House Bill 823: Mental Health Law –
Assisted Outpatient Treatment Programs
Committee: Health and Government Operations
Date: March 14, 2023
POSITION: Unfavorable

I feel compelled to submit testimony on HB823 based on my 40 years of experience as a public health professional working in the public mental health system, both in New York City and then in Maryland. 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 the debate about the involuntary aspect, and instead focus on the pragmatic question of whether HB823 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 but telling irony about the origins of New York's AOT program. Andrew Goldstein, the man who pushed Kendra Webdale to her death in the pathway of a subway train would not have been eligible for the AOT program established in reaction to this incident. Mr. Goldstein, who had schizophrenia, was successfully living in a step-down program that provided housing, medication supervision and other supports following his discharge from a state psychiatric hospital. Unfortunately, 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, *is not sufficient* 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 expanded supportive housing – critical to a stable life in the community for people with SPMI, such as Mr. Goldstein.

Even with this enormous infusion of funding and the subsequent expansion of access to treatment and community-based services and resources, the value of court-ordered treatment alone – just one component of

what was implemented along with New York's AOT program – 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 treatment plus 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, then, 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 considering this bill, and the problem it aims to solve, 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

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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.

the fiscal challenges due to issues with the state's Administrative Services Organization. Access to treatment is currently a serious problem for many Marylanders who *voluntarily* seek mental health treatment. And Maryland is sorely lacking in supported housing and other community-based programs needed to by those with SPMI. Yet HB823 bill appears to focus on treatment alone, does not address the lack of capacity in the treatment system and does not fund the 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 as well as the other needed critical community-based services and supports? *Without a significant infusion of funding, it would be naïve to expect that court-ordering people into treatment is going to address 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 HB823. 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.

Contact: Jane Plapinger, MPH
8612 Lawrence Mill Court
Ellicott City, MD 21043
jdplapinger@gmail.com
410-868-4057