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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