SB480 Testimony, Senate Finance Committee, February 28, 2023
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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.

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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.