February 19, 2024

SB453 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 Members of the Maryland Senate:

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 SB453, Mental Health-Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment Programs.

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 anosognosia. Some refer to this as a lack of insight or lack of ability to appreciate that one has an 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 or other preventable causes. 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 SB453.

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