ON OUR OWN OF MARYLAND

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WRITTEN TESTIMONY IN OPPOSITION TO HB 576 - Mental Health - Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment Programs

Thank you Chair Peña-Melnyk, Vice Chair Cullison, and committee members for your commitment to improving the quality and accessibility of healthcare services for Marylanders, especially community members who experience significant behavioral health challenges. On Our Own of Maryland (OOOMD) is a nonprofit behavioral health education and advocacy organization, operating for 30+ years by and for people with lived experience of mental health and substance use recovery. Our affiliated network of 16+ peer-operated Wellness & Recovery Organizations throughout Maryland offer free, voluntary recovery support services to nearly 8,500 people, many of whom live with serious mental illness and socioeconomic barriers.

OOOMD strongly opposes HB 576, which would establish a statewide involuntary outpatient mental health civil commitment program ("assisted outpatient treatment (AOT)"). Since our founding, OOOMD has remained fundamentally opposed to any expansion of involuntary treatment as a core tenant of our mission. Our goal in this testimony is to illuminate the serious flaws with the AOT model and the specific program proposed in HB 576, and to highlight the availability of effective viable alternatives. Our major areas of concern include:

1. **Lack of Evidence:** Multiple rigorous research studies show that involuntary outpatient programs do not produce better outcomes than voluntary services.

2. **Inherent Harm & Race-Based Disparities:** Involuntary treatment creates significant and long-lasting negative impact, creating further barriers to engagement and recovery. People of color experience higher rates of involuntary and forced treatment, including chemical (forced medication) and physical restraints.

3. **Broad Eligibility Criteria:** Broadly scoped eligibility criteria invite unnecessary petitions, and may enable use of AOT instead of less restrictive options.

4. **Implementation Expectations:** The AOT process proposed is not well aligned with the realities of our legal system, care coordination, and service delivery.

5. **Lack of Consideration for Non-Clinical Needs:** Structural and logistical barriers to seeking and receiving effective services are not addressed.

6. **Better Alternatives Exist:** Evidence-based and best practice program models already exist in Maryland and in other states, which can achieve the same or better results without infringement on civil rights.

Comparison to 2023 HB 823

Last year, OOOMD was grateful to participate in the 2023 HB 823 working group, which resulted in many important updates to bill language ensuring appropriate civil rights and legal due process protections, narrowing of eligibility criteria, and required outcome data reporting.

As submitted, HB 576 does not match the substantially amended bill from last session, but instead contains many extremely concerning and contraindicated provisions. We have been informed that amendments are forthcoming to restore the protections instituted in last year's bill, and we look forward to being able to review those when they are made available.

Lack of Evidence

Rigorous independent research studies and randomized control trials have not shown convincing evidence that outpatient civil commitment programs achieve results they claim:

- 6 large systematic research literature reviews conducted between 2001-2013 show very limited to no evidence that mandating outpatient treatment reduces hospital readmissions or improves social functioning or psychiatric symptoms.[1,2,3,4,5]
- In a 2001 randomized control trial study in North Carolina, the number of hospital readmissions and arrests measured 1 year after discharge did not differ between those court-ordered to outpatient treatment and those who received services voluntarily.[6]
- The 2001 Bellevue Outpatient Commitment Study from New York concluded that those provided with voluntary enhanced community services "did just as well" as those under commitment orders who had access to the same services. Researchers also found no

[1] Maughan, D., Molodynski, A., Rugkåsa, J., & Burns, T. (2013). A systematic review of the effect of community treatment orders on service use. Social Psychiatry and Psychiatric Epidemiology, 49(4), 651–663. https://doi.org/10.1007/s00127-013-0781-0

[2] Kisely, S.R, Campbell, L.A, & Scott, A (2007). Randomized and non-randomised evidence for the effect of compulsory community and involuntary outpatient treatment on mental health service use. *Psychological Medicine* 37(1). https://doi.org/10.1017/s0033291706008592

[3] Kisely S.R & Hall K (2014). Community Health Systems: An updated meta-analysis of randomized controlled evidence for the effectiveness of community treatment order. *Canadian Psychiatric Association.*

[4] Kisely, S. R., Campbell, L. A., & Preston, N. J. (2011). Compulsory community and involuntary outpatient treatment for people with severe mental disorders. *Cochrane Database of Systematic Reviews*. https://doi.org/10.1002/14651858.cd004408.pub3

[5] Ridgely, M. Susan, John Borum, and John Petrila (2001). The Effectiveness of Involuntary Outpatient Treatment: Empirical Evidence and the Experience of Eight States. Santa Monica, CA: *RAND Corporation.* https://www.rand.org/pubs/monograph_reports/MR1340.html.

[6] Swartz, M. S., Swanson, et al (2001). A randomized controlled trial of outpatient commitment in North Carolina. Psychiatric Services. https://doi.org/10.1176/appi.ps.52.3.325

additional improvement in patient treatment compliance, no difference in hospitalization rates or lengths of stay, arrest rates, or rates of violent acts. [7]

- A 2013 randomized control trial study published in The Lancet found "no difference in the proportion of patients readmitted to hospital between study groups, nor in the time to readmission over a 1-year follow-up. The overall duration of hospital care did not decrease nor did clinical or social functioning improve despite an average of 6 months additional compulsion. These findings confirm previous evidence that CTOs [Community Treatment Orders] do not confer benefits on patients with a diagnosis of psychosis"[8]

- A 2018 systematic review of 41 studies concluded that compulsory community treatment "does not have a clear positive effect on readmission and use of inpatient beds."[9]

Inherent Harm & Race-Based Disparities

Involuntary commitment is rejected by leading health policy organizations including Mental Health America, Bazelon Center for Mental Health Law, and the World Health Organization.[10,11,12] Research has shown that forced treatment can negatively impact individuals' future experience with behavioral health care, including voluntarily sought services, and can result in a loss of social support and "increased stigma stress [that has] a long-term negative effect on recovery."[13,14]

Non-engagement or refusal of treatment is a rational response for many people living with 'Serious Mental Illness' who have experienced inaccessible, inconsistent, ineffective, coercive, or harmful treatment from our fragmented healthcare system, such as:

- Previous experiences with the mental health system that have been alienating, traumatic, or led to broken trust, such as being subject to Emergency Petition, involuntary evaluation or hospitalization, seclusion, restraint, or forced medication. Inpatient units, which can

[7] Steadman HJ, Gounis K, Dennis D, Hopper K, Roche B, Swartz M, Robbins PC. (2001). Assessing the New York City involuntary outpatient commitment pilot program. Psychiatry Serv. ;52(3):330-6. doi: 10.1176/appi.ps.52.3.330.
[8] Burns, T., Rugkåsa, et al (2013). Community treatment orders for patients with psychosis (octet): A randomised controlled trial. The Lancet. https://doi.org/10.1016/s0140-6736(13)60107-5
[9] Barnett, P., Matthews, H., Lloyd-Evans, B., et al (2018). Compulsory community treatment to reduce readmission to hospital and increase engagement with community care in people with mental illness: A systematic review and meta-analysis. *The Lancet Psychiatry*, *5*(12), 1013–1022. https://doi.org/10.1016/s2215-0366(18)30382-1
[10] Mental Health America. Position Statement 22: Involuntary Mental Health Treatment. https://www.mhanational.org/issues/position-statement-22-involuntary-mental-health-treatment
[11] Bazelon Center for Mental Health Law. Forced Treatment. https://www.bazelon.org/our-work/mental-health-systems/forced-treatment/
[12] World Health Organization (2021). Guidance on community mental health services: promoting person-centered and rights-based approaches. WHO Report. https://www.who.int/publications/i/item/9789240025707
[13]Xu, Z., Lay, B., Oexle, N., et al. (2018). Involuntary psychiatric hospitalisation, stigma stress and recovery: A 2-Year study. Epidemiology and Psychiatric Sciences, 28(04), 458–465. https://doi.org/10.1017/s2045796018000021
[14] Strauss, J. L., Zervakis, J. B., Stechuchak, et al (2012). Adverse impact of coercive treatments on psychiatric inpatients' satisfaction with care. Community Mental Health Journal, 49(4), 457–465. https://doi.org/10.1007/s10597-012-9539-5

have highly regimented protocols that violate personal integrity (e.g. being stripped, searched, restrained, watched, coerced to take medications, etc.) can be actively (re)traumatizing, particularly for survivors of assault or abuse.

- Clinical treatment that has been ineffective or harmful, such as intense negative side effects from prescribed medications, not being believed when reporting positive or negative experiences, and clinicians being unequipped to support complex trauma, co-occurring substance use, somatic conditions, other disabilities (cognitive, or physical), or specific demographic, cultural, or language needs.

- Lack of available or accessible treatment due to long waitlists, limited program operating hours, narrow eligibility criteria, maximum length of stay limits, and logistical barriers such as housing instability, food insecurity, lack of transportation, lack of social support, and financial cost of care with limited or no insurance.

To illustrate the intensity and negative impact of forced treatment experiences, we offer these personal examples from peers engaged with our statewide network:

"The police came to my house [for a wellness check after speaking about suicide to a friend]. They handcuffed me roughly. I had no shoes on when they took me outside to the car. At the hospital, they put me in a small room with two other handcuffed men. I was afraid. The staff ignored us. They strapped me to a stretcher and took me to another hospital. I was in restraints for at least 24, maybe 32 hours. They treated me like I was a criminal or a wild animal. It was horrible and embarrassing."

"I was Emergency Petitioned at 19 years old because I refused to take medication [that caused troubling side effects]. I did not scream, curse, or be disrespectful; I did not threaten to do anything to myself or anyone else. The therapist claimed I would become a 'danger to myself and others,' even though my mood was good. The police slammed me into the car door and handcuffed me as tight as possible, groped and laughed at me, as I heard my mother's sobbing and begging behind me. In the hospital, I experienced assault, seclusion, and humiliation. I still have flashbacks, nightmares, and horrible, intrusive memories… it will likely haunt me for the rest of my life. I have become scared of the police, wary of my neighbors, lost trust in my friends, and I isolate much more now."

"I've been receiving psychiatric care since I was 17. There were always times when my ability to make decisions was disregarded. There were multiple occasions where I was forced to remove my clothing in front of male guards and be forcibly medicated, without my consent or my knowledge of what the medication was. I have a pre-existing thyroid condition and my psychiatrist had never prescribed it to me because of this. [During one hospitalization] staff informed me that my options were to take Lithium or to do electroshock treatment. I was exhausted…and agreed to take [it]. After release, my psychiatrist immediately took me off it because of how it would affect my thyroid."

Unfortunately, these types of experiences are not rare for Marylanders who who experience self-harm or thoughts of suicide, or who disagree with and refuse treatment. Many individuals

living with serious mental illness who would be targeted for an AOT program will have had repeated exposure to this type of treatment by outpatient clinicians, crisis services providers, emergency and hospital staff, and law enforcement officers. As a 2021 *SMI Adviser* report, published by SAMHSA and the American Psychiatric Association, explains: "For many people living with SMI, their first contact with the system is during a crisis. This is a time of extreme vulnerability… Some individuals have experienced restraint, seclusion, and/or forced medication. This can result in refusal to re-engage in a system that they do not trust or that causes fear."[15]

Race-Based Disparities in Involuntary Treatment: Across the country, there is a startling lack of available and transparent data or consistent evaluation regarding use of involuntary interventions (inpatient and outpatient) and results in general or analyzed with a racial equity lens. However, recent research continues to confirm that higher rates of involuntary hospitalization and use of restraints are used against people of color:

- **Use of Restraints During Emergency Psychiatric Evaluation (2021):** This study examined emergency psychiatric evaluations performed between 2014-2020 at a large academic medical center in Durham, NC. Findings showed "Black patients undergoing psychiatric evaluation were at higher odds of experiencing physical or chemical restraint compared with White patients, which is consistent with the growing body of evidence revealing racial disparities in psychiatric care."[16]

- **Involuntary Hospitalization (2022):** This study analyzed data collected over a 6-year period on all admissions to a general inpatient psychiatric unit in a large general hospital in Boston. Findings showed "patients of color were significantly more likely than White patients to be subjected to involuntary psychiatric hospitalization, and Black patients and patients who identified as other race or multiracial were particularly vulnerable."[17]

- **Use of Restraints During Hospitalization (2023):** A sample study of medical records of youth and adult inpatient psychiatric hospitalization (2012-2019) found that Black patients were 85% more likely to be physically restrained or force medicated than White patients, and often for longer periods.[18]

[15]Henry, Patrick. What are some of the key reasons individuals do not follow up on treatment following their initial engagement for crisis care? SMI Adviser Knowledge Base. November 18, 2021.
[16] Smith CM et al. (2021) Association of Black Race With Physical and Chemical Restraint Use Among Patients Undergoing Emergency Psychiatric Evaluation. Psychiatric Services. 73(7), 730-736. doi: 10.1176/appi.ps.202100474
[17]Shea T et al. (2022). Racial and Ethnic Inequities in Inpatient Psychiatric Civil Commitment.. Psychiatric Services. 73(12), 1322-1329. doi: 10.1176/appi.ps.202100342
[18] Singal S et al. (2023). Race-Based Disparities in the Frequency and Duration of Restraint Use in a Psychiatric Inpatient Setting. Psychiatric Services. https://doi.org/10.1176/appi.ps.20230057

Broad Eligibility Criteria

We have serious concerns about the following aspects and implications of HB 576's proposed eligibility criteria, particularly:

- **Definition of "Harm to the Individual:"** The bill proposes four aspects of harm, each of which are overly broad and lack clarity:
    - *Self–harming behavior or an attempt at suicide:* Many individuals engage in self-harming behaviors as a means of coping. Numerous research studies have shown that receiving involuntary inpatient treatment following an act of deliberate self-harm significantly increases the risk for repeated self-harm and suicide.[19]
    - *Failure to protect oneself from danger:* This is not sufficiently defined.
    - *Inability to meet one's basic needs:* This does not address socioeconomic barriers and social/healthcare services network inadequacy which prevent, delay, or complicate basic needs being met.
    - *Failure to obtain medically necessary treatment to prevent serious physical or psychiatric deterioration:* This is open to interpretation and biased prediction.

- **3 Year Lookback Period:** Any incidents of voluntary hospital use, "threat" or enacted self-harm, suidice attempt, disagreement with a treatment plan or refusal of treatment within a three year period becomes evidence for forced treatment. This discourages individuals from voluntarily seeking help for fear of it being used against them.

- **Insufficient Evaluative Assessment:** There is no requirement for clinical assessment of capacity for medical decision-making or for a "thorough psychiatric and physical examination," which is advised by the American Psychiatric Association's position statement on involuntary civil commitment "because many patients… also suffer from other medical illnesses and substance use disorders that may be causally related to their symptoms and may impede recovery."[20]

- **No Assurance of Least Restrictive Alternative:** There is no requirement for a comprehensive evaluation of all current or available support services that could meet the individual's needs, without which an accurate assessment of whether AOT is truly the "least restrictive alternative" cannot be made.

[19] Olfson M, Wang S, Blanco C. National trends in hospital-treated self-harm events among middle-aged adults. Gen Hosp Psychiatry. 2015;37:613–619

[20] American Psychiatric Association (2020). Position Statement on Involuntary Outpatient Commitment and Related Programs of Assisted Outpatient Treatment. APA. https://www.psychiatry.org/getattachment/d50db97b-59aa-4dd4-a0ec-d09b4e19112e/Position-Involuntary-Outpatient-Commitment.pdf

Implementation Expectations

People living with serious mental illness already face high levels of stigma that result in a perceived lack of credibility.[21] Maryland and the medical profession have established practices to determine capacity and competency for decision-making in healthcare settings and in legal matters. A program which may result in a long-lasting legal order for medical treatment that may be renewed indefinitely should take every precaution to protect against overriding the civil rights of a person who can be found capable and competent to make decisions about their healthcare.

We urge critical review of the HB 576's proposed implementation process, particularly:

- **Sole Evaluators Are Vulnerable to Bias:** Sole evaluators are undeniably vulnerable to bias, whether explicit or unintentional, and Maryland's current Involuntary Admission certificate requires agreement between two evaluators, one of whom must be a medical doctor. This bill proposes much lower standards for civil commitment:
    - Only one clinician (treating psychiatrist) is required to participate in the initial evaluation to determine AOT eligibility. This is inconsistent with the current regulations on involuntary admission (IVA) (COMAR 10.21.01.04), which requires evaluation by two clinicians, including at least one physician.
    - A completely different clinician (psychiatrist) may lead the treatment plan design without having actually met the individual.
    - An emergency psychiatric evaluation may be conducted by a nurse practitioner. It is unclear how this interfaces with current IVA regulations (COMAR 10.21.01.04), which require agreement between two clinicians, including at least one physician.
- **Exclusion of MH Advance Directive and Guardians/Healthcare Agents:** There is no requirement for the individual, their guardian, or their health care agent to be involved in any treatment plan decisions, including medication. Only "a reasonable opportunity to participate" must be offered, and the timeline between petition and hearing is undefined. A Mental Health Advance Directive (MHAD) may be disregarded at the discretion of the care coordination team, who are only required to "consider" its provisions.
- **Unclear Controls for Treatment Plan Changes:** The bill appears to allow for changes to the treatment plan which may ordinarily require a hearing to be implemented "as circumstances may immediately require" at the sole discretion of the treating psychiatrist. This may create substantial confusion and lack of transparency.

[21] Crichton, P., Carel, H., & Kidd, I. J. (2017). Epistemic injustice in psychiatry. BJPsych Bulletin, 41(2), 65–70. https://doi.org/10.1192/pb.bp.115.050682

We also ask the committee to carefully consider the underlying assumptions that are being made about how implementation of an AOT program will take place within the reality of our overstrained, understaffed, and resource-limited behavioral health and judicial systems.

- **Statewide Implementation:** The bill requires all jurisdictions in Maryland to establish an AOT program without any assessment for minimum standards of local capacity (ex: Local Behavioral Health Authority oversight of AOT Care Coordination Teams) or network adequacy (ex: community–based providers agreeable to providing services required under an AOT treatment plan).

- **Lack of Training:** In 2021, the Maryland Behavioral Health Administration's *Involuntary Stakeholders' Workgroup Report* acknowledged that "there is unclear language in the statutes and regulations, which has led to wide interpretation of the law on involuntary civil commitment" in our state, and recommended both "comprehensive training around the dangerousness standard" and collection of "additional data elements about civil commitment."[22] The addition of an outpatient civil commitment program with even different criteria is likely to increase confusion and potential misuse.

- **Volume of Petitions:** Included in the 2021 BHA report referenced above were statistics from the Maryland Office of the Public Defender showing nearly 10,000 Involuntary Admission (IVA) cases referred to their office in 2020. Notably, this figure does include many more individuals for whom an Emergency Petition was filed but who were found not to meet IVA criteria upon evaluation.

- **Expected Enrollment Rate:** As potential comparison, a retrospective evaluation of New York's AOT program shows that over 10,000 individuals were referred to local AOT coordinators for investigation of eligibility between 1999 and 2004. Of these, only 37% of these individuals were ultimately issued a court order to undergo AOT; the majority of individuals referred did not meet the criteria.[23] The time, effort, and funding required for these cases could have been invested toward further developing comprehensive services and supports that would better engage and serve the community. Notably, New York has recently expanded its INSET program, which was specifically created as an alternative to AOT. *See **Better Alternatives Exist** below.*

[22] Behavioral Health Administration (2021). Involuntary Stakeholder's Workgroup Report.
[23] Pataki G.E., Carpinello, Sharon E. (2005). Kendra's Law: Final Report on the Status of Assisted Outpatient Treatment. New York State Office of Mental Health. https://mentalillnesspolicy.org/wp-content/uploads/kendras-law-study-2005.pdf

Lack of Consideration for Non-Clinical Needs

While HB 576 lists case management as a required service in an AOT treatment plan, it is unclear how or if the bill intends to create access to critical non-clinical services which are the foundation of sustained engagement in services. Many individuals who are likely to be targeted for AOT may be experiencing multiple barriers to accessing effective treatment, such as:

- **Basic Needs:** housing instability, food insecurity, lack of transportation, limited social support, limited income, uninsured or underinsured for behavioral healthcare services
- **Cultural and Language:** member of a historically marginalized community experiencing discrimination, stigma, and/or health inequities; need for culturally specific care (ex: immigrant, asylee, or refugee) or language services.
- **Disability:** experiencing a perceived or active disability which entitles the individual to reasonable accommodations under federal law, including but not limited to: mental health disorders, diabetes, HIV, autism, Deafness or hearing loss, blindness or low vision, mobility disabilities, intellectual disabilities, and traumatic brain injury.[24]

Better Alternatives Exist

Recovery is possible for persons who live with Serious Mental Illness, even if clinical symptoms continue to be experienced. Numerous research studies have found that engaging individuals with serious mental health conditions requires the following core components: “therapeutic alliance between staff and clients, persistence and consistency, the provision of practical assistance and support rather than a sole focus on medications, the team decision making process, acceptance of clients as they are, and flexibility.”

SAMHSA recognizes the four major dimensions that support recovery are health, home, purpose, and community,[25] and a 2018 cross-sectional survey on recovery and remission from Serious Mental Illness found that “contrary to traditional beliefs about a consistently deteriorating negative outlook… . High levels of quality of life and community participation (e.g., work, school, parenting, leisure and recreation) occur even when impairments are present.”[26]

We are glad to highlight several choice-based, trauma-informed, and recovery-oriented models actively in use across the country which we believe are better viable alternatives to AOT.

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[24] US Department of Justice, Civil Rights Division. Introduction to the Americans with Disabilities Act. https://www.ada.gov/topics/intro-to-ada/

[25] Substance Abuse and Mental Health Services Administration (last updated 2023, Feb 16). Recovery and Recovery Support. *SAMHSA*. https://www.samhsa.gov/find-help/recovery

[26] Salzer, M. S., Brusilovskiy, E., & Townley, G. (2018). National estimates of recovery-remission from serious mental illness. *Psychiatric Services*, *69*(5), 523–528. https://doi.org/10.1176/appi.ps.201700401

Peer Support and Recovery Support

A 2014 study published in the journal *World Psychiatry* identifies 10 empirically-validated interventions that support recovery, including: peer support workers, advance directives, wellness recovery action planning, illness management and recovery, strengths model, recovery education programs, individual placement and support, supported housing, and mental health trialogues.[27]

A number of these are already actively used in Maryland, including through OOOMD's statewide network of peer-operated Wellness & Recovery Organizations. Peer support and recovery support programs are high quality, low-barrier, open access, and cost-effective options which can be delivered independently or in partnership with clinical services, and can be shaped to meet the specific needs of a local community or target population. Unfortunately, many of these community-based support programs are not yet sufficiently resourced and so limited in capacity for outreach, engagement, and service delivery.

Intensive & Sustained Intensive Engagement (INSET) Model

Launched in New York in 2018, this program model is an entirely voluntary, peer-led, trauma-informed approach that specifically engages with individuals who meet criteria for AOT. Multi-disciplinary teams provide mobile support by meeting individuals and providing consistent wraparound support to meet basic needs, access resources, establish recovery goals, and connect with additional services or treatment. Based on its success, the New York State Office of Mental Health made additional funding available in 2023 to expand the model over 5 years.

Peer Respite Model

Peer respites are voluntary, short-term, non-clinical crisis residential programs where individuals at risk of psychiatric hospitalization can receive 24/7 peer support in a home-like setting. Peer respites currently operate in 15 states across the US, and adoption of the model continues to expand. Peer respites have been effective in reducing Medicaid expenditures, reducing hospitalizations, improving mental health symptoms, and improving quality of life when compared to inpatient hospitalization.[28,29,30] While Maryland does not currently have any peer respite programs, a recent feasibility study commissioned by Behavioral Health Systems Baltimore found strong interest and supportive conditions for launching this type of program in Central Maryland.

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[27] Slade M, Amering M, & Farkas M, et al (2014). Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems. *World Psychiatry*: 13(1):12-20. doi: 10.1002/wps.20084.

[28] Pelot, M., & Ostrow, L. (2021). Characteristics of peer respites in the United States: Expanding the continuum of care for psychiatric crisis. Psychiatric Rehabilitation Journal;

[29] Peer Respites as an Alternative to Hospitalization. Legislative Analysis and Public Policy Association. (2021).

[30] Bouchery, E.E., Barna, M., Babalola, E. (2018). The effectiveness of a peer-staffed crisis respite program as an alternative to hospitalization. Psychiatric Services.

Mental Health Self-Directed Care (SDC) Services

This person-centered approach provides individualized support and financial resources for individuals living with serious mental health conditions to foster resilience, stability, and autonomy. Participants create a partnership with a support broker who assists them with the development and implementation of a self-directed recovery plan. The support broker also assists with facilitating access to services and financial resources to help meet the participant's unique mental health, social, and somatic needs. Not only does this model emphasize choice, but it also instills a sense of personal responsibility for one's recovery.

Self-Directed Care Services currently exist in Maryland, but only individuals with developmental disabilities are able to access this program model. People who live with a sole diagnosis of a mental illness are explicitly excluded. Mental Health SDC has successfully been implemented in 6 states, and the evidence for this approach is strong. When compared to those who received services as usual, those who received Mental Health SDC services experienced significantly better clinical outcomes, ability to maintain employment, increased self-esteem and confidence related to their ability to manage challenges related to their mental health, and improved satisfaction.[31,32]

Conclusion

There is a dire need to increase access and decrease barriers to services for Marylanders living with behavioral health challenges. Unfortunately, HB 576 will not create more appropriate and accessible services, but would instead entangle individuals living with disabilities and complex challenges into a complicated legal process that dismisses and silences their voice and choice.

Forced treatment is inherently harmful, and should only ever be used as the very last resort in situations with significant, current safety concerns. The best use of state resources is to enhance and expand voluntary, community-based services that are already working well instead of wagering a wealth of unknown consequences through creation of the proposed AOT program.

We strongly urge an unfavorable report on HB 576. Thank you.

[31] Cook JA et al (2019). Mental Health Self-Directed Care Financing: Efficacy in Improving Outcomes and Controlling Costs for Adults With Serious Mental Illness. Psychiatr Serv; 70(3):191-201. doi: 10.1176/appi.ps.201800337. Epub 2019 Jan 11. PMID: 30630401.

[32] Smith GP & Williams TM (2016). From providing a service to being of service: advances in person-centered care in mental health. *Curr Opin Psychiatry* (5):292-7. doi: 10.1097/YCO.0000000000000264. PMID: 27427855.