HB823 Testimony, House Health and Government Operations Committee
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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 HB823 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 four years.

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

Opponents claim that Maryland has inadequate services to implement AOT and existing 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. 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 the Baltimore OCC pilot program is Maryland's unique form of AOT and should be expanded. But, OCC is not an evidence-based program while AOT is evidence-based. OCC is designed to serve primarily voluntary individuals and no outcome data specific to

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

involuntary individuals under a court order have been reported. The OCC pilot has failed the sickest individuals since they will not join the program voluntarily. Reports on OCC submitted to the legislature indicate that in the four years covered, the program only served a total of three individuals under a court order. No outcome data on hospitalization, incarceration, arrest, violence, homelessness, victimization have ever been reported. No analysis of net costs has been made. Extensive data reported on AOT from other states and SAMHSA grantees show significant reductions in all of above metrics as well as significant cost savings.

Some opponents state that many thousands of people in Maryland will be court-ordered under AOT, but 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, and AOT must be the least restrictive alternative appropriate to maintain the health and safety of the individual. In addition, a jurisdiction has the option of limiting the enrollment numbers to match the available services and funding. Plus, not every jurisdiction in Maryland will choose to implement AOT. I did a ballpark estimate of number of people that might be served in my own county, Howard, under a mature AOT program. I grew up in Queens, NY which has had AOT for around 20 years. According to the New York State Office of Mental Health website, 273 people are currently under active court order in Queens, population 2.4 million people. Howard County has a population of approximately 350,000 people, which would mean that a mature AOT program in Howard County might serve around 40 individuals.

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 HB823 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.

In conclusion, the AOT program in HB823 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 HB823.

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Comparison of Assisted Outpatient Treatment (AOT in HB1017/SB807[from 2022]) and the Baltimore Outpatient Civil Commitment Pilot Program: **Designed for Different Populations**.

EXECUTIVE SUMMARY: Assisted Outpatient Treatment (AOT) as proposed in HB1017/SB807 and the Baltimore Outpatient Civil Commitment (OCC) Pilot and are designed to serve different populations. The Baltimore OCC pilot program implemented in 2017 has tragically failed to demonstrate it can successfully enroll or provide positive outcomes for the target population that evidence based AOT programs, as the one proposed in SB807/HB1017, have successfully served for years across the nation. These are the individuals that have consistently failed to adhere to voluntary outpatient services or refused all voluntary outpatient services, often because the illness itself prevents insight into their need for treatment. The Baltimore OCC Pilot program is intentionally designed to exclude many of these individuals and instead focuses on individuals willing to voluntarily enter their program without being under a court order. The OCC program has reported enrolling only voluntary participants for the past three and a half years. SAMHSA considers AOT a successful evidence-based program and has awarded over 40 grants nationwide to promote establishment of AOT programs. The Baltimore OCC program initially received one of these grants. However they lost the funding because their program design was not compatible with evidence based AOT and was able to serve more than a handful of individuals who needed a judicial order to comply with treatment.

MINIMAL ENROLLMENT in Baltimore OCC Pilot over 4+ years: The attached Baltimore OCC Pilot report, entitled "Eligibility Checklist" is from the Maryland Health Department's Involuntary Commitment Stakeholders' Workgroup Report of 9-11-21. (Highlights added) It shows that in four years, a total of only 14 individuals were enrolled in the program. Only three of those 14 enrolled had refused to voluntarily agree to participate in the OCC pilot and were thus enrolled under an administrative law judge's (ALJ) order ("involuntarily enrolled"). All three were enrolled in FY18 and zero were reported in FY19, 20, and 21. Updated information reported to the HGO Committee on March 10, 2022, indicated that total enrollment in FY21 was two and is five so far in FY22, although it failed to indicate if any were involuntarily enrolled under an ALJ order.

The Baltimore OCC Pilot had to give up the final 2 years of funding of a four-year SAMHSA grant because it was unable to achieve promised grant enrollment requirements of 75 enrollees under a court order. In over 4 years it has failed to demonstrate that it can serve a significant number of those who fail at or refuse voluntary outpatient treatment. Eighteen other pilot AOT programs who received SAMHSA grant funding the same year as Baltimore, were able to enroll at least 75 participants per year under a court order.(see attachment)

OUTCOME MEASURMENTS:

The Baltimore OCC pilot has failed after 4.5 years to report on any outcome measures for participants compared to a pre- OCC period This includes a lack of analysis of outcomes on" the use of emergency departments and inpatient services… [and] arrest" as was promised in the March 2018 OCC Pilot report. The minimal raw data that was reported for current services was never reported separately for the involuntary participants. Therefore, there is no way to even determine how many or to what extent the involuntary enrollees, who are the only ones under a court order, even participated in the program or for how long. The Mental Health Association's Quality Treatment Team only reported several statements from participants with no analysis of how many participants agreed with those statements, and no analysis of important participant attitudes such as the percent of participants satisfied with the services received or the percent that felt the program helped them with adherence to treatment.

Research over many years has consistently shown that evidence based AOT, as is authorized by HB1017/SB807, is successful in engaging individuals in outpatient treatment who previously have not consistently engaged or have refused voluntary outpatient treatment. Results show positive participant outcomes, including 77-87% reductions in emergency department visits and hospitalizations as well as significant reductions in arrests, incarceration, violence, victimization, and participant cost. Research also shows 92% participant satisfaction with the AOT services. (See attachments)

CONCLUSION: The Baltimore OCC pilot for over four years has failed to show that it can provide outpatient treatment to any significant number of patients who have previously been unable or unwilling to engage in voluntary treatment. This is despite available funding for higher enrollments. It also has failed to demonstrate that it can improve any outcomes for participants, including critical outcomes such as reduced hospitalization or involvement with the criminal justice system. The Baltimore OCC pilot continues to focus on expanding service for patients willing to agree to its program voluntarily. It has rejected adopting evidence-based best practices of AOT found to enable successful engagement and recovery for individuals who have been unable or unwilling to engage in voluntary outpatient treatment.

Marylanders with severe mental illness who lack the ability to voluntarily engage with outpatient services and are cycling between hospitals, jails and homelessness, deserve a program for which they are eligible and that is founded on evidence-based practices for recovery that have repeatedly demonstrated successful outcomes for this population. Currently there is no such program in Maryland. Their recovery depends on the establishment of an evidence based AOT program, as would be demonstrated by a pilot program authorized by SB807/HB1017.

Below is a discussion of some of the specific Baltimore OCC program design factors which differ from evidence based AOT, that have contributed to the OCC Pilot program's failure to enroll any significant number of participants and reduces the likelihood of achieving positive outcomes, for those with a history of failure to engage or refusing voluntary services.

ADMISSION CRITERIA:

Those in charge of the Baltimore pilot have steadfastly opposed and continue to oppose changing admission criteria and using operating procedures like those used by successful evidence based AOT programs to serve individuals, who have failed to consistently engage or refused outpatient treatment. The Baltimore OCC revised regulations have only expanded admission criteria for patients in their "voluntary" program which does not include an order by an ALJ. The OCC Pilot admission criteria program excludes most "involuntary" patients by using more restrictive admission criteria than any AOT program in the nation. It requires that the patient was "retained" at least twice in an inpatient psychiatric hospital in the past 12 months. This means retention at a commitment hearing by an administrative law judge (ALJ). This excludes the great majority of patients repeatedly brought involuntarily to an Emergency Department for evaluation, who then agree to voluntary hospital admission and never go before an ALJ. It also excludes patients who cycle in and out of hospitals asking for voluntary admission for suicidal ideation who may accept treatment while in the hospital, only to repeatedly deteriorate when they refuse voluntary outpatient treatment after discharge.

The AOT Program proposed in HB1017/SB807 is designed according to evidence-based best practices for AOT to serve all of the groups mentioned above that have failed or been unable to engage in voluntary outpatient services. Admission criteria are modeled after successful AOT programs in other states (See Section 10–6A–05 in HB1017/SB807)

BEST PRACTICES : The Baltimore OCC Pilot fails to use the AOT best practices below, developed by a national team of experts lead by the American Psychiatric Association under a SAMHSA grant. (See SMI Advisor document at: https://smiadviser.org/wp-content/uploads/2019/10/White-Paper-FINAL-1.pdf)

Incorporation of a Treatment Plan: The Baltimore OCC Pilot order by an ALJ does not incorporate a treatment plan into the ALJ order. Instead, the ALJ order requires the patient to regularly meet with a peer recovery specialist in the hope that the peer can persuade the AOT participant to voluntarily agree with treatment by a provider. The result is the judge has no oversight authority over the service provider. Also the provider has no judicial order authorizing them to continue to repeatedly follow-up with a non-adherent client who tells them they no longer want their services.

HB1017/SB807 follows recommended best practice for AOT programs by incorporating into the judicial order, a treatment plan developed by the treatment provider, in collaboration with the AOT participant. This helps define treatment expectations among the participant, providers, and the court. By including the responsibilities of the provider in the court ordered treatment plan, it obligates and authorizes the provider to make a consistent effort to engage the AOT participant in treatment, even if the participant becomes non-adherent with treatment.

Respond appropriately and effectively to treatment non-adherence.
Consequences for non-adherence to treatment is sometimes needed to promote treatment engagement for a long enough period to enhance recovery.

In the Baltimore OCC Pilot, the ALJ is only involved in the initial order. Only the peer recovery specialist has authority under the order to repeatedly follow-up to monitor the

participant's condition and encourage engagement with treatment if the participant rejects treatment. If there is no current professional treatment provider, the peer advisor can petition the court for emergency evaluation if there is a clear danger to self or others.

Under AOT best practices in HB1017/SB807, the provider team, which can include peers and professionals, has legal authority under the order to make repeated attempts to monitor the health & safety of the participant and reengage them in treatment. The judge can convene a status hearing to monitor patient satisfaction, encourage provider and patient collaboration and encourage compliance. If the treatment provider, after taking into consideration past danger to self or others during non-compliance, concludes that a more restrictive level of care is needed, they may execute a petition for emergency evaluation. According to current statute, emergency petition evaluees must be evaluated within 6 hours and released if inpatient admission criteria are not met. If released, the judicial AOT order remains in place enabling the judge to order a prompt follow-up status hearing. This affords an opportunity to reconnect the participant with the treatment team and court and is usually effective in getting the participant reengaged with treatment.

Maintain a sufficient duration of commitment for each participant:

Research has found that AOT participants whose court order lasted one year largely sustained their clinical gains. According to the SMI Adviser "This should not be surprising. The goal of AOT is to help a participant engage with the treatment team, develop therapeutic relationships, and come to recognize the improvements to their quality of life. For a participant with a long history of disengagement, the process of gaining trust in the treatment system and finding value in treatment requires sufficient time to take root."

The Baltimore OCC Pilot programs only provides for a 6-month treatment order with no provisions in statute or regulation for renewal.

HB1017/SB807 provides for a 12-month treatment order with a provision for renewal if the AOT participant continues to meet admission criteria. However, the order can be terminated at any time if the participant has come to understand the benefits of maintaining consistent treatment engagement and is equipped to keep it going without the court's involvement.

Baltimore Pilot OCC Report:

PROGRAM DATA

Fiscal Year	Number of Referrals	Voluntarily Enrolled	Involuntarily Enrolled
FY18	10	3	3
FY19	8	3	0
FY20	7	4	0
FY21	6	1	0

- 31 referrals/ 14 participants enrolled
- Out of 17 referrals not enrolled:
  - 7 were due to eligibility criteria not being met
  - 5 were discharged prior to OCC hearing
  - 3 moved out of Baltimore City at discharge from hospital
  - 1 transitioned to a state hospital
  - 1 withdrew their referral (voluntary admission)
- 11 of the 14 participants connected with behavioral health services