Testimony to Support

HB 1396:

Drug and Alcohol Treatment Programs – Discharge of Patients and Referral Services – Standards

House Government Operations Committee
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Submitted by Lisa Lowe

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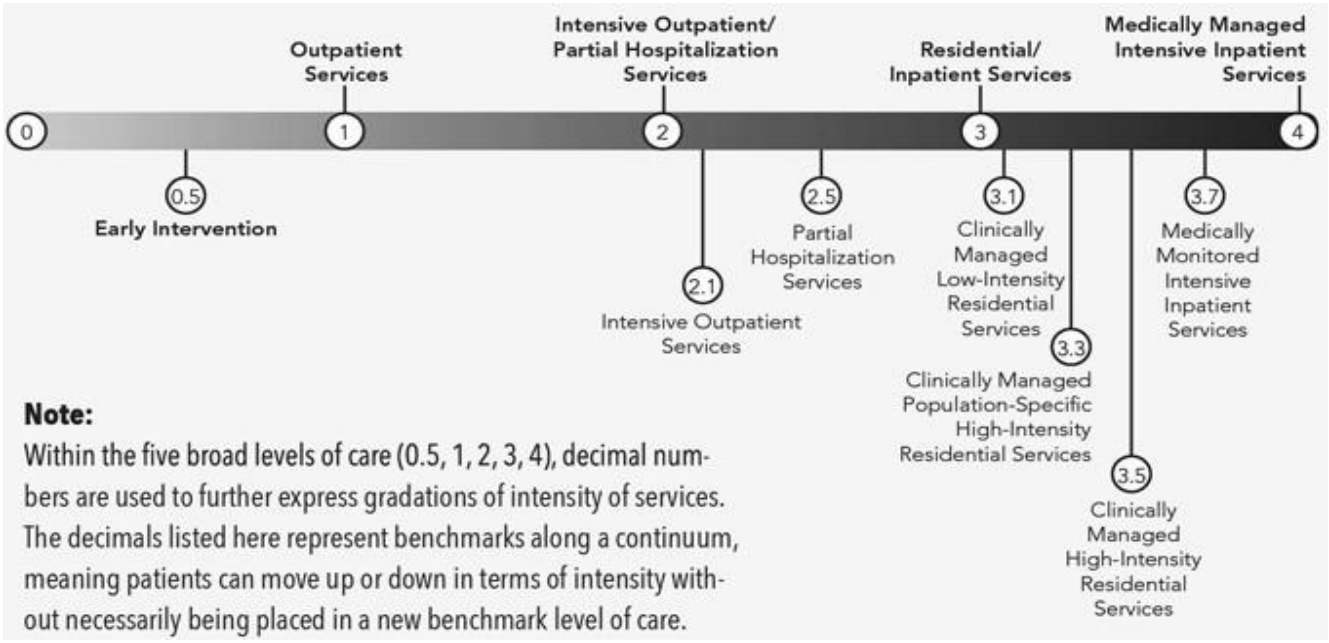
Under Maryland COMAR (10.47.01.04, 10.47.02.07, and 10.47.02.08.), certain specified clinical services must be performed in higher levels of residential / inpatient behavioral health programs (Clinically Managed Medium Intensity Treatment Level III, Clinically Managed High Intensity Treatment Level III, etc. –see ASAM Continuum of Care (COC) diagram below). These services include "referrals" to services identified as necessary for the person's recovery in their individualized ASSESSMENT and TREATMENT PLAN, as required under COMAR. They can include anything from "legal services" to "job support" to "family services" to "counseling" to "housing". These are long-term supports that cannot be effectively implemented in the brief time that a patient is in a higher level of care program (typically one to three weeks). Hence, the necessity for a robust DISCHARGE PLAN –that includes coordinated referrals to the wrap-around services listed in this bill.

ASAM's Continuum of Care:

CRITERIA FOR TREATMENT WITHIN A MEDICAL MODEL



Source: American Society of Addiction Medicine

As you can see from the diagram, in an ideal world, the level of care increases or decreases along a continuum depending on the needs of the patient. This COC is written into Maryland COMAR, and Maryland has long used these same guidelines for its own Behavioral Health COC.

The Behavioral Health Administration provides the following definition: "'ASAM Level 3.1 Services' means the level of clinically managed, low-intensity residential **services** for the treatment of addictive, substance-related, and co-occurring conditions described by The American Society of Addiction Medicine."

Unfortunately, Maryland barely has any 3.1 Clinically Managed Low-Intensity Residential Services in existence. And as you may recall when this Committee passed HB 869 – Recovery Residence Protection Act, in 2017, advocates pointed out that the 400+ Recovery Residences in operation across the state were basically founded to fill this gap. You may also recall that HB 869 mandated:

"A BEHAVIORAL HEALTH PROGRAM OR HEALTH PROFESSIONAL" to "(1) PROVIDE THE INDIVIDUAL WITH A LIST OF CERTIFIED RECOVERY RESIDENCES OPERATING IN THE STATE THAT IS PUBLISHED BY THE DEPARTMENT UNDER § 19–2503(B) OF THIS ARTICLE; AND (2) PROVIDE TO AN INDIVIDUAL WHO HAS BEEN ASSESSED AS IN NEED OF ASAM LEVEL 3.1 SERVICES, INFORMATION ON WHERE THE INDIVIDUAL MAY RECEIVE THOSE SERVICES."

Thus, under Chapter 580, these higher level of care providers are still required to refer their patients to all the services that the individual would normally receive in a 3.1 level of care. Hence, the "Continuum" of Care is still intact, despite the fact that we are utilizing 'citizen-operated' Recovery Residences, as opposed to BHA-regulated healthcare-provider-operated 'Halfway Houses' (ASAM Level 3.1).

Entrance into either a 3.1 state-regulated residential program, or an unregulated (but BHA certified) citizen-operated residential program, REQUIRES a formal official REFERRAL from the higher level of care, as well as a bed-to-bed transfer. But INSTEAD, **SOME** 3.3, 3.5, 3.7, and 4.0 level providers are failing to assist in this capacity, thereby flaunting the intent of COMAR and the intent of Chapter 580, and are discharging their patients directly into homeless shelters, or directly to the street.

For instance, in Montgomery County, 19% of vulnerable (disabled in some capacity) adults in the County shelter system came directly from a higher level psychiatric or substance use residential treatment program, and an additional 13% came directly from a hospital. These programs have already been reimbursed by private insurance / Medicaid for planning a coordinated and effective discharge for these patients to an appropriate level of care.

Homeless shelters, with notoriously high rates of drug and alcohol use, and little support if any for behavioral health manifestations, are not conducive to the further successful recovery of these patients, and are not, as you can plainly see, a bullet point on the ASAM Continuum. More often than not, these individual's fragile initial steps toward recovery quickly unravel once these patients are homeless. In fact, homelessness is the biggest factor contributing to relapse –both mental health and substance-use disorder, according to scientific data and replicated surveys. The tax dollars that we, Marylanders, spend in good conscience to help these vulnerable adults recover their lives, are virtually wasted due to the lack of effort on the part of poorly trained, overworked, over-extended, incompetent, or just plain lazy discharge planners.

This bill fixes that problem by making perfectly clear what is already implied under COMAR and Chapter 580, and it also forces the BHA to become involved to a greater extent than it has previously been, and to take a role in enforcing these provisions, by reporting to this legislative body on our state's progress toward these goals each year.