland
National Alliance on Mental Illness

February 28, 2023

Chairwoman Griffith, Vice Chair Klausmeier, and other members of the Finance committee,

The National Alliance on Mental Illness, Maryland and our 11 local affiliates across the state represent a statewide network of more than 58,000 families, individuals, community-based organizations, and service providers. NAMI Maryland is a non-profit that is dedicated to providing education, support, and advocacy for persons with mental illnesses, their families and the wider community.

SB480 would authorize an Assisted Outpatient Treatment program in the state of Maryland. Maryland is one of three states without this program 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). There is a specific subset of individuals suffering from severe mental illness that get caught in a cycle of recurring hospitalizations, incarcerations, and homelessness. Relying on voluntary engagement leaves a small percentage of people out that refuse to engage on their own volition. AOT was established to ensure that people who are experiencing severe negative consequences from serious mental illness participate in treatment.

NAMI believes that all people should have the right to make their own decisions about medical treatment. However, NAMI is aware that there are individuals with serious mental illnesses such as schizophrenia and bipolar disorder who, at times, due to their illness, lack insight or good judgment about their need for medical treatment. When people with severe mental illness remain untreated, they are left to deteriorate needlessly. People need treatment to be supplied when they cannot choose it for themselves.

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. It should be seen as a less restrictive, more beneficial, and less costly treatment alternative to involuntary inpatient treatment.

AOT should be utilized when an individual:

- presents a danger to themselves or another;
- is likely to substantially deteriorate if not provided with timely treatment;
- 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 needs for treatment, care, or supervision

We know that AOT works when it is done right. Opponents of AOT claim that it doesn't work, that it is coercive forced treatment. However, we've seen in states that have implemented AOT carefully, like New York, that it

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

Contact: Morgan Mills
Compass Government Relations
mmills@compassadvocacy.com

does work; both in improving outcomes and in reducing costly and harmful consequences of lack of treatment—including, but not limited to hospitalizations, homelessness, and arrests. Additionally, as outlined in the fiscal note, there is an initial increase of cost when implemented, but AOT does not result in long term increases of costs because of the reductions in other costly outcomes—such as hospitalizations or imprisonment.

It is important to emphasize that this is not forced treatment. Maryland must still meet the legal criteria for medications over objections set forth in state law. AOT is not forced care—it is a system to engage people in services and commit the mental health system to serve those most in need. If an individual does not comply with their treatment under AOT, they are not found in contempt of court. They do not face criminal charges. Instead, they may be brought in for emergency evaluation to see if inpatient treatment is necessary.

AOT should be used judiciously for people who meet legal criteria like repeated hospitalizations and arrests, a history of non-participation with voluntary care, include strong due process, and more. Even in states that actively use AOT, relatively small numbers of people are under AOT orders. AOT is a tool that Maryland needs. Ultimately, the goal of AOT is to help people take more active roles in their own care.

For these reasons, we urge a favorable report.

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

Contact: Morgan Mills
Compass Government Relations
mmills@compassadvocacy.com

SB0480-FIN_MACo_SUP.pdf
Uploaded by: Sarah Sample
Position: FAV

MARYLAND Association of COUNTIES

Senate Bill 480

Mental Health Law – Assisted Outpatient Treatment Programs

MACo Position: **SUPPORT**

To: Finance Committee

Date: February 28, 2023

From: Sarah Sample

The Maryland Association of Counties (MACo) **SUPPORTS** SB 480. This bill authorizes counties to establish an Assisted Outpatient Treatment (AOT) program for mental health treatment in their local jurisdictions. Having the option to provide these types of services gives county governments the tools to serve residents in need at a time when the demand has reached record heights.

The pressure for mental health services increased exponentially during and following the COVID-19 pandemic, which effectively overwhelmed existing resources that are available in communities for vulnerable populations. Many private and public programs that provide inpatient and outpatient treatment simply did not have the capacity to care for the number of people in crisis. Staffing shortages have exacerbated this problem. These realities have resulted in the diversion of mental health patients from the appropriate programs into emergency rooms and county correctional facilities, which compromises safety and medical resources for all residents.

The shortfall of bed space in State mental health facilities has multiple dire effects. Local detention centers face a persistent critical backlog of inmates suited for transfer to such a facility, many under court order for such a relocation. But the lack of available space leaves local detention centers housing and trying to care for people who need and deserve proper psychiatric care elsewhere. The flexible and early intervention for these individuals through AOT programs can result in less demand on programs that are becoming *de facto* treatment centers but are simply not equipped to provide this type of care.

Counties applaud the potential expansion of AOT within Maryland, as it has been shown to reduce rates of hospitalization, arrest, and incarceration in states where it has been implemented. Individuals experiencing ongoing mental illness are often met with the unfortunate reality that many communities do not yet have the state-provided programs in place to meet their unique needs. This can lead to their admittance into emergency rooms or correctional facilities, circumstances which could severely aggravate their already potentially dire health condition. These institutions are simply not functionally equipped nor properly intended to serve those needs.

By providing outlets appropriately tailored to this vulnerable population, this legislation could serve to alleviate the mounting pressure that has been hampering emergency rooms and correctional facilities across the state. The benefits are innumerable to staffers and residents alike as more resources will be effectively employed for their expected use rather than overwhelmed by the needs of individuals who require an entirely different type of intervention and care.

Counties can see the obvious, and proven, results these programs have the potential to produce and accordingly urge a **FAVORABLE** report on SB 480.

AOT Support Testimony.pdf
Uploaded by: Shannon Harris
Position: FAV

Bill Number: SB 480

Initials: S.H.

Position: SUPPORT

I've been a resident of Montgomery County, District 18, since 2013. I've spent the last 14 years working in the mental health field and I'm currently a student in the MSW program at the University of Maryland School of Social Work. I do have professional insight into this issue but I'd like to share a personal story in support of SB480/HB823 regarding Assisted Outpatient Treatment (AOT).

My mother-in-law, Jan, passed away in 2019, the week of Mother's Day. For nearly a decade Jan struggled with complex mental illness. Overtime she was no longer able to work and eventually retreated into complete isolation. She became estranged from her friends and family because she was no longer behaving in socially acceptable ways. For years, my husband and I lived in a toxic state of anxiety trying to help Jan. I've worked in mental health for more than 14 years and my knowledge of resources to help Jan was useless because she wasn't able to engage with treatment. As her mental health declined so did her physical health. She was diagnosed with breast cancer and because of her untreated mental health, she delayed cancer treatment resulting in her cancer becoming terminal. Those who argue against AOT see it as a violation of freedom. I encourage you to view AOT as a chance at freedom for those with serious mental illness who have become victims of the imprisonment of their illness. There is a neurological condition called anosognosia that a lot of people with SMI have which actually prevents them from having insight into their illness. So not engaging in treatment is not a matter of will-power, it's the result of a neurological condition. If AOT had been a path my husband and I could have pursued for Jan, maybe she'd be here today.

Wilkes_SB480_Support final.pdf
Uploaded by: Sharon Wilkes
Position: FAV

SB480 Mental Health Law - Assisted Outpatient Treatment Programs
Senate Finance Committee
Chair: Senator Melony Griffith
Date: February 28, 2023

Sharon Wilkes, Montgomery County
Position: **SUPPORT**

My thirty-year-old daughter, who grew up and lived in Maryland almost all her life, has been suffering from psychosis and delusions for almost 3 years. We finally moved her up to New York with the hope of getting her placed in Assisted Outpatient Treatment there. A symptom of her illness prevents her from having any insight as to how sick she is. As a result, she cycles in and out of hospitals for short stays, only to be put back out into shelters until the cycle repeats itself with no plan or treatment.

She has been hospitalized 25 times since 2017. Fifteen of those hospitalizations were involuntary. At times she has been very physically aggressive and has had several interactions with the criminal justice system, including incarceration in the Women's Psych Unit at Clarksburg Prison and a 9-month stay in Spring Grove. During a hearing where we looked to the state to help place her in a treatment program, social services told us "If you can't get her to take her medicine, why do you think we can?" In response the judge told us unfortunately neither he nor I had the legal ability in our state to help her get the treatment she so desperately needs. With the passage of SB480 and implementation of AOT in Maryland families will have an ability to help their loved ones get the treatment they need and allow them to remain close to their families.

My daughter, once a Bethesda Chevy Chase honor student, has been poorly served by the Maryland mental health system for many years. She first experienced depression and ADHD at age 5. Over the years she was diagnosed bipolar 1, a sexual abuse victim, schizoaffective disorder once she developed, psychosis and dissociative. Due to her constant state of psychosis and delusions, she refuses the medication that could suppress the psychosis. In addition, in most instances the hospital puts her out the door as a result of her refusal to take the medication the supervising doctor prescribes, nor will she agree to being admitted voluntarily. Over the years she has attacked me and a nurse, destroyed property and, in a severe delusional state, wandered the streets in the middle of winter without a phone, coat or ID for almost 12 hours until she was found.

Even with this long history of multiple mental illnesses, violence and non-compliance with treatment, providers in Maryland, continued to treat her briefly then discharge her, after which she declines again and repeats the cycle. For example, here is what happened to her in 2020-21:

- January-February 2020 – completed her 9 month stay in Spring Grove as a forensic patient, she was discharged the most stable she had been in over a year.
- March-June – She initially was very happy to be living and part of Cornerstone Montgomery. However, soon after she began living there an inexperienced nurse practitioner on her first job, took her off her anti- psychotic without consulting with her former psychiatrists at Spring Grove or her supervising psychiatrist. Within a few weeks, my daughter realized something was wrong, but due to Covid-19 and bureaucracy, by the time she was able to see the psychiatrist , she had descended into full-blown psychosis and lost all the progress she made in the past year.
- June – involuntary hospitalization Northwest Hospital, Randallstown 7 days
- July – Crisis Center Cornerstone 20 days
- August – involuntary hospitalization Adventist Shady Grove 8 days then released to safe journey crisis house
- August – Sept. while there the team at Cornerstone advised us that my daughter could not return to the program unless she agreed to a long term antipsychotic shot due to her noncompliance of her medicine. Advised by her extremely misguided court appointed attorney to refuse, she was discharged from Safe Journey crisis house for 2 weeks
- September - November – court ordered temporary housing with aide prompted by an action against me by her attorney. Within a few weeks she refused to have the aide give or observe medication and she became further paranoid and delusional.
- December – She calls 911 4 times in 7 days complaining of various severe somatic physical illness and each emergency room visit she has various tests. As her temporary guardian, I communicate with the doctors and she received involuntary hospitalization at Shady Grove Adventist for 12 days.
- December – November of the following year, she lived in and out of shelters, had hospitalizations at Sheppard Pratt, John Hopkins, and Sinai Hospital which either resulted in a discharge within 48 hours due to refusing to be voluntary or kept for a week but then discharged still psychotic and without any treatment plan or housing. As she ran out of options in the Maryland system due to now having a reputation of aggressiveness and hallucinations, all because she was never the properly medicated, she ended up in the District of Columbia's shelter system. From the district shelter she was placed in a welfare hotel in a dangerous area, still suffering from severe psychosis. It was then we knew we had to find a jurisdiction that had both AOT and facilities to support it.

My daughter's treatment is inhumane and preventable. Please pass SB480 so that my daughter's illness can be stabilized.

SB 0480 FAV OCE Testimony JF LS23.pdf
Uploaded by: Victoria Venable
Position: FAV

Jessica Fitzwater
County Executive

FREDERICK COUNTY GOVERNMENT

OFFICE OF THE COUNTY EXECUTIVE

SB 0480 - Mental Health Law - Assisted Outpatient Treatment Programs

DATE:	February 28, 2023
COMMITTEE:	Senate Finance Committee
POSITION:	Favorable
FROM:	The Office of Frederick County Executive Jessica Fitzwater

As the County Executive of Frederick County, I urge the committee to give SB 0480 - Mental Health Law - Assisted Outpatient Treatment Programs a favorable report. This bill will allow counties to establish assisted outpatient treatment programs, providing local governments with an additional tool to address the mental health crisis.

Assisted outpatient treatment (AOT) is the practice of delivering outpatient treatment under a civil court order to a small, high-risk subset 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. This allows time for lasting stabilization on medication & treatment.

As the Frederick County Executive, I have been working closely with partners, public and private, to address the mental and behavioral health challenges we see in the community and ensure residents of Frederick County have access to a comprehensive continuum of behavioral health care. I lean on experts in our Behavior Health Services Division, Health Department, and Local Behavioral Health Authority to build a system of care that prioritizes the wellbeing and integrity of patients and residents. Despite having a robust combination 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. This challenge is not unique to Frederick County; leaders across our state are looking for creative solutions. This bill aims to offer local governments one more tool to fill this gap.

Thank you for your consideration of SB 0480. I commend the bill sponsors for introducing this bill and I urge the committee to give it a favorable report.

Respectfully,

Jessica Fitzwater, County Executive
Frederick County, MD

SB480_Kblair-fav.pdf
Uploaded by: Kathryn Blair
Position: FWA

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To the Committee,

My name is Kathryn Blair and I am a third-year psychiatry resident at Johns Hopkins University. The views expressed in this letter are my own and **are not representing Johns Hopkins**. I am also a member of the Maryland Psychiatric Society (MPS) and am on the legislative committee of the MPS. **I am writing this letter in support of state legislation (SB480) to enable the establishment of Assisted Outpatient Treatment (AOT) programs in Maryland with amendments.** Though I am writing this letter independently, my views are intended to be in line with those of the MPS.

Maryland is one of only three states that does not already have an established AOT program, which gives the ability to mandate outpatient treatment for the most vulnerable and psychiatrically ill patients. Multiple studies that have been done in other states have demonstrated AOT programs reduce hospitalizations, reduce homelessness, reduce arrests, reduce suicidal behaviors, reduce violence towards others, reduce caregiver stress, and improve treatment compliance among these patients. Throughout the last three years at Hopkins caring for psychiatric patients, I have seen a large number of patients that are suffering because of a lack of such a program in our state.

One particular patient comes to mind. He is in his 30s, has a history of schizophrenia and end stage kidney disease. He requires dialysis three times weekly to keep him alive. His schizophrenia is severe and difficult to treat. Part of his illness is that he does not believe he has schizophrenia. He also has the delusion that the staff at the dialysis center are trying to harm him, so he does not attend his dialysis sessions or his outpatient treatment for his schizophrenia. Over the last year and a half, I have played a part in his care from multiple angles. The revolving door starts when he is found unconscious, *near death*, by bystanders in the street due to missing dialysis. He is brought to the hospital in critical condition, requiring a prolonged ICU course to stabilize him. He is then admitted to psychiatry and given the proper treatment for his schizophrenia. But each time he is discharged, he does not attend his outpatient treatment and ends up back in the ICU a week or two later. I even believe he is currently hospitalized right now. If he leaves the hospital, what if no one finds him next time he is unconscious? He will certainly die, only in his 30s.

This is just one single example and I have many more in the shallow depths of my pocket after only a few years of practice in the state. These patients are spending prolonged periods in psychiatric hospitals, jails, emergency departments, and on the streets when they could have much better outcomes if they were enrolled in an AOT program. Not to mention, millions of dollars are being spent to care for these patients in the acute setting, when what they really need is long-term support. I even know a patient who died this summer from a drug overdose who had severe mental illness but did not have the insight to stay in outpatient care. I strongly believe the system is failing this population and that we have the chance to really make a difference in their lives by establishing an AOT program in Maryland. **I urge you to vote in favor of SB480 with the following amendments, which I believe will make this good bill into a great one:**

1. On page 5, in line 12, strike “A”, and substitute “THE RESPONDENT’S TREATING”.

o Reason: Only a treating psychiatrist (Emergency Department, Inpatient, or Outpatient) MUST have examined an individual within 10 days of the petition in order to testify or affirm a patient's need for AOT. I believe that it is imprudent to allow any psychiatrist, especially one who has not physically examined an individual, to refer a patient to AOT.

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2. On page 7, in line 23, strike “3 BUSINESS” and substitute “10”.

o 3 business days for the hearing to occur after the petition is served puts an undue burden on the court system who is already overburdened with cases and long wait times. 10 days is a more reasonable turnaround time.

Finally, the funding of AOT is paramount. Unfunded AOT programs prove time and again to be less effective or even ineffective. Should the Maryland General Assembly (MGA) pass this law, the MGA should look to Medicaid, the Maryland Department of Health, community mental health block programs, private insurance, and philanthropic sources to achieve the appropriate funding for this much-needed program.

With the above amendments adopted, I ask this committee for a favorable report on SB480.

Thank you,

Kathryn Blair, MD

SB 480 - SWA - MPS WPS.pdf
Uploaded by: Thomas Tompsett
Position: FWA

February 26, 2023

The Honorable Melony Griffith
Finance Committee
3 East - Miller Senate Office Building
Annapolis, MD 21401

RE: Support with Amendments – Senate Bill 480: Mental Health Law - Assisted Outpatient Treatment Programs

Dear Chair Griffith 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 with amendment Senate Bill 480: Mental Health Law - Assisted Outpatient Treatment Programs (SB 480). Assisted outpatient treatment (AOT) programs, also known as outpatient commitment, refer to court-ordered treatment for individuals with severe mental illness who may have difficulty adhering to treatment plans on their own, leading to improved outcomes and quality of life. Some of the benefits of AOT programs for mental health include:

- **Improved treatment adherence:** AOT programs can help individuals with mental illness stick to their treatment plans, leading to better symptom management and overall health outcomes.

- **Reduced hospitalizations:** AOT programs have been shown to decrease the need for hospitalizations and emergency room visits by helping individuals stay on their medication and attend appointments with mental health professionals.

- **Reduced homelessness:** AOT programs can also reduce homelessness among individuals with severe mental illness by ensuring they receive the necessary treatment and support to remain stable in the community.

- **Improved quality of life:** By providing individuals with access to ongoing treatment and support, AOT programs can help them achieve and maintain a higher quality of life.

- **Increased public safety:** AOT programs can help prevent individuals with untreated severe mental illness from engaging in behavior that could harm themselves or others, which can improve public safety.

MPS/WPS believe that the following amendments are needed, however, to make this good bill and great one:

1. On page 5, in line 12, strike "A", and substitute "**THE RESPONDENT'S TREATING**".

    - Reason: Only a treating psychiatrist (Emergency Department, Inpatient, or Outpatient) MUST have examined an individual within ten days of the petition in order to testify or affirm a patient's need for AOT. MPS/WPS believe that it is imprudent to allow any psychiatrist, especially one who has not physically examined an individual, to refer a patient to AOT.

2. On page 7, in line 23, strike "3 BUSINESS" and substitute "**10**".

    - From MPS/WPS perspective, three business days for the hearing to occur after the petition is served puts an undue burden on the court system, which is already overburdened with cases and long wait times. Therefore, ten days is a more reasonable turnaround time.

Finally, the funding of AOT is paramount. Unfunded AOT programs prove time and again to be less effective or even ineffective. Should the Maryland General Assembly (MGA) pass this law, the MGA should look to Medicaid, the Maryland Department of Health, community mental health block programs, private insurance, and philanthropic sources to achieve the appropriate funding for this much-needed program.

With the above amendments adopted, MPS/WPS ask this committee for a favorable report on SB 480. If you have any questions concerning this testimony, please contact Thomas Tompsett Jr. at tommy.tompsett@mdlobbyist.com.

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

SB 480_Mental Health Law – Assisted Outpatient Tre
Uploaded by: Adrienne Breidenstine
Position: UNF

Behavioral Health System Baltimore

February 28, 2023

Senate Finance Committee
TESTIMONY IN OPPOSITION
SB 480 Mental Health Law – Assisted Outpatient Treatment Programs

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 480 Mental Health Law – Assisted Outpatient Treatment Programs. This legislation would expand the use of involuntary commitment in ways that undermine the existing OCC program that already exists in Maryland.

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.

SB 480 Creates a Program that 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, this approach undermines the therapeutic alliance between the provider and consumer of mental health services. People subject to the AOT program proposed in this bill would lose the right to make decisions about the psychiatric medications they may be required to take, as SB 480 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 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 are engaged in behavioral health services after they have completed the six-month timeframe for the program. 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 480 would expand the use of involuntary commitment in ways that 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 480 and provide an unfavorable report.**

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SB0480 AOT.pdf
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Senate Bill 480 Mental Health Law –
Assisted Outpatient Treatment Programs
Finance Committee
February 28, 2023
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 480.

SB 480 would provide for the establishment of preventive Assisted Outpatient Treatment (AOT) programs in jurisdictions across the state.

AOT is a form of mandatory community mental health 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. 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[2]	New York Total Population Race/Ethnicity Data[3]
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 schizophrenia diagnosis – even after controlling for all other demographic variables[4] – and more than twice as likely to be involuntarily committed to state psychiatric hospitals.[5]

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

[2] New York State Office of Mental Health, Assisted Outpatient Treatment Reports, Program Statistics, current through February 21, 2023.
[3] United States Census Bureau. https://www.census.gov/quickfacts/NY
[4] 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.
[5] 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 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).

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 there are now questions about the effectiveness of existing medications, with a new paper authored by scientists at the U.S. Food and Drug Administration showing the most prominent drugs for treating depression work better than placebos in only 15% of patients[6]. This growing acknowledgement of the limited effectiveness of many existing medications, along with a slowly rising chorus of concern about the long-term impact of psychotropic medications and renewed attention to alternative treatment approaches, make it 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]

But there is evidence to support the idea that increased outreach and engagement to individuals with serious mental illness improves health outcomes. This is the approach stakeholders have been working to implement via an outpatient civil commitment (OCC) pilot

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[6] Moncrieff, J., Cooper, R.E., Stockmann, T. *et al.* The serotonin theory of depression: a systematic umbrella review of the evidence. *Mol Psychiatry* (2022). https://doi.org/10.1038/s41380-022-01661-0

[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.

program in Baltimore City, and we urge the legislature to support a continued evolution of this effort.

Maryland launched the OCC pilot in October 2017. The program offers a comprehensive range of community-based and client-centered services and supports – with a heavy focus on peer supports – to individuals committed involuntarily to an inpatient psychiatric hospital, either through voluntary engagement *or involuntarily as a condition of release*. Individuals served by the program are being effectively engaged, have experienced positive results, and have continued to participate in services – a major breakthrough in better serving a small yet high-cost population of hard-to-engage individuals whose needs have not been well met by existing programming.

We believe the effectiveness of Maryland's OCC pilot program lies in is fundamental approach, which focuses on holding the behavioral health system accountable to the individual in the program rather than a more coercive approach that applies forced treatment and legal consequences for not following through with a treatment plan. The individuals served through the program have shown improved health outcomes and positive quality of life changes, including avoiding rehospitalization and a continued connection to treatment after 6 months.

Frustratingly, stakeholders working to expand enrollment in the OCC program have been stifled by a series of systemic challenges, including:

- *A delay in promulgation of regulations developed specifically to increase program enrollment.* The OCC stakeholder group spent several months in early 2021 drafting regulations to remove barriers that prevent the program from serving a greater number of people with complex mental health needs. In sum, these regulations would:

    - Expand residency requirements to expand access beyond Baltimore City to those living in contiguous zip codes
    - Ensure a prior commitment in a state hospital does not preclude OCC eligibility
    - Expand eligibility criteria to include emergency department visits, not just inpatient admissions
    - Remove the Administrative Law Judge hearing requirement for voluntary enrollments to allow for an expedited enrollment process and lessen the administrative burden on hospital social workers

    These proposed regulatory changes were submitted to BHA on August 3, 2021, but they have yet to be acted upon.

- *Significant hospital hiring and retention challenges, particularly as relates to hospital social workers.* Due to staffing challenges, social worker caseloads are much higher, and per hospital reporting, they are often not able to complete an OCC referral and adhere to the administrative requirements of the referral process in addition to making other outpatient

referrals for the patient. Additionally, high turnover requires frequent education to bring new hires up to speed on the benefits and requirements of OCC.

- *ASO inability to produce data reports necessary to identify eligible patients.* Since the transition to the new Administrative Services Organization (ASO) at the beginning of 2020, the OCC program has not had access to frequent inpatient utilizer data. This data is critical in identifying potential OCC referrals and allows for more proactive outreach and engagement with hospitals. Multiple requests for this report have been made to the current ASO but it has still not been developed.

We believe the approach taken in the OCC pilot offers an effective and humane method of serving Marylanders with serious mental illness. We urge the legislature to support a continued expansion of this program instead of the more coercive AOT approach outlined in SB 480.

For these reasons, MHAMD opposes SB 480 and urges an unfavorable report.

AOT Senate Bill 480 Testimony.pdf
Uploaded by: Emma Holcomb
Position: UNF

Disability Rights Maryland

Empowerment. Integration. Equality.

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Senate Bill 480 – Mental Health Law – Assisted Outpatient Treatment Programs
Finance Committee
February 28, 2023
Position: Unfavorable

Disability Rights Maryland (DRM) is Maryland's designated Protection & Advocacy agency, 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 and to make meaningful choices about their supports and services. Senate Bill 480 would authorize counties to establish involuntary outpatient civil commitment programs that authorize courts to order individuals adhere to an outpatient mental health treatment regimen, forcing treatment and violating the civil rights of individuals with psychiatric disabilities, resulting in disparities in treatment that will negatively impact people of color and those living in poverty.

Mandating involuntary outpatient commitment is an infringement on an individual's constitutional rights. This bill would authorize involuntary outpatient commitment in order to "prevent a relapse or deterioration that would likely make the respondent a danger to the life or safety of the respondent or others." But such a determination is just speculation. The potential for a relapse or deterioration that would make it *likely* for an individual to be a danger to themselves or others does not constitute a risk of imminent, significant physical danger to self or others—the only standard for involuntary commitment found constitutional by the Supreme Court.[1]

If a respondent declines to submit to a psychological examination or fails to appear at a hearing, § 10-6A-06(E)(3)(I) and (II) allow a judge to order they be detained by law enforcement, taken to a facility, and forced to submit to a psychological examination. While the proposed bill requires "clear and convincing evidence" for the court to order that an individual adhere to Assisted Outpatient Treatment (AOT), the bill requires only "probable cause" for this detention and forced examination. This bill would allow an individual with a psychiatric disability to be forcefully removed from their home without any showing that the individual poses a danger to themselves or others. Respondents could be detained for up to 24 hours, again without a showing of current dangerousness or any of the other requirements for an emergency evaluation outlined in HG § 10-622. Detaining an individual based only on their failure to appear at a civil hearing or a psychiatric examination constitutes unreasonable search and seizure, violating the 4th Amendment to the Constitution.

[1] Humphrey v. Cady, 405 U.S. 504, 509 (1972).

Detentions for forced examination also place individuals who may have psychiatric disabilities in contact with the police. Across the country and in Maryland, individuals with mental illnesses face higher rates of excessive force and violence from police. The Department of Justice found that police in Baltimore routinely used unreasonable force when escorting individuals to hospitals for mental health evaluations under emergency petitions.[2] Officers made "little, if any, effort to de-escalate or engage peaceably," using force as a "first option" in detaining and transporting individuals with mental health disabilities. Not only is this unreasonable and excessive, it can escalate situations and lead people who are being detained for evaluations to perceive that they are being attacked or arrested. This can further escalate the encounter and lead to additional force and violence, disproportionately impacting Black and Brown Marylanders. Police have also decided to arrest individuals with mental health disabilities instead of detaining them for evaluation, subjecting them to jail and the criminal justice system just because of their perceived mental illness. Such encounters between people with mental health disabilities and the police have even led to deadly force against individuals with disabilities. Allowing for respondents to be detained based only on their failure to appear at a civil hearing or refuse a psychiatric examination places them at risk of a violent, traumatizing, and even deadly encounter with police.

The process in this bill for creating the individual's mandated treatment plan is also concerning. § 10-6A-05 (B)(1) 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. The bill further states that "types of medication to be taken shall be identified, although the specific medication or doses need not be identified." Medication is the only treatment explicitly contemplated in the bill. Under state and federal law, an individual can only be forced to take psychiatric medication in very limited circumstances. Individuals have the right to choose or refuse medication, including the type and dosage. Many psychiatric medications have long-lasting and permanent harmful side effects. 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. Even under the limited circumstances when an individual can be forced to take psychiatric medication, non-emergency medications must be approved by a Clinical Review Panel, and an individual can appeal the panel's decision. This bill contains no such procedures or protections, raising significant questions of state and constitutional law regarding forced medication under an AOT program.

In addition to infringing on an individual's constitutional rights, Senate Bill 480 fails to provide the necessary intensive services required to effectively provide outpatient mental health treatment that would reduce emergency room visits, hospitalizations, homelessness, and incarceration. Instead, court-ordered treatment plans may contain whatever unspecified treatment is <u>available</u> and which a community provider has volunteered to provide. The issue this bill seeks to address—the provision of mental health services for individuals who are

[2] U.S. Department of Justice, Civil Rights Division, *Investigation of the Baltimore City Police Department* (August 10, 2016), 80.

frequently hospitalized or arrested as a result of their mental illness—will not be addressed without available services. Ultimately, this bill seeks to remediate the issue of limited available services and barriers to service access by forcing people into treatment. But if those services do not exist, the treatment will not be provided. Nothing will change for these individuals, except they will now be subject to the court's supervision. Without providing for intensive services, there is no way for this bill to achieve its stated goals. The lack of provision for services is especially concerning when you consider that this bill explicitly allows a treating psychiatrist to consider if an individual has "failed to comply with the order of assisted outpatient treatment" in determining whether a petition for an emergency evaluation is warranted. Thus, in areas with few treatment options, an individual may be subject to an emergency evaluation for "fail[ing] to comply" with an order for assisted outpatient treatment. Increasing availability of outpatient community mental health services, as well as resources like housing, transportation and case management, could better prevent the hospitalizations and incarcerations that this bill cites as reasons to commit an individual to AOT, and would better achieve the goals of this bill.

Finally, and importantly, this bill will have a disproportionate impact on people of color. An evaluation of New York's outpatient commitment program over a nearly 10-year period demonstrated that Black and Hispanic individuals are subject to court-ordered treatment at disproportionately high rates. Maryland's Office of the Public Defender has similarly identified that Black and Hispanic individuals are involuntarily committed at significantly disproportionate rates. There are no provisions under this bill to ensure that it will be implemented in a non-discriminatory manner, leaving the law vulnerable to attack on disparate treatment grounds.

DRM encourages the Committee to consider the negative impact of this bill on the disability community in Maryland. For the reasons stated above, Disability Rights Maryland urges the committee to issue Senate Bill 480 an unfavorable report. For more information, please contact Em Holcomb at 443-692-2536 or EmH@DisabilityRightsMD.org.

2023 - SB 480 - AOT (HTalwar).pdf
Uploaded by: Huck Talwar
Position: UNF

WRITTEN TESTIMONY IN OPPOSITION OF

SB 480 - Mental Health Law–Assisted Outpatient Treatment Programs

Finance Committee

Thank you Chair Griffith, Vice-Chair Klausmeier and committee members for the care and effort that you have put into improving the quality and accessibility of healthcare services for Marylanders of all ages. My name is Huck Talwar, and I am writing to you as a patient, peer, and professional.

I am in strong opposition to SB 480 - Mental Health Law–Assisted Outpatient Treatment Programs. If passed, this bill would subject thousands of Marylanders to court-ordered outpatient treatment (forced mental health treatment in the community), where noncompliance would result in emergency evaluation for involuntary commitment. I am writing you today to share …..

Involuntary commitment, court-ordered outpatient treatment, or other types of forced treatment often lead to long-term negative psychological effects–especially trauma and PTSD–on people who are already struggling with their mental and behavioral health.

The first time I was emergency petitioned into the hospital, I was violently handled by a police officer that handcuffed me in front of my mother, who cried like I have never seen before–all because I did not want to take a certain medication. My mother and I both still have nightmares about that day. My first time in an inpatient unit, staff strip searched me on a daily basis on the “hunch” that I was self-harming; they never found any evidence, but they kept strip searching me for two weeks straight. While this treatment is humiliating in general, it was worse for me as a transgender man with C-PTSD that stems from sexual assault. On the same unit, I was subjected to violence and racism at the hands of another patient.

I transferred units shortly after, but my hope was quickly diminished by the treatment I received on the new unit, too. Up at 5am for a six-minute shower. I remember one day I went to seven minutes and was dragged out of the shower room, naked, in front of all the other patients (we were in an eating disorders unit, so this was especially harmful to all the patients therein). To this day, I take six-minute showers for fear of punishment. There was little-to-no procedure when one of the 15 patients with PTSD dissociated or had a flashback. I have seen some of my best friends dragged limp and seemingly lifeless across the floor while the rest of us tried our best to finish our meals (we did not). I remember being name-called by staff, being the butt of fat jokes, and being treated like a criminal by staff.

Some of the worst parts of my experiences being involuntarily hospitalized dozens of times are the fact that my treatment team would not let me have a say in my treatment plan and I had no resources upon discharge. My psychiatrists made changes to my medication without telling me and punished me if I refused to take the medications I knew nothing about. I lost visitation, phone, bathroom, and outside privileges. When they finally got sick of me not getting better, I was discharged with a brown paper bag of my belongings and a wave goodbye. I had no follow-ups, no doctors in place, no team to continue treatment… It was truly terrifying, feeling so alone and vulnerable. Not only this, but it felt as if I had wasted my life in a hospital that did not even help me.

There are things within the behavioral health system that helped me, like my peers, my own chosen outpatient providers, safe environments, trust from my providers, and the freedom to start, change, and stop treatment whenever I wanted to. Now, my providers work together to support me and compromise with me so I can live the best life possible.

After that first hospitalization, though, I lost trust in my providers. I lost faith in the behavioral health system. I gained fear of both. I did not get treatment for a long time afterwards because I did not want to be subjected to that kind of abuse anymore. And things got worse and worse until I was forced back in the hospital walls again and again, gaining new trauma every time. Senate Bill 480 will not only put more people in humiliating circumstances, but will negatively impact their identity, autonomy, dignity, and self-respect. I urge you to oppose Senate Bill 480 because of the risk of traumatizing and retraumatizing individuals with serious mental illness.

SB480_Jane Plapinger_Unfavorable.pdf
Uploaded by: Jane Plapinger
Position: UNF

Senate Bill 480 Mental Health Law –
Assisted Outpatient Treatment Programs
Committee: Finance
Date: February 28, 2023
POSITION: Unfavorable

I feel compelled to submit testimony on SB480 based on my experience as a public health professional working in the public mental health system, both in New York City and then in Maryland for a total of 40 years. Most relevant to my testimony, from 1998 to 2007 I served as Assistant Commissioner for the Manhattan Borough Office of New York City's public behavioral health agency. In this capacity I witnessed firsthand the implementation of New York's Assisted Outpatient Treatment Program.

While there is ideological debate about the involuntary aspect of AOT, I believe we are all united in our belief that people with serious and persistent mental illness (SPMI) deserve to have access to the treatment, services and supports they need to live successfully in the community, with minimal crises and hospitalizations. So I will by-step that debate and instead focus on the pragmatic question of whether SB480 is likely to achieve its aims, and whether it is a prudent use of public dollars. I will share some facts and myths about AOT from my experience in New York, as they relate to the likelihood of success for an AOT program in Maryland.

First, I will share a little-known irony about the origins of New York's AOT program. Andrew Goldstein, the man who pushed Kendra Webdale in front of a subway train to her death, would not have been eligible for the very program established in the aftermath of this incident. Mr. Goldstein, who had schizophrenia, was successfully living in a step-down program that provided housing and medication supervision following his discharge from a state psychiatric hospital. Unfortunately, some time before the incident, he was discharged from the step-down program to make room for another patient, and ended up renting a basement apartment in the house of an elderly woman. Without supervision to take his meds, he stopped taking them, became psychotic, heard voices, became frightened, and pushed Ms. Webdale onto the subway tracks. The irony is that Mr. Goldstein would not have been eligible for AOT because he never refused treatment. Rather, he lost access to the supports he needed – supervision by the public mental health system -- through no action on his part.

When New York established its AOT program, it was understood that psychiatric treatment, while necessary for most people with SPMI, <u>is not sufficient</u> to stabilize individuals in the community and keep them from repeated hospitalizations and involvement with the criminal justice system. Therefore, along with Kendra's Law, New York State appropriated an enormous amount of funding in order to build out a full range of community-based services and resources. The funding included $32 million per year to directly support the AOT program (with medication grants, prison and jail discharge managers, new case management slots and oversight programs), and a whopping $125 million yearly for enhanced community services. During that time, New York also expanded supportive housing – critical to a stable life in the community for people with SPMI.

Even with this enormous infusion of funding and expansion of access to treatment and community based services and resources, the value of court-ordered treatment – just one component of what was implemented in New York – remains unsettled. The legislatively-mandated independent evaluation of New York's AOT

program[1] was unable to determine conclusively that the court order in and of itself had an independent impact on outcomes. However, what was shown to clearly improve outcomes was access to a wide range of community-based services and resources. There was also a suggestion that the monitoring of individuals contributed to positive outcomes. This monitoring required that the AOT program make every effort to do outreach as needed to stay in contact with clients to make sure they continued to access treatment and the range of community-based services listed in their treatment plan. *Enhanced services and staying in touch with individuals to support their access to the range of services they need to live stably in the community appear to be the two components needed to support the SPMI population, and reduce repeated hospitalizations, criminal justice system involvement and other negative outcomes.* There is no consensus that the court order in and of itself had a positive impact.

Two other randomized controlled evaluations of AOT likewise failed to substantiate the value of the court order. The Bellevue Pilot[2] [3] was a Manhattan-based four-year pilot of the AOT program mandated by the legislature that preceded the implementation of Kendra's Law. Individuals with SPMI were randomized into two groups; one group received AOT plus enhanced services and the control group received enhanced services only. The study found no difference in outcomes between the two groups. Instead its finding was that the enhanced services, not the court order, was associated with improved outcomes. (Note: It was political pressure that compelled New York to move forward with the AOT program, despite the negative findings of the Bellevue Pilot.)

The third randomized trial of AOT was done in the United Kingdom – the Oxford Community Treatment Order Evaluation Trial Study.[4] Subjects were individuals who were discharged from involuntary hospitalization and randomly assigned to AOT or a control group. They looked at outcomes relating to hospital readmission, and clinical and social functioning. The results: no significant differences were found across any of the outcomes at the 12-month follow-up.

A key question, then, is whether the Maryland legislature is prepared to appropriate the significant amount of funding needed for people with SPMI to access the full range of services and supports they need to live stable lives in the community, and achieve its desired aims of fewer psychiatric crises hospitalizations, and less involvement with the criminal justice system. Everyone who works in the public mental health system frequently sees individuals like Andrew Goldstein who are stabilized in the hospital, discharged with effective medication, and then decompensate in the community due to lack of supported housing, supervision to take their meds and community-based programs to reduce their isolation and help them living a meaningful life.

In addition, one cannot ignore the current lack of capacity in our state's mental health treatment system. Providers have been struggling with staff turnover, staff vacancies and the fiscal challenges due to issues with the state's ASO. Access to treatment is currently a serious problem for people who *voluntarily* seek mental

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1 Swartz M, Wilder C, Swanson J, et al. Assessing outcomes for consumers in New York's assisted outpatient treatment program. Psychiatr Serv. 2010;61(10):976–981. [PubMed] [Google Scholar]
2 Policy Research Associates. Final report: research study of the New York City involuntary outpatient commitment pilot program. Delmar, NY: Policy Research Associates; 1998
3 Steadman HJ, Gounis K, Dennis D, Hopper K, Roche B, Swartz M, et al. Assessing the New York City Involuntary Outpatient Commitment Pilot Program. Psychiatr Serv 2001; 52: 330–6 [PubMed] [Google Scholar]
4 Burns T, Molodynski A. Community treatment orders: background and implications of the OCTET trial. Psychiatr Bull (2014). 2014 Feb;38(1):3-5. doi: 10.1192/pb.bp.113.044628. PMID: 25237481; PMCID: PMC4067841.

health treatment. Yet SB480 bill appears to focus on treatment alone, does not address the lack of capacity in the treatment system and does not mention the broad range of services needed in addition to treatment to address the problem of individuals with SPMI cycling in and out of hospitals and the criminal justice system. Is there the political will to fund more treatment capacity and the other needed critical community-based services and supports? *It would be naïve to expect that court-ordering people into treatment is going to achieve the very legitimate concerns about our need to do better in serving the SPMI population.* Research has indicated otherwise.

Furthermore, the bill as drafted lacks a rigorous evaluation. Should this bill pass and an AOT program be implemented, it will be costly, and only an independent evaluation could determine whether the program is an effective use of taxpayer dollars. Every AOT program is different, as is the context for the program. Given the ambiguity regarding the value of court-ordered treatment and the significant cost of establishing and operating an AOT program, it would be imprudent to fund an AOT program in Maryland without a rigorous evaluation.

In summary, I do not believe the evidence exists to expend state funds to authorize AOT programs per SB480. A more pragmatic approach, with a stronger evidence base, would be to fund increased outpatient treatment, and expand ACT teams, case management, clubhouses, employment services and supported housing. In addition, the state should pilot approaches to holding providers accountable for following up and monitoring individuals with SPMI post-hospital discharge, relying on approaches which are sounder and less costly than funding an infrastructure to hold court hearings and issue court orders.

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On Our Own of Maryland - 2023 - SB480 (AOT) - OPP.
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WRITTEN TESTIMONY IN OPPOSITION TO SB 480 Mental Health Law – Assisted Outpatient Treatment Programs

Thank you Chair Griffith, Vice Chair Klausmeier, and committee members for your commitment to improving the quality and accessibility of healthcare services for Marylanders. On Our Own of Maryland (OOOMD) is a nonprofit behavioral health 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 throughout Maryland offer free, voluntary recovery support services to nearly 6,500 community members, many of whom live with 'Serious Mental Illness' and socioeconomic barriers.

OOOMD strongly opposes SB 480, which would authorize counties to establish involuntary outpatient commitment programs ("assisted outpatient treatment" or AOT) with parameters significantly outside the current scope of permitted use of forced treatment, and which expose Marylanders experiencing behavioral health challenges to multiple risks for harmful impact.

While we appreciate the sponsors' goal of increasing engagement between people experiencing behavioral health conditions and recovery support services, the program model proposed suffers from a number of serious flaws:

1. The broad eligibility criteria and process associated with AOT programs invites unnecessary, inappropriate, excessive, or malicious potential application.
2. Involuntary treatment is inherently harmful, and involuntary outpatient commitment programs do not produce better outcomes than voluntary programs.
3. AOT programs fail to acknowledge known evidence about the recovery process, address obvious and current structural barriers to seeking and receiving effective behavioral health services, or leverage voluntary best practices (e.g. Assertive Community Treatment, Peer-Delivered Recovery Support Programs, etc.) to achieve the same or better results without infringement on civil rights.

We also respectfully challenge the characterization of people living with 'Serious Mental Illness' as described in the Preamble of the bill:

Engagement is Based in Experience, Not Insight: Many people living with 'Serious Mental Illness' have experienced inaccessible, inconsistent, ineffective, or coercive treatment from our fragmented healthcare system, and it is on the basis of these bad experiences that they hesitate or choose not to further engage. As described in the *SMI Adviser*, a joint resource produced by SAMHSA and the American Psychiatric Association:

"For many people living with SMI, their first contact with the system is during a crisis. This is a time of extreme vulnerability… Some individuals have experienced restraint, seclusion, and/or forced medication. This can result in refusal to re-engage in a system that they do not trust or that causes fear. Some feel that clinicians only remember them as they were during crisis and do not perceive them as they currently are… The failure of clinicians to establish an alliance with the individual is a frequent cause of disengagement or refusal of all treatment."[1]

When it comes to questions of insight, the most pervasive and persistent issue is service systems' lack of acknowledgement and redress to the deep and lasting impact of paternalistic and coercive treatment on individuals' reasonable concerns about violations of bodily integrity, priority for self-protection, awareness of disparate and discriminatory treatment of persons from marginalized identity groups, and subsequent lack of trust in service providers.

Engagement Requires Support for All Life Dimensions: The bill language focuses narrowly on the role of psychiatry and medication, but there are multiple other factors that can support or disrupt both an individual's wellness as well as their ability to participate or 'maintain compliance' in services. Some of these factors include: co-occurring medical conditions, stress in employment, familial, or social relationships, limitations on insurance coverage, lack of financial resources, housing instability, transportation access, and/or the loss of social support and reduced perception of self-worth stemming from experiences of coercive treatment.[2]

Program Design Threatens Patient Rights

The bill proposes an AOT program with excessively broad criteria, and which prioritizes predictions by a single clinician over actual comprehensive assessment of that unique individual's status.

This proposed program would ultimately allow for an individual to be made the subject of a court case wherein they must defend against being involuntarily committed to a required mental health treatment plan (including medication) designed without their consent or involvement, by clinicians with whom they may have no or minimal interaction, and which could rest in large part on the basis of an psychiatric evaluation gained by forceful means initiated via the initial hearing.

Eligibility Criteria: We have serious concerns about the following aspects and implications of the proposed program's eligibility criteria:

- At no point is AOT eligibility limited only to cases where a person is verified as unwilling to voluntarily engage in services. Persons who demonstrate agreement to voluntary treatment should not be subject to involuntary means.

[1]Henry, Patrick. What are some of the key reasons individuals do not follow up on treatment following their initial engagement for crisis care? SMI Adviser Knowledge Base. November 18, 2021.
[2]Xu, Z., Lay, B., Oexle, N., et al. (2018). Involuntary psychiatric hospitalisation, stigma stress and recovery: A 2-Year study. Epidemiology and Psychiatric Sciences, 28(04), 458–465. https://doi.org/10.1017/s2045796018000021

- The 'lookback' period of four (4) years for incidents of hospitalization or harm (threatened or actual) is surprisingly long, and effectively turns voluntary disclosure of distress or voluntary use of emergency behavioral services into evidence for forced treatment.
- The petition may be based on the opinion of a single psychiatrist not required to personally examine the individual, and who is afforded an outsized assumption of reliability with regard to predicting the individual's current and future medical status and their ability and access to voluntarily use services and support at present or in the future. There is no requirement for clinical assessment of capacity for medical decision-making or for a "thorough psychiatric and physical examination," which is advised by the American Psychiatric Association's position statement on involuntary civil commitment "because many patients… also suffer from other medical illnesses and substance use disorders that may be causally related to their symptoms and may impede recovery."[3]
- There no requirement for a comprehensive evaluation of all current or possibly available support services that may meet the individual's needs, or for sufficient consideration of the full scope of an individual's reasons for disengagement or barriers to accessing services, such as economic or logistical barriers, social and cultural considerations, or any history of unsatisfactory, poor, or traumatic previous experiences with healthcare or social service systems. Without this information, an accurate assessment of whether AOT is truly the "least restrictive alternative" and would effectively "maintain the health and safety" of the individual cannot be made.

Petition Process: Embedded in the petition process are multiple opportunities to disregard the individual's rights, expressed needs, preferences, or choices, including:

- Neither the individual, nor their guardian, nor their health care agent are required to be involved in any treatment plan decisions (including medication) required under the AOT program. Given that most individuals may not have a ready representative or advocate, and that only "a reasonable opportunity to participate" must be offered, this item combined with the short timeline between petition and hearing provides cover for effective silencing of the individual in healthcare decisions about their mind and body.
- Only one specific clinician (psychiatrist) is required to participate in the evaluation and lead the treatment plan design. Sole evaluators are undeniably vulnerable to bias, whether explicit or unintentional, and Maryland's current involuntary admission certificate requires agreement between two evaluators. While the AOT process as outlined in the bill may in practice involve more than one clinician (ex: providing testimony for petition, treatment plan design, emergency evaluation), the terms as drafted appear to technically allow this to occur on a sequential basis without real-time collaboration or conference.

[3]American Psychiatric Association (2020). Position Statement on Involuntary Outpatient Commitment and Related Programs of Assisted Outpatient Treatment. APA. https://www.psychiatry.org/getattachment/d50db97b-59aa-4dd4-a0ec-d09b4e19112e/Position-Involuntary-Outpatient-Commitment.pdf

- A Mental Health Advance Directive may be disregarded at the sole discretion of the aforementioned psychiatrist, if assumed to be "contrary to [the individual's] best interest." It is unethical to determine 'best interest' without meaningful consultation with the individual whose interests are at stake, as could be permitted by this program.[4]

Court Ordered Treatment: The hearing to mandate participation in an AOT program must be completed within three (3) business days of the petition, leaving an extremely short time in which the individual must secure legal representation and assemble their defense. Additionally, we are highly concerned about the following aspects of AOT program implementation:

- The hearing may be conducted in the absence of the individual, despite having a significant and lasting impact on their liberty and collateral consequences (e.g. employment opportunities) of an involuntary commitment status determination.
- If the individual refused evaluation at the time of the petition filing, the hearing judge may order the individual to be taken into custody for an emergency psychiatric evaluation without meeting the criteria for Maryland's Emergency Petition process.
- The order for AOT may be established for a period of up to one (1) year, but there is no provision or requirement that court order be immediately terminated as soon as the person no longer meets criteria for involuntary treatment.
- "Material Changes" to the healthcare treatment plan may be made without the prior approval of the court in the case where "circumstances may immediately require" as determined by a singular treating psychiatrist.[5]

People living with 'Serious Mental Illness' already face high levels of stigma that result in a perceived lack of credibility.[6] Maryland and the medical profession have established practices to determine capacity and competency for decision-making in healthcare settings and in legal matters. A program which may result in a long-lasting legal order for medical treatment that may be renewed indefinitely should take every precaution to protect against overriding the civil rights of a person who can be found capable and competent to make decisions about their healthcare, even if their decisions contradict the opinions of some single medical professional.

[4] 10-6A-03(C)(2) allows for the absence of direct evaluation of the individual prior to petition filing. 10-6A-05(B)(1) allows for disregard of the Mental Health Advance Directive. 10-6A-06(D) allows for a hearing to take place in the absence of the individual against whom the petition has been filed.

[5] 10-6A-07(C) allows for the court to amend the Treatment Plan and require the individual's compliance. 10-6A-07(F) allows for a treating psychiatrist to make material changes without prior approval from the court.

[6] Crichton, P., Carel, H., & Kidd, I. J. (2017). Epistemic injustice in psychiatry. BJPsych Bulletin, 41(2), 65–70. https://doi.org/10.1192/pb.bp.115.050682

Forced Treatment Does More Harm Than Good

Involuntary commitment is rejected by leading health policy organizations including Mental Health America, Bazelon Center for Mental Health Law, and the World Health Organization.[7,8,9] Research has shown that prior forced treatment can negatively impact individuals' future experience with behavioral health care, including voluntarily sought services.[10] To illustrate the intensity and negative impact of forced treatment experiences, we offer these personal examples from our statewide peer network:

- "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."
- "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."
- "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. I have a pre-existing thyroid condition and my psychiatrist had never prescribed it to me because of this. [During one hospitalization] staff informed me that my options were to take Lithium or to do electroshock treatment. I was exhausted…and agreed to take [it]. After release, my psychiatrist immediately took me off it because of how it would affect my thyroid."

[7] Mental Health America. Position Statement 22: Involuntary Mental Health Treatment. https://www.mhanational.org/issues/position-statement-22-involuntary-mental-health-treatment

[8] Bazelon Center for Mental Health Law. Forced Treatment. https://www.bazelon.org/our-work/mental-health-systems/forced-treatment/

[9] World Health Organization (2021). Guidance on community mental health services: promoting person-centered and rights-based approaches. WHO Report. https://www.who.int/publications/i/item/9789240025707

[10] Strauss, J. L., Zervakis, J. B., Stechuchak, et al (2012). Adverse impact of coercive treatments on psychiatric inpatients' satisfaction with care. Community Mental Health Journal, 49(4), 457–465. https://doi.org/10.1007/s10597-012-9539-5

Lack of Evidence for AOT Outcomes: At least 6 large systematic research literature reviews show very limited to no evidence that mandating outpatient treatment reduces hospital readmissions or improves social functioning or psychiatric symptoms.[11,12,13,14,15] 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.[16] A 2018 systematic review of 41 studies concluded that compulsory community treatment "does not have a clear positive effect on readmission and use of inpatient beds."[17]

Lack of Data on Civil Commitment Practices and Outcomes: Across the country, there is a startling lack of available and transparent data or consistent evaluation regarding how involuntary civil commitment (inpatient and outpatient) is used, and what positive or negative outcomes result. Even those working within behavioral health services may carry incorrect assumptions about eligibility criteria; in a 2001 national survey of psychiatrists, approximately 30% of respondents "gave incorrect answers about… grounds for civil commitment in their state." [18]

Closer to home, the Maryland Behavioral Health Administration's 2021 *Involuntary Stakeholders' Workgroup Report* acknowledged that "there is unclear language in the statutes and regulations, which has led to wide interpretation of the law on involuntary civil commitment" in our state, and recommended both "comprehensive training around the dangerousness standard" and collection of "additional data elements about civil commitment."[19] To our knowledge, neither effort has commenced as of yet.

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[11] Maughan, D., Molodynski, A., Rugkåsa, J., & Burns, T. (2013). A systematic review of the effect of community treatment orders on service use. Social Psychiatry and Psychiatric Epidemiology, 49(4), 651–663. https://doi.org/10.1007/s00127-013-0781-0

[12] 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. *Psychological Medicine* 37(1). https://doi.org/10.1017/s0033291706008592

[13] Kisely S.R & Hall K (2014). Community Health Systems: An updated meta-analysis of randomized controlled evidence for the effectiveness of community treatment order. *Canadian Psychiatric Association.*

[14] Kisely, S. R., Campbell, L. A., & Preston, N. J. (2011). Compulsory community and involuntary outpatient treatment for people with severe mental disorders. *Cochrane Database of Systematic Reviews*. https://doi.org/10.1002/14651858.cd004408.pub3

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

[16] Ibid

[17] Barnett, P., Matthews, H., Lloyd-Evans, B., et al (2018). Compulsory community treatment to reduce readmission to hospital and increase engagement with community care in people with mental illness: A systematic review and meta-analysis. *The Lancet Psychiatry*, *5*(12), 1013–1022. https://doi.org/10.1016/s2215-0366(18)30382-1

[18] Brooks RA (2007). Psychiatrists' opinions about involuntary civil commitment: results of a national survey. *J Am Acad Psychiatry Law*; 35:219–228 as *cited in* https://ps.psychiatryonline.org/doi/10.1176/appi.ps.202000212

[19] Behavioral Health Administration (2021). Involuntary Stakeholder's Workgroup Report.

Better Options Are Available

In practice, AOT programs can fail to acknowledge known evidence about how best to support the recovery process, address obvious and current structural barriers to seeking and receiving effective behavioral health services, or leverage voluntary best practices to achieve the same or better results.

Understanding Recovery: SAMHSA recognizes the four major dimensions that support recovery are health, home, purpose, and community.[20] Recovery is possible for persons who were previously institutionalized and who live with Serious Mental Illness. A 2018 national, geographically stratified, and random cross-sectional survey on recovery and remission from Serious Mental Illness includes the following findings:[21]

- A series of studies show 20% to 70% of people with a carefully determined schizophrenia diagnosis who leave institutional settings experience significant periods of symptom abatement, limited hospitalizations, and enhanced functioning over time.
- Approximately one third of individuals who experienced a serious mental illness in their lifetime reported current "recovery-remission" (i.e. no impairments in the previous 12 months). "This finding is contrary to traditional beliefs about a consistently deteriorating negative outlook… Being in remission does not imply that impairments may not return, but the remission rate is consistent with findings suggesting that these conditions are typically episodic... High levels of quality of life and community participation (e.g., work, school, parenting, leisure and recreation) occur even when impairments are present. Therefore, although one-third of individuals were found to be in recovery-remission over a 12-month period, this likely does not reflect recovery to the degree that these individuals, as well as those still reporting impairments, are leading satisfying and fulfilling lives."

Assertive Community Treatment (ACT): The ACT model is recognized by SAMHSA as an Evidence-Based Practice and has been the subject of more than 25 Randomized Controlled Trials, with research showing it to be effective in reducing hospitalization while being no more expensive than traditional care and more satisfaction to consumers and their families.[22] However, the State of Maryland has only 25 ACT teams in operation,[23] which is insufficient to meet the current demand for voluntary enrollment in these services. Expansion of ACT teams so that any person experiencing 'Serious Mental Illness' in Maryland could receive this high-intensity, cost-effective

[20] Substance Abuse and Mental Health Services Administration (last updated 2023, Feb 16). Recovery and Recovery Support. *SAMHSA*. https://www.samhsa.gov/find-help/recovery

[21] Salzer, M. S., Brusilovskiy, E., & Townley, G. (2018). National estimates of recovery-remission from serious mental illness. *Psychiatric Services*, *69*(5), 523–528. https://doi.org/10.1176/appi.ps.201700401

[22] Substance Abuse and Mental Health Services Administration (2008). Assertive Community Treatment: The Evidence. *Center for Mental Health Services, SAMHSA, US DHHS*,Pub. No. SMA-08-4344.

[23] As reported by the Evidence-Based Practice Center of the University of Maryland School of Medicine, Department of Psychiatry. https://ebpcenter.umaryland.edu/Training-Topics/Assertive-Community-Treatment/

service would likely result in the sort of positive outcomes desired by proponents of the AOT model, but with a higher degree of confidence and no infringement on civil rights.

Peer Support and Recovery Support Practices: A 2014 study published in the journal *World Psychiatry* identifies 10 empirically-validated interventions that support recovery: peer support workers, advance directives, wellness recovery action planning, illness management and recovery, REFOCUS, strengths model, recovery colleges or recovery education programs, individual placement and support, supported housing, and mental health trialogues.[24] A number of these practices are already available in Maryland, including through On Our Own of Maryland's statewide network of peer-operated Wellness & Recovery Centers. Unfortunately, these tremendously affordable and highly desirable peer-delivered self-management programs and low-barrier, open access community support options are significantly under-resourced.

Conclusion

There is a dire need to increase access and decrease barriers to services for Marylanders living with behavioral health challenges, as recognized in several other bills introduced this session.[25]

SB 480 not only does nothing to create appropriate and accessible services, but it adds serious consequences for individuals determined "non-compliant" in the eyes of a treatment provider. AOT's unspoken expectations are that the individual will follow complex rules and requirements even if they are effectively absent from the decision-making process; will sustain the emotional and legal resources necessary to resist paternalistic or ill-fitting treatment plans or advocate for needed updates; and will somehow successfully maintain consistent care in a variety of services despite well-established network inadequacy and workforce shortages. It is the availability of appropriate, accessible services – not a loved one's concern, a psychiatrist's prediction, or a judge's order – that actually determine who receives care in the community, and who is institutionalized, incarcerated, or offered nothing.

Forced treatment is inherently harmful, and should only be used as the very last resort in situations with significant safety concerns. People experiencing emotional distress need services, not sentences. The best use of state resources is to enhance and expand voluntary, community-based services that are already working well instead of wagering a wealth of unknown consequences through creation of the proposed AOT program.

We strongly urge an unfavorable report on SB 480. Thank you for listening.

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[24] Slade M, Amering M, & Farkas M, et al (2014). Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems. *World Psychiatry*: 13(1):12-20. doi: 10.1002/wps.20084.

[25] Bills from 2023 Legislative Session: SB 362/HB 1249 (Certified Community Behavioral Health Clinics - Established); SB 582/HB 1148 (Behavioral Health Care - Treatment and Access); SB 283/HB 418 (Mental Health - Workforce Development – Fund Established)

OPD SB0480 Written Testimony.pdf
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MARYLAND OFFICE OF THE PUBLIC DEFENDER

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ELIZABETH HILLIARD
ACTING DIRECTOR OF GOVERNMENT RELATIONS

POSITION ON PROPOSED LEGISLATION

BILL: SB0480/HB0823 – Mental Health Law – Assisted Outpatient Treatment Programs

FROM: Maryland Office of the Public Defender

POSITION: Unfavorable

DATE: 2/21/2023

The Maryland Office of the Public Defender respectfully requests that the Committee issue an unfavorable report on Senate Bill 0480 for the following reasons:

1. **SB0480 violates fundamental constitutional rights including the right to due process.**
2. **SB0480 is not evidence-based and will have negative collateral consequences for Marylanders.**
3. **SB0480 contains numerous procedural and logistical limitations that render this bill unrealistic and ineffectual in practice.**

Due to the seriousness of the above-listed issues, our office cannot support legislation that would impact our clients in such ways. Each of these points is detailed in the following paragraphs.

1. **SB0480 violates fundamental constitutional rights including the right to due process.**

The right to refuse mental health treatment is well-established through constitutional amendments and by both the Supreme Court of the United States and the Supreme Court of Maryland.[1] The exception to this fundamental right is extremely limited and narrowly tailored to preserve an individual's right to bodily integrity: psychiatric treatment may be involuntarily administered only if an individual with a mental illness presents a danger to themselves or others. SB0480 introduces a far broader exception to this fundamental right by allowing any individual living in the community with a history of a "lack of compliance with treatment" to be petitioned to appear in court to determine if the individual should be forced into mental health treatment. While SB0480 does include a set of criteria that must be met by clear and convincing evidence to force treatment, the requirements are overly broad and are not indicative of whether the individual is so in need of treatment that his/her fundamental rights ought to be violated. For example, § 10-6A-04(A)(5) states that the individual must be in need of treatment "in order to prevent a relapse or deterioration that would likely make the respondent a danger to the life or safety of the respondent or others." This standard is not only exceedingly vague but also requires that the court

[1] 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).

make a determination about the individual based on speculative future mental health decline rather than the individual's present state.

§ 10-6A-03 allows for any adult "who has a legitimate interest in the welfare of the respondent" to submit such a petition for forced treatment, thereby initiating this legal process. Allowing any interested party to file such a petition introduces opportunities for malicious filings, a practice that is regular under the current context of involuntary inpatient commitment and most common in situations involving domestic violence, divorce and custody proceedings, and control over familial assets. Under SB0480, the petition need only be accompanied by an affidavit from a psychiatrist who is willing to testify that s/he has reason to believe the individual meets the requirements for forced treatment. Notably, SB0480 specifically does NOT require that the psychiatrist has successfully evaluated the individual in order to file a petition.

§ 10-6A-06(A)(2) provides that a hearing be held not later than 3 business days after the date the petition is received by the court, and § 10-6A-06(B)(2) provides that respondents unable to afford an attorney will be provided representation by an entity the county designates. Both state and federal courts have held that the right to counsel means the right to *effective* assistance of counsel.[2] Effective assistance of counsel in hearings pursuant to SB0480 demands that the attorney obtain and review up to four years of medical and psychiatric treatment records (including criminal records), locate/interview collateral witnesses, and retain expert psychiatrists to evaluate respondents, review said records, and provide expert testimony. Three days does not allow for any attorney to provide effective assistance of counsel in these cases and therefore violates the fundamental constitutional right to such counsel in cases involving deprivations of liberty.

Per § 10-6A-06(D), the court may hold a hearing in absentia if the respondent fails to appear at the hearing. The Maryland Court of Special Appeals (now called the Maryland Court of Appeals), in an unreported opinion, *Dennehy v. Risk Management Baltimore Washington Medical Center*,[3] held that permitting Dennehy to discharge counsel, denying her a postponement, then ordering her removal from the hearing room and excluding her entirely from participating in the proceeding, failed to provide her with minimally sufficient due process. The judgment involuntarily committing her to an inpatient psychiatric hospital was reversed. While this decision is not legal precedent, it calls into question the constitutionality of this provision.

§ 10-6A-06(E)(3)(I) and (II) permit a judge to have a respondent taken into custody by law enforcement and transported to an appropriate facility for examination by a psychiatrist if the respondent does not consent to an examination or has not appeared at a hearing. This seizure can be authorized without a finding that the respondent is dangerous or the issuance of an Emergency

[2] *See e.g., Cirincione v. State*, 119 Md.App. 471(1998) " We have long recognized that the right to counsel entitles individuals to more than the mere presence of someone who happens to possess a law degree. The right to counsel is the right to effective assistance of counsel, the benchmark of which is whether counsel's advocacy was sufficient to maintain confidence that the adversarial process was capable of producing a just result." *Coles v Peyton*, 389 F.2d 224 (1968) The Fourth Circuit Court of Appeals held that "Counsel for an indigent defendant should be appointed promptly. Counsel should be afforded a reasonable opportunity to prepare to defend an accused. Counsel must confer with his client without undue delay and as often as necessary, to advise him of his rights and to elicit matters of defense or to ascertain that potential defenses are unavailable. Counsel must conduct appropriate investigations, both factual and legal, to determine if matters of defense can be developed, and to allow himself enough time for reflection and preparation for trial."

[3] *Dennehy v. Risk Mgmt. Balt. Wash. Med. Ctr*., No. 1948 (Md. Ct. Spec. App. Jan. 29, 2021)

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Petition pursuant to HG 10-622. The respondent can be detained for 24 hours. These provisions of the statute violate the 4th amendment of the U.S. Constitution which protects individuals from unreasonable searches and seizures. The Supreme Court of the United States and The Supreme Court of Maryland have made clear the extremely limited exceptions to our 4th amendment protections. Failing to appear at a civil hearing and refusing a psychiatric examination are not exempted conduct.

Perhaps most concerning is that, should an individual be ordered by the court to submit to forced treatment, § 10-6A-08(A) indicates that the administration of medication may be included in the course of the individual's forced treatment. Even when an individual is involuntarily hospitalized, forced medication requires additional scrutiny by a clinical review panel who must consider every alternative treatment option as well as the health risks associated with taking the medication before compelling an individual to be forcibly medicated. SB0480 contains no such protections for individuals if they are forced into treatment, thereby functionally rendering this bill a way to forcibly medicate individuals in the community who do not pose a risk of dangerousness.

2. SB0480 is not evidence-based and will have negative collateral consequences for Marylanders.

In addition to constitutional violations, SB0480 outlines procedures for implementing forced mental health treatment that lack any clinical justification. In fact, research shows that forced treatment in this context is no more effective than voluntary, readily available community mental health services. Further, the mere understanding that the treatment is compulsory undermines the therapeutic alliance between the individual and the provider, thereby introducing an inherent barrier to any potential therapeutic progress. This suggests that funding for SB0480 is far better spent increasing the availability of intensive community services and improving the quality of existing outpatient programming.

Notably, the World Health Organization published a report in 2022 regarding guidelines for mental health treatment that includes a discussion of the harms associated with forced mental health treatment.[4] The report expressly promotes *supported* decision-making over *substitute* decision-making (i.e. forced treatment) as an evidence-based practice that allows the individual to receive mental health support without employing coercive practices. Marylanders would undoubtedly benefit from this progressive approach to mental health care.

Proponents of SB0480 have repeatedly pointed to studies that suggest forced treatment in the community results in improved patient outcomes, but this argument lacks nuance. Such studies are based on a review of all sources of forced outpatient mental health treatment, including treatment that is mandated in a *forensic* context. In contrast, SB0480 concerns individuals in a *civil* context who have not committed a crime that would initiate a judicial proceeding; as such, upon review of studies limited to outpatient civil commitment outcomes, this argument fails. Similarly, proponents of SB0480 assert that Maryland is one of only a handful of states that has not enacted legislation that mandates outpatient mental health treatment; rather, Maryland does have legislation that allows for mandatory outpatient mental health treatment, and like many other states, Maryland has limited such treatment to a forensic context.

[4] World mental health report: Transforming mental health for all. Geneva: World Health Organization; 2022. https://www.who.int/publications/i/item/9789240049338

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Significantly, it has been well-established that Black Marylanders are not only more likely to be subjected to Petitions for Emergency Evaluation, but they are also more likely to be retained at involuntary commitment hearings as compared to their white peers. SB0480 is likely to exacerbate this racial disparity among Marylanders. Evidence shows that similar legislation ("Kendra's Law") in New York State has resulted in exactly this – 77% of those who have been forced into outpatient treatment since the introduction of this legislation in New York City are Black and Brown individuals; this disparate impact has been observed in other states as well.

It is also important to note that forced outpatient treatment would have the same collateral consequences as involuntary inpatient treatment. Civil commitment statutorily limits individuals from engaging in certain occupations, places restrictions on one's immigration status, potentially impacts driving privileges, can have implications in child custody disputes, restricts an individual's right to own a firearm, and prohibits individuals from serving on a federal jury. In addition to these consequences, individuals must also live with the social stigmatization of mental illness, which can deter individuals from voluntarily seeking out subsequent treatment.

3. SB0480 contains numerous procedural and logistical limitations that render this bill unrealistic and ineffectual in practice.

The following is a list of just some of the procedural and logistical limitations that would not only undermine the spirit of this bill but also contribute to the severity of both constitutional and social justice concerns described above:

A. Per § 10-6A-02, counties "may" establish programs to implement forced treatment. If some counties do not opt to establish this programming while others do, jurisdictional issues will arise. For example, a resident of one county could avoid a hearing altogether by simply moving to a county that has opted out of establishing such programming.
B. SB0480 does not provide any source of funding for forced treatment programming should a county wish to establish such programming, nor does it state whether psychiatrists involved in providing treatment would be employed by the county or serve as independent practitioners, thereby introducing ethical considerations for psychiatrists who participate in such programming.
C. SB0480 also lacks a source of funding for individuals who do not have health insurance, which is typically a significant portion of the population that SB0480 aims to impact. Since individuals cannot be compelled to apply for subsidized social assistance programs such as Medicaid, it is unclear how forced treatment will be provided to these individuals or whether an individual will be considered "non-compliant" with their treatment plan if they are unable to afford it, thereby potentially exacerbating existing disparities among individuals with limited income.
D. SB0480 does not define "compliance," first referred to in § 10-6A-04(A)(3), leaving excessive ambiguity as to how the court should interpret a respondent's "lack of compliance with treatment." Since the outcome of hearings under SB0480 is entirely dependent on the court's understanding of whether or not a respondent has complied with treatment, such ambiguity will lead to, at best, inconsistency in application, and at worst, significant violations of a respondent's constitutional rights.
E. Similarly, SB0480 leaves other significant terms undefined: "hospitalization" and "mental disorder" for the purposes of qualifying an individual for forced treatment under § 10-6A-

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04, are broad terms that, left open to interpretation, are likely to result in inconsistent standards and thus, inequitable outcomes.

F. § 10-6A-06(E)(I) allows for a respondent who declines a psychiatric examination or declines to attend their hearing to be detained at an "appropriate facility" for up to 24 hours for evaluation. SB0480 does not define what kind of facility might be deemed appropriate, whether it be a mental health facility or correctional facility, thus introducing further ambiguity that will contribute to the overcrowding of both Maryland hospitals and correctional institutions (in addition to the constitutional concerns arising from this provision that are detailed above).
G. Per § 10-6A-06, the court must schedule a hearing no later than 3 business days following receipt of a petition. Counties do not have the authority to designate Maryland District Courts to hear these cases so hearings pursuant to SB0480 would be held in the Circuit Court where the civil rules of procedure, discovery and evidence apply. This provision is logistically impossible given the time frames outlined in the rules of civil procedure, not to mention the current delay in nearly all Circuit Court proceedings across the state.
H. Also per § 10-6A-06, if the respondent cannot afford counsel, "representation shall be provided by an entity that the county designates." In past versions of this bill, the Office of the Public Defender has been designated to provide representation; not only is likely that counties would want to designate our office to provide such representation if SB0480 is passed, but counties nether have the authority to do so nor it is feasible for our office to handle the increased caseload that would result.
I. § 10-6A-10 provides that an order for involuntary outpatient treatment can be extended for a year. SB0480 does not state that a new hearing is required. Forced mental health treatment is a serious deprivation of liberty that requires due process protections; again, SB0480 lacks such protections by not delineating a timeframe under which the court must review an individual's need for forced treatment.
J. SB0480 effectively renders guardianship valueless, as it merely allows an individual's guardian to have an "opportunity" to participate in the development of a forced treatment plan, rather than the opportunity to make decisions about the individual's need for treatment, as is purpose of guardianship. Similarly, SB0480 does not require forced treatment plans to honor an individual's mental health advance directive if the treating psychiatrist does not agree that the directives are in the best interest of the respondent.
K. The preamble to this bill states, "A small but persistent subset of individuals with severe mental illness struggle to adhere voluntarily to treatment…" This language makes it appear and its proponents have argued that the bill is only intended to apply to a small group of people. This bill is not narrowly drafted to apply to a small subset of people. The Mental Health Division of the Public Defender's Office has represented a little over 30,000 people in involuntary civil commitment cases in the past 5 years. These clients were certified for involuntary admission because they had a mental illness and were a danger to self or others. This bill casts an extremely large net and many thousands of individuals with mental illness currently meet most of the eligibility criteria for forced outpatient treatment. As such, the constitutional, social, and fiscal consequences of passing SB0480 are likely to be significant.

In sum, the constitutional issues that arise from SB0480 are highly concerning and the lack of evidence to support the implementation of forced outpatient treatment programming suggests

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that SB0480 would cause Marylanders far more harm than good. Considering that many Marylanders are voluntarily seeking treatment and are unable to access it, legislative efforts to improve mental health outcomes are better focused on improving the quality of and access to voluntary mental health services in our communities.

For these reasons, the Maryland Office of the Public Defender urges this Committee to issue an unfavorable report on SB0480.

Submitted by: Maryland Office of the Public Defender, Government Relations Division

Authored by: Carroll McCabe
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sb480.pdf
Uploaded by: Matthew Pipkin
Position: UNF

MARYLAND JUDICIAL CONFERENCE
GOVERNMENT RELATIONS AND PUBLIC AFFAIRS

Hon. Matthew J. Fader
Chief Justice

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 480 Mental Health Law – Assisted Outpatient Treatment Program
DATE:	February 8, 2023 (2/28)
POSITION:	Oppose

The Maryland Judiciary opposes Senate Bill 480. This bill establishes the Assisted Outpatient Treatment Pilot Program.

This bill sets requirements for a pilot program including requirements regarding eligibility, hearings, and treatment which seem very well intended, but need procedural work to be logistically implemented, at a minimum. The times outlined in this bill are unrealistic and there are due process considerations. On page 7, lines 23-24, the bill requires that a hearing on a petition be held "not later than 3 business days after the date the Petition is received by the Court." That timeline is unworkable and would not even allow notice. It also does not recognize the demands of other cases pending. Also on page 10, lines 14-16, the bill mandates that a hearing be held within 5 days on any change to a treatment plan. That timeline is also unrealistic; should not be mandated; and would not even allow for notice to the parties. The Judiciary is in the best position to schedule the matters before it and any attempt to mandate the docket structure runs afoul of the separation of powers doctrine.

Additionally, the Judiciary is unsure how to interpret the "reasonable efforts to secure the Respondent's appearance" provision on page 8, line 5 and lines 14-20. It is unclear what those reasonable efforts would be or how those efforts would comport with other notice provisions. It is also unclear how the court would "direct that the Respondent be taken into custody" and who would do that. Is that a local law enforcement agency? A health department employee? There is no express authority for such an act within the bill. It is also unclear where the individual would be taken. The bill indicates the Respondent will be "transported to an appropriate facility for examination by a psychiatrist" but there is no mechanism for the court or the transporting agency/individual to make such a determination.

The 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 but there is no indication within the bill how counsel will be assigned, retained or compensated.

The bill goes on to state that, upon scheduling the petition for a hearing, the court cannot compel the testimony of the treating psychiatrist. It is unclear how, then, the court would have any means of determining whether the Respondent should be ordered into the treatment prescribed? It appears that the testimony of the treating psychiatrist is necessary, as the petitions filed contain the opinions and requests of the treating psychiatrist. How would the court logistically proceed with a hearing and consider the relief requested without the testimony of the treating psychiatrist?

The bill also states that the Respondent may not be found in contempt of court or involuntarily admitted to a facility for noncompliance with the court-ordered mental health treatment. As such, there is no mechanism by which the court can enforce compliance with the underlying order for outpatient mental health treatment. If there is no mechanism by which the court can enforce compliance, then the court should not be statutorily required to review petitions, hold hearings, and order such treatment.

This bill attempted to address some of the issues that the Judiciary raised last year. Despite efforts to address the issues raised, the bill still has logistical challenges, is unrealistic, and desires that the court exercise its power to order treatment without also empowering the court with the authority to enforce compliance.

cc. Hon. Karen Lewis Young
Judicial Council
Legislative Committee
Kelley O'Connor

2023-SB480- AOT- Oppose.pdf
Uploaded by: Melinda Morgan
Position: UNF

Written Testimony in Opposition to
Senate Bill 480: Mental Health Law:
Assisted Outpatient Treatment Programs

Thank you Chair Griffith and Vice-Chair Klausmeir and committee members for your time.

My name is Mindy Morgan and I am 43 years old. I am here to state my position in opposition to Senate Bill 480. I am a mother of three, a member of my local church, a taxpayer, a clinical social worker, and the clinical director for a substance use treatment program. I have a Masters Degree in Social Work and have worked in the field with those with mental health issues for over 20 years.

I was diagnosed with bipolar disorder at age 21. I didn't seek treatment until age 35. I have been hospitalized three times over the last nine years. Through my hardest times, I maintained my full time job and was the sole breadwinner for my family while fighting to get the care I needed.

I spent over a decade of my young life afraid and ashamed. The people I trusted helped me see that I needed treatment. People don't develop the trust and openness to seek help through court orders.

In my third hospital stay I was held against my will. I wanted to leave a dangerous environment and I was not assessed to be at risk for harm. But I was locked in anyhow. As a result, I have told myself that never again will I seek help at a hospital. Forced treatment was harmful to me.

Am I less entitled to my constitutional rights because of my bipolar diagnosis? Are we proposing this for those with diabetes or heart disease who are struggling?

From my personal experiences as both a consumer and a professional, I will be clear that establishing court-ordered outpatient treatment will significantly increase barriers to individuals seeking care. People already don't trust the system. I know I don't. We will be far less likely to be honest and open in treatment or even to seek it at all if we know that our medical records will be open for examination should some person file a petition against us- with legitimate concern or not.

Now, as a taxpayer, I'm also concerned that this will burden our already overburdened systems- with people who are likely not fully engaging with care because our treatment systems are broken- not because they don't want help. It takes months to see psychiatric provider in some counties. Limited services are covered by insurance. Some people have no insurance. Schedules are full, providers are scarce and when you do see a provider there is little to no choice if you feel the care is of poor quality. Those providers who are skilled, competent and caring are poorly paid, overburdened with demand and paperwork, and are struggling with burnout.

Forced commitment programs operate from the standpoint that the consumer is the one who is broken. This couldn't be further from the truth. Our system is broken.

Please, let's take the target off those with mental health issues, address these systems, and fund real solutions. Forcing people into broken systems is not the way to help them get well. Thank you for your time.

SB 480 assisted outpatient tx MR OPD opposition .p
Uploaded by: Melissa Rothstein
Position: UNF

NATASHA DARTIGUE
PUBLIC DEFENDER

KEITH LOTRIDGE
DEPUTY PUBLIC DEFENDER

MELISSA ROTHSTEIN
CHIEF OF EXTERNAL AFFAIRS

ELIZABETH HILLIARD
ACTING DIRECTOR OF GOVERNMENT RELATIONS

POSITION ON PROPOSED LEGISLATION

BILL: SB 480 Mental Health Law – Assisted Outpatient Treatment Program

FROM: Maryland Office of the Public Defender

POSITION: Oppose

The Maryland Office of the Public Defender respectfully requests that the Committee issue an unfavorable report on Senate Bill 480. OPD's Mental Health Division Chief, Carroll McCabe, and Assistant Public Defender Sanjeev Varghese, who represents individuals at Spring Grove Hospital Center, are providing separate testimony to detail the significant substantive concerns that we have with this bill. My testimony focuses on the cost impact of the bill, particularly with respect to the representation required to challenge involuntary treatment orders for people who cannot afford a private lawyer.

SB 480 does not authorize OPD to provide representation in involuntary outpatient commitment proceedings. But it does include a right to counsel -- as it must, given the liberty interests threatened. Our office currently represents over 99% of individuals facing involuntary inpatient commitment. Private attorneys generally do not provide this representation and it is unclear whether the counties would be able to secure sufficient outside counsel to provide adequate representation.

Whether inpatient or outpatient, involuntary treatment is a significant liberty infringement. Effective assistance of counsel in these proceedings requires substantial effort to protect the right to bodily integrity interests at stake. Collateral sources need to be interviewed; expert psychiatrists hired; State witnesses deposed; and years' worth of available records – including records relating to inpatient and outpatient treatment, criminal history, corrections institutional history, and housing – must be obtained and reviewed.

This level of effort will need to occur for each of the individuals who require representation. Last year, our Mental Health Division represented over 9,600 clients in involuntary admission cases. Thousands of those clients, as well as an unknown number of

people who are not initially subject to involuntary hospital admission, could be subject to involuntary outpatient treatment under this bill. Representation costs alone would require millions of dollars in appropriations.[1]

A similar pilot project in Baltimore City highlights the high cost for little to no benefit for involuntary outpatient services. At the start of the pilot, nearly $400,000 was expended to provide nine individuals (six voluntary patients, three involuntary patients) with peer support, clinical supervision, quality assurance, attorney representation and oversight.[2] The additional investment needed to develop and maintain this level of infrastructure statewide, and for the full patient base anticipated, would exponentially increase these costs.

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 so that individuals voluntarily seeking treatment can receive the services they need. The funds proposed to be spent here would be better utilized by developing such 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 480.

Submitted by: Government Relations Division of the Maryland Office of the Public Defender.
Authored by: Melissa Rothstein, Chief of External Affairs,
melissa.rothstein@maryland.gov, 410-767-9853.

[1] Outpatient treatment representation is beyond the parameters of OPD's authorizing statute. If that statute was amended to authorize this representation, OPD estimates requiring more than $7 million to add this representation to our already overburdened Mental Health Division (MHD). The details of these costs are specified in the Agency Explanation of Impact that we submitted to the Department of Legislative Services.
[2] Fiscal and Policy Note, 2019 HB 427, online at https://mgaleg.maryland.gov/2019RS/fnotes/bil_0007/hb0427.pdf.

IL Written Testimony SB480 2023.pdf
Uploaded by: Sarah Basehart
Position: UNF

SB480-Mental Helaqth Law-Assisted Outpatient Treatment Programs - Oppose

Testimony of Maryland Centers for Independent Living

Senate Finance Committee 02/28/2023

The Maryland Centers for Independent Living oppose SB480.

Assistive outpatient treatment is involuntary and coercive. Demand for mental health treatment already outweighs supply. This bill could put an individual who does not want treatment ahead of an individual who does. Many studies show that involuntary treatment is ineffective. To effectively treat people with serious mental illness, you must first address social determinants of health such as housing, healthcare, food, transportation, etc. This bill does not address any of these issues. This bill does not provide any safeguards against it being disproportionately used on people of color. For these reasons, the Maryland Centers for Independent Living are opposed to this bill.

The seven Centers for Independent Living (CIL) were established by federal law and work to ensure the civil rights and quality services of people with disabilities in Maryland. Centers for Independent Living are nonprofit disability resource and advocacy organizations located throughout Maryland operated by and for people with disabilities. CIL staff and Boards are at least 51% people with disabilities. We are part of a nationwide network which provides Information and Referral, Advocacy, Peer Support, Independent Living Skills training, and Transition Services.

Contact Information:

Sarah Basehart
Independence Now
240-898-2183
sbasehart@innow.org

Hindley Williams
The IMAGE Center
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Uploaded by: Svetlana Shargorodskaya
Position: UNF

1.

What is it like to be given pills that make you forget the names of your loved ones? Or make your fingers so stiff that you can't type, can't dial a phone, can't open a bag of chips? Or make you slur your words, so you can't communicate intelligibly, especially by phone? Or make your ears ring, or your vision blur, impairing your ability to perceive your surroundings?

What is it like to have no choice about whether to continue to take such pills? Anyone reading this may experience psychosis someday, even if you never have before, in rare reactions to antibiotics, antidepressants, cough syrup, recovery from surgery and even to Covid.

This policy isn't just about the rights of scary, smelly homeless people to push their shopping carts into traffic. The civil rights to bodily autonomy may someday well be your own rights.

2.

You may have heard stories from family members of psychotic people, who ask you to provide the legal tool of AOT so that they can force their loved ones into taking pills. I have heard the other side.

I used to participate in online Zoom meetings about psychopharmacology research. Twice, such meetings were hijacked by family members went off-topic to plead for legal help to free their loved ones from AOT orders that were already in place. These family members saw their loved ones experiencing horrendous side effects that were incapacitating, leading to both mental and physical deterioration, and putting their loved ones on a path to an early death. They were literally crying, begging for help in their struggle against the judges and psychiatrists who imposed the AOT orders.

They clearly did not feel that the involvement of the legal system in their loved ones' treatment was beneficial. Their anguish was real, and I can only imagine the far greater suffering of their loved ones, the AOT recipients themselves, incapacitated, deteriorating, and dying due to side effects.

3.

You may have also heard stories about psychotic people committing violent crimes. In a statistical approach, if you look at another group of people – males between age 15 and 24 – you find that these young males commit violent crimes at a much higher rate than psychotic people do. If your goal is to keep society safe from violence, will you preemptively lock up every young male? Of course not, because in our legal system, people have the civil right to be punished for crimes that they committed in the past, not crimes that they may commit in the future, no matter what statistical group they belong to. Just as young males have this civil right, so do people who experience psychosis.

4.

In conclusion, there is an old proverb in German and in Arabic:

Don't ask the doctor, ask the patient!

2023-SB 480-Oppose.pdf
Uploaded by: Yvonne Perret
Position: UNF

ADVOCACY AND TRAINING CENTER

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TESTIMONY
SB 0480/HB0823
Mental Health Law –Assisted Outpatient Treatment

I am writing to oppose the above referenced legislation for the following reasons:

I am a licensed clinical social worker who has worked with adults who are experiencing homelessness and who have serious mental illness and/or co-occurring disorders for the past 32 years. Throughout these years, I have learned and implemented the following:

1, The most effective way to facilitate adherence to outpatient treatment is through positive outreach, engagement, and the provision of welcoming and individually-determined treatment and services.

2. In my years of working with people who are unhoused, I and my staff, in Baltimore City over the period of 10 years, facilitated engagement with treatment for numbers of individuals who had never stayed in treatment previously. We were able to accomplish this through partnering with Assertive Community Treatment (ACT) teams, homeless service providers outreach teams, our own outreach and engagement, and the initial provision of ensuring that we met individuals' basic needs for housing, food, income, and other necessities. We have multiple examples of success with this approach.

3. "Assisted" outpatient treatment is a euphemism for forced involuntary treatment. Although coercing someone into treatment may make sure they attend, it doesn't ensure their being engaged in treatment, a big difference. I, too, hope that all individuals who are experiencing harshness and the lack of having needs met are able to improve their lives. Coercion isn't the answer. Time spent engaging, treating individuals with respect and hope, and meeting with them where they are, frequently and consistently, are the answers. The incorporation of peer support can be an invaluable tool in doing so.

I urge the Committee to vote no on this legislation and to consider the submission of greater funding for the services that we who do this work know are effective.

Thank you.

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Uploaded by: State of Maryland (MD)
Position: INFO

Maryland
DEPARTMENT OF HEALTH

Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary

February 28, 2023

The Honorable Melony Griffith
Chair, Senate Finance Committee
3 East, Miller Senate Office Building
Annapolis, Maryland 21401

RE: SB 480 – Mental Health Law - Assisted Outpatient Treatment Programs – Letter of Information

Dear Chair Griffith and Committee Members:

The Maryland Department of Health (MDH) respectfully submits this letter of information for Senate Bill (SB) 480 – Mental Health Law – Assisted Outpatient Treatment Programs. SB 480 authorizes a county to establish an assisted outpatient treatment program. Assisted Outpatient Treatment (AOT) is a civil commitment to outpatient behavioral health treatment. It is used for individuals who will not voluntarily accept outpatient treatment but who have a history of endangering themselves or others. An individual in AOT who does not engage in treatment will be involuntarily committed to a hospital prior to becoming a danger to self or others.

An individual's voluntary acceptance of treatment is always preferred. However, research shows that AOT programs may reduce the incidence and duration of hospitalization, homelessness, incarcerations, and interactions with the criminal justice system for individuals with severe mental illness who have (1) histories of non-compliance with treatment and (2) repeated psychiatric crises. The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) further reports that "... for individuals with serious mental illness, outpatient commitment orders, if kept in place for at least six (6) months and paired with intensive services, are associated with reduced incidence of hospitalization and improved quality of life for many persons with a serious mental illness."[1]

The Moore-Miller administration is committed to supporting Marylanders with serious mental illness. The Department will consult with stakeholders during the 2023 legislative interim and report to the General Assembly before the 2024 legislative session with recommendations on establishing an AOT program in Maryland.

[1] Substance Abuse and Mental Health Services Administration: Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice. Rockville, MD: Office of the Chief Medical Officer, Substance Abuse and Mental Health Services Administration, 2019.

If you would like to discuss this further, please do not hesitate to contact Megan Peters, Acting Director of Governmental Affairs at megan.peters@maryland.gov or (410) 260-3190.

Sincerely,

Laura Herrera Scott, M.D., M.P.H.
Secretary