STATE OF MARYLAND
DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

December 10, 2014

The Honorable Thomas M. Middleton
Chair, Senate Finance
Committee
3 East Miller Senate Office Building
11 Bladen Street
Annapolis, MD 21401-1991

The Honorable Peter A. Hammen
Chair, House Health and Government
Operations Committee
241 House Office Building
6 Bladen Street
Annapolis, MD 21401-1991

Re: Senate Bill 882/House Bill 1267 – Department of Health and Mental Hygiene – Outpatient Services Programs Stakeholder Workgroup

Dear Chair Middleton and Chair Hammen:

Pursuant to Chapters 352 and 353 of the Acts of 2014, the Department of Health and Mental Hygiene respectfully submits this report on the Outpatient Services Programs Stakeholder Workgroup. Specifically, the report includes proposals to: establish an outpatient civil commitment program in Maryland, expand access to voluntary outpatient mental health services, and an evaluation of the dangerousness standard for involuntary admissions and emergency evaluations.

If you have any questions, please contact Gayle Jordan-Randolph, M.D., Deputy Secretary of Behavioral Health, at (410) 767-3167.

Sincerely,

Joshua M. Sharfstein, M.D.
Secretary

Enclosures

cc: Gayle Jordan-Randolph, M.D.
Rianna Brown, J.D.
Allison Taylor, J.D., M.P.P.
Sarah Albert, MSAR# 10174

Report of the Outpatient Services Programs Stakeholder Workgroup

Maryland Department of Health and Mental Hygiene

December 10, 2014

Senate Bill 882, Chapter 352 and House Bill 1267, Chapter 353 of the Acts of 2014

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Message From the Workgroup Chair

Dear Colleagues:

I am pleased to submit the final report of the Outpatient Services Programs Stakeholder Workgroup.

Just one year ago, the Department of Health and Mental Hygiene released the Continuity of Care Advisory Panel's final report. That report included 25 recommendations to improve continuity of care for individuals with serious mental illness. Among other things, the report indicated the need for a well designed outpatient civil commitment program.

Building upon the Continuity of Care Advisory Panel's work, the Outpatient Services Programs Stakeholder Workgroup developed three proposals, which are contained in this report: (1) a proposal to establish an outpatient civil commitment program; (2) a proposal to enhance access to voluntary outpatient mental health services; and (3) a proposal to define dangerousness in regulations and provide comprehensive training around the dangerousness standard. It is anticipated that during the 2015 legislative session legislation will be considered to implement the outpatient civil commitment program contained in this report.

I am grateful for the opportunity to chair this Stakeholder Workgroup. Stakeholders dedicated significant time to develop the proposals contained in this report. The implementation of these proposals will address gaps in the Public Behavioral Health System and improve access to outpatient mental health services.

Gayle Jordan-Randolph, M.D.
Deputy Secretary for Behavioral Health
Department of Health and Mental Hygiene

Outpatient Services Programs
Stakeholder Workgroup
Final Report

Introduction

Senate Bill 882/House Bill 1267 of the 2014 legislative session required the Secretary of Health and Mental Hygiene to convene a stakeholder workgroup to examine the development of assisted outpatient treatment (also known as outpatient civil commitment) programs, assertive community treatment programs, and other outpatient services in the state; develop a proposal for a program in the State; and evaluate the dangerousness standard for involuntary admissions and emergency evaluations.

More specifically, the workgroup was required to develop a proposal that (1) best serves individuals with mental illness who are at high risk for disruptions in continuity of care; (2) respects the civil liberties of individuals to be served; (3) addresses the potential for racial bias and health disparities in program implementation; (4) is based on evidence and effectiveness of outpatient civil commitment programs, assertive community treatment programs, and other outpatient services programs with targeted outreach, engagement, and services in other jurisdictions; (5) includes a data-monitoring strategy; (6) promotes parity between public and private insurers; (7) addresses the potential for variance in program implementation among urban and rural jurisdictions; and (8) assesses the cost of the program to the Department of Health and Mental Hygiene (Department) and other state agencies, including the feasibility of securing federal funding for services provided by the program. The Department was also required to recommend draft legislation as necessary to implement the program included in the proposal.

Additionally, the workgroup was required to evaluate the dangerousness standard for involuntary admissions and emergency evaluations of individuals with mental disorders. As part of this evaluation, the workgroup was required to discuss options for clarifying the dangerousness standard in statute or regulations and initiatives to promote the appropriate and consistent application of the standard.

Dr. Gayle Jordan-Randolph, Deputy Secretary for Behavioral Health was appointed by Secretary Sharfstein to chair the Outpatient Services Programs Stakeholder Workgroup, and the Department convened the Outpatient Services Programs Workgroup in May of 2014. Through a series of seven meetings, the workgroup examined both voluntary and involuntary outpatient services, as well as the dangerousness standard. The Department provided opportunities for stakeholder input at each meeting. Further, stakeholders had the opportunity to submit written comments, for the Department's review, after each meeting and provide suggested edits to the draft proposals. Using the stakeholder input, the Department developed this report.

Included in this report are three proposals. These proposals: (1) establish an outpatient civil commitment program, that is outlined in Part I of this document; (2) enhance access to voluntary outpatient mental health services, which is discussed in Part II of this report; and (3) evaluate and clarify the dangerousness standard for involuntary admissions and emergency evaluations of individuals with mental disorders, which is included in Part III of this report. It is important to note that legislation would be necessary to implement an outpatient civil commitment program. It is anticipated that legislation to establish an outpatient civil commitment program will be considered during the 2015 legislative session.

The voluntary outpatient services proposal can be implemented with programmatic changes. The dangerousness standard for inpatient admissions can be further clarified through regulations.

The Department consulted with workgroup participants on each element of this report and incorporated many stakeholder comments and suggestions into the final proposals. As expected, however, there were areas where there was no consensus among stakeholders. This is particularly applicable to the outpatient civil commitment proposal. The Department invited participants to submit a written response to the proposals. These responses are included in **Appendix 2** of this report.

I. Proposal 1 - Establish an Outpatient Civil Commitment Program in Maryland

Currently, 45 states have outpatient civil commitment laws. In comparison to inpatient commitment, which confines an individual to a hospital setting, outpatient commitment is court-ordered treatment provided in a community setting. These laws help individuals receive much-needed treatment while remaining in the community. Generally, to qualify for outpatient civil commitment, an individual must have: a mental illness; the capability to survive safely in the community with supports; a need for treatment to prevent further deterioration; and an inability or unwillingness to participate in treatment voluntarily.

In Maryland, however, this option is not available. Court-mandated treatment is currently only permissible in inpatient hospital settings. As a result, many individuals with serious mental illness who refuse to engage in treatment experience homelessness, frequent hospitalizations, increased contact with law enforcement, and incarceration. Both they, and their families, remain in a constant state of crisis. By learning from other states and developing the best possible proposal, we can promote continuity of effective care, as well as help improve the well-being and independence of individuals with severe mental illness.

A. Continuity of Care Advisory Panel

The Department first examined the issue of outpatient civil commitment through the Continuity of Care Advisory Panel, which was formed during the 2013 legislative interim. At the direction of Governor O'Malley, the Department convened the seven-member Continuity of Care Advisory Panel to explore ways to enhance continuity of care for individuals with serious mental illness. The Advisory Panel was charged with examining barriers to continuity of care – economic, social, legal, and clinical – and making recommendations to strengthen the public behavioral health service delivery system, improve health outcomes, and address deficiencies that lead to interruptions in care.

To further assist the Advisory Panel with their deliberations, the Department contracted with an independent consultant to provide an analysis of the origin of outpatient civil commitment, a review of outpatient civil commitment research, and options to outpatient civil commitment. The report – *Involuntary Outpatient Commitment: Current Evidence and Options* – found that there is emerging evidence that outpatient civil commitment reduces hospital use and increases engagement in services.[1]

[1] Retrieved from: http://dhmh.maryland.gov/bhd/Documents/Morrissey_OPC_Final_Report_%20110413(1).pdf

The Advisory Panel issued a final report in January 2014 that included twenty-five recommendations to strengthen the public behavioral health service delivery system, improve health outcomes, and address deficiencies that lead to interruptions in care. A copy of the workgroup's final report may be accessed on the Department's website at: http://dhmh.maryland.gov/bhd/Documents/Continuity%20of%20Care%20Final%20Report.pdf. In this report, the Advisory Panel noted that there is a need for a well-designed outpatient civil commitment program in Maryland and recommended that the Department convene a workgroup to further examine the implementation of a program in Maryland and develop an outpatient civil commitment program proposal. After the Advisory Panel issued its report, the Department worked with stakeholders and legislators on the development and passage of Senate Bill 882/House Bill 1267.

B. Stakeholder Process for Comments

Four of the seven workgroup meetings were devoted to the topic of outpatient civil commitment. At each meeting, the applicable provisions of Laura's Law – California's outpatient civil commitment law – were examined and contrasted to outpatient civil commitment laws in select states. The Department provided opportunities for stakeholder input at each meeting. Stakeholders also had the opportunity to submit written comments for the Department's review after each meeting. The workgroup's schedule is outlined below:

- May 25, 2014: The workgroup discussed who should be the target demographic under an outpatient civil commitment program in Maryland and what criteria should be used when determining program eligibility. In order to facilitate conversation in this area the Department provided an overview of Laura's Law and an overview of outpatient civil commitment criteria in select states.

- June 11, 2014: The workgroup focused on determining which outpatient service should be available under an outpatient civil commitment program and estimating the program costs for those services. In addition, this meeting covered the Department's ability to secure federal funding for services and the potential costs to the Department and other state agencies. The Department provided presentations on outpatient services currently available in the public mental health system; opportunities for federal funding; an overview of service provision under Laura's Law; and outpatient civil commitment services in select states.

- July 9, 2014: This meeting included discussion on the data that would need to be collected under an outpatient civil commitment program and developing Departmental reporting requirements. The workgroup also discussed how to avoid racial bias and health disparities and promote parity/access across the State between urban and rural jurisdictions. The workgroup was provided with presentations on reporting requirements under Laura's Law; program evaluation requirements in New York; and the Maryland Program Evaluation Act.

- July 23, 2014: This meeting was dedicated to the rights of the individuals and the potential role of the Judiciary, the Office of Administrative Hearings, and the Office of the Public Defender under an outpatient civil commitment program. The meeting included presentations from each of these agencies as well as a presentation on the rights' of the individual in select states.

Using stakeholder input, the Workgroup developed a proposal for outpatient civil commitment that is modeled after Laura's Law in California. This proposal was circulated to all workgroup participants and other stakeholders for review during the two week comment period. **Appendix 1** includes written comments received from stakeholders and the Department's response, including whether an individual's comments were integrated into the final report.

C. Proposal

Proposal 1 would establish a targeted outpatient civil commitment program in Maryland that provides resources to individuals with severe mental illness who have a history of non-adherence with treatment that has led to repeated inpatient civil commitments. The goal of this program is to improve continuity of care by decreasing interruptions in treatment, stabilizing the individual in the least restrictive environment, and reducing preventable hospitalizations, including inpatient civil commitments. Stakeholders who are supportive of the establishment of outpatient civil commitment indicated that they were generally pleased with the proposal contained in this report and offered comments related to the program's criteria, which are discussed later in this report. Below is a brief overview of this proposal.

1. Petition/Hearing Process

Under this proposal, members of the community can initiate the civil commitment process by submitting a request for investigation to the Department.[2] All requests must be investigated to determine whether an individual meets the criteria for outpatient civil commitment. Only the Secretary of Health and Mental Hygiene, or his/her designee, can file a petition for outpatient civil commitment with the Office of Administrative Hearings if it is determined that it is likely that all the necessary elements for an outpatient civil commitment petition can be proven by clear and convincing evidence.

Each petition must include: the facts that support the determination that the individual meets each criteria for outpatient civil commitment; a proposed treatment plan; and a certificate signed by a licensed mental health treatment provider certifying that the individual meets the criteria for outpatient civil commitment. If an individual refuses to submit to an examination, he/she can be required to submit to an emergency evaluation. This emergency evaluation process is similar to that used for inpatient admissions. The Office of Administrative Hearings (Office) will hold a hearing on each petition. After considering the evidence presented by the petitioner and the subject of the petition, the Office will grant the petition if the criteria for outpatient civil commitment has been met.

By creating a statewide program that is administered by a single petitioning entity, we can help ensure that services are available in both urban and rural areas and that the program criteria is applied uniformly. This will help avoid health disparities and racial bias in program implementation. Some stakeholders supported this recommendation and noted that a centralized petitioning entity would promote consistency in the program's application; however, others argued that other individuals, particularly

[2] The following individuals may request the Department to conduct an investigation: (1) any adult who resides with the person who is subject of the petition; (2) any adult, who is the parent, spouse, sibling, or child of the person who is the subject of the petition; (3) the director of a hospital in which the person who is the subject of the petition is, or has been, hospitalized; (4) a licensed mental health treatment provider who is supervising or providing, or has supervised or provided, treatment of the person who is the subject of the petition; (5) a peace officer, parole officer, or probation officer assigned to supervise the person who is the subject of the petition; or (6) a guardian.

family members, should have the ability to petition the Office of Administrative Hearings directly.

2. Criteria

The vast majority of workgroup participants indicated that they were supportive of the outpatient civil commitment criteria outlined in the first reader version of Senate Bill 831/House Bill 767 (2014) - Public Health - Mental Hygiene Law - Assisted Outpatient Treatment. Criteria under Senate Bill 831/House Bill 767 included the following provisions: (1) the individual must be an adult; (2) the individual must have a mental disorder; and (3) the individual must be capable of surviving safely in the community with appropriate outpatient treatment and support; (4) the individual, if not adherent to outpatient treatment, is likely to deteriorate such that he or she will present a danger to the life or safety of the individual or others; (5) the individual must be unlikely to adequately adhere to outpatient treatment on a voluntary basis, as demonstrated by the individual's prior history of nonadherence to voluntary treatment; or specific characteristics of the individual's clinical condition that prevent the individual from making rational and informed decisions regarding mental health treatment; and (6) outpatient civil commitment must be the least restrictive alternative appropriate to maintain the health and safety of the individual.

Despite this consensus, a number of stakeholders supported certain changes to the program criteria, specifically around an individual's capacity to make treatment decisions. Furthermore, there was interest in targeting outpatient civil commitment services to individuals who have frequent contact with the State's psychiatric facilities. While hospitalized and adherent to treatment, these individuals' conditions improve. However, when they return to the community, many refuse to engage in treatment, and their condition deteriorates. Consequently, individuals with serious mental illness who refuse to engage in treatment may experience homelessness, frequent hospitalizations, increased contact with law enforcement, and incarceration.

An outpatient civil commitment program targeting this population would improve continuity of care by decreasing interruptions in treatment, stabilizing the individual in the least restrictive environment, and reducing preventable hospitalizations, including inpatient civil commitments. Therefore, the following criteria is proposed:

(1) The individual is an adult;
(2) The individual has a mental disorder as defined by Health- General § 10-101;
(3) The individual is not providing for or meeting the needs of daily living in the community without supervision, based on a clinical determination;
(4) At least twice within the past 48 months, the individual has been involuntarily admitted to a facility or Veteran's Administration Hospital under Title 10, Subtitle 6, Part III of the Health-General Article;
(5) The individual has been offered an opportunity to participate voluntarily in recommended treatment but either declines to do so or fails to adhere to treatment recommendations;
(6) In view of the individual's treatment history and current behavior, the individual is in need of mandatory outpatient treatment in order to prevent deterioration that would be likely to result in the individual meeting the criteria for involuntary admission under Health-General § 10-617;
(7) The individual is likely to benefit from outpatient treatment that will help protect the individual

from interruptions in treatment, relapses, or deterioration of mental health; and

(8) There is no appropriate and less restrictive alternative.

3. Mandated Services

The majority of stakeholders noted that intensive case management or Assertive Community Treatment should be a mandated service under an outpatient civil commitment program. Nontraditional outpatient services, such as mobile treatment were also recommended. Therefore, this proposal includes either case management or Assertive Community Treatment Services as mandated services to ensure care coordination. Optional services include: medication; periodic blood tests or urinalysis to determine compliance with prescribed medications; individual or group therapy; day or partial day programming activities; education and vocational training or activities; alcohol or substance use disorder treatment, counseling, and periodic tests for the presence of alcohol, illegal drugs, or prescription drugs, if an individual has a history of substance use disorder; supervision of living arrangements; and peer support. This is not an exhaustive list; other services necessary to treat the individual's mental illness and assist the individual in living and functioning in the community should be provided under this program, including services aimed at preventing a relapse or further deterioration that may result in suicide or the need for hospitalization.

4. Civil Liberties

The Workgroup recognizes that any outpatient civil commitment program must include clear civil liberty protections to ensure that individuals' rights are safeguarded throughout each stage of the process. Therefore, this proposal includes language explicitly detailing the rights of individuals that are subject to a petition for outpatient civil commitment. These rights include: the right to retain counsel, or if the individual qualifies, use the services of a court-appointed public defender; the right to receive notice of the Department's petition and notice of the hearing; the right to receive a copy of the results of the investigation of the Secretary; the right to present evidence, call witnesses, and cross-examine adverse witnesses at the outpatient civil commitment hearing; the right to be informed of the right to judicial review of the Office's decision; the right not to be involuntarily committed solely for failure to comply with an order; the right to be present at a hearing, unless the individual waives that right; the right to receive treatment in the least restrictive setting deemed appropriate and feasible; and to the extent possible, the right to have any conditions and treatments stated in the subject of a petitions advanced directive for mental health treatment to be honored and included in the treatment plan.

Further, the proposal also lists those actions that would not be considered a refusal to comply with a treatment order. Those actions include: a willingness to take medication as required under an order, but a reasonable disagreement about the type or dosage of the medication; an inability to obtain access to appropriate treatment because of inadequate health care coverage or an insurer's refusal or delay in providing coverage for the treatment; or the inability of an individual who is in the custody of the Department of Public Safety and Correctional Services or a local detention center to participate in treatment.

5. Data Collection and Reporting

Stakeholder feedback on data and reporting requirements under an outpatient civil commitment program was diverse. Reporting requirements under Kendra's Law – New York's outpatient civil commitment law – and requirements included in the 2005 reauthorization of the law were cited by several stakeholders as an appropriate starting point when developing reporting requirements in Maryland. Additional data identified by stakeholders included information on the number of petition requests filed by non-providers; an individual's living situation pre and post program participation; quality of life assessments; demographic information such as race; and treatment outcomes, including medication outcomes. Stakeholders also noted that having a program evaluation conducted by an entity other than the Department would be beneficial.

Based on these comments, this proposal requires the Department to submit an annual report to the General Assembly summarizing the number of orders issued during a 12-month period. For individuals that were the subject of an order, the Department should report on the number of individuals who: (1) maintained contact with the treatment system; (2) maintained housing; (3) participated in employment services; (4) were hospitalized; and (5) came in contact with local law enforcement. Demographic information – including race, gender, income, education and disability – by jurisdiction should also be reported. Costs to administer the program within the Department, as well as costs to other agencies should also be reported. Additional reporting requirements should also include adherence to treatment plans; treatment outcomes, including medication outcomes; substance abuse by individuals who are the subject of an order; type, intensity, and frequency of treatment that are included in treatment plans included in orders; satisfaction with outpatient civil commitment by individuals receiving services and by their families when relevant; and the extent to which enforcement mechanisms are used and the outcome of the enforcement mechanism. In addition to annual reporting, this proposal requires that the program undergo a Sunset Evaluation in accordance with the Maryland Program Evaluation Act. Such an evaluation should also examine the impact of capitated programs, such as Assertive Community Treatment, they were originally designed.

6. Proposed Costs

It is estimated that an additional $3.0 million per 100 individuals would be needed to administer an outpatient civil commitment program, and provide needed community-based services. This includes $2.5 million, or approximately $25,000 per individual committed, for services. These estimates were developed based on costs in other states, namely New York and California. To the extent that an individual is Medicaid-eligible, the State would receive federal financial participation for services offered under the program.

This estimate also includes approximately $0.5 million for increased staffing to manage an outpatient civil commitment program. The following positions would be necessary for every 100 individuals committed to services: 2 Social Workers, 1 Management Associate, 0.5 Assistant Attorney General, and 0.5 Staff Attorneys. The Department estimates that this would costs approximately $0.4 million for salaries and fringe benefits for this staffing compliment. Attorney representation and consultation is necessary due to the administrative process associated with the program, social workers would be needed to monitor the program and assist in program development, and a management associate

is needed to provide administrative support. Staffing estimates also include $0.1 million to conduct evaluations and for expert testimony at administrative hearings.

This proposal would also have to reimburse the Office of Administrative Hearings based on the proportion of their time spent on outpatient civil commitment cases. If the Office of Administrative Hearings spent 1 hour on each case, and there were 100 cases, the Department's Office of Administrative Hearings-related charges would increase by approximately $20,000[3]. According to its Managing for Results measures, the Office of the Public Defender has 8.5 attorney's in its mental health division. These public defenders have a caseload of roughly 850 cases annually. To the extent that caseloads increase, the Office of the Public Defender's expenditures may increase.

7. Federal Funding Opportunities

It is important to note that newly authorized federal funding may also be available to support an outpatient civil commitment program. H.R.4302 was signed into law on April 1, 2014. While the majority of the law relates to Medicare payments to physicians, it also authorizes a total of $60 million over four years to fund the expansion of outpatient civil commitment. ·Congress authorized $15 million annually for fiscal years 2015 through 2018. Through a four-year pilot program, the federal government must award no more than 50 grants each year to eligible entities for outpatient civil commitment programs for individuals with serious mental illness.

Eligible entities who may apply for grants include counties, cities, mental health systems, mental health courts, or any other entities with authority under the law of the State in which the grantee is located to implement, monitor, and oversee outpatient civil commitment program. In order to apply for funding, applicants must not have previously implemented an outpatient civil commitment program, and must agree to evaluate and report on treatment outcomes and other criteria. When awarding grants, the federal government must evaluate applicants based on their potential to reduce hospitalization, homelessness, incarceration, and interaction with the criminal justice system while improving the health and social outcomes of the patients.

Programs that receive funding under H.R. 4302 must: (1) evaluate the medical and social needs of patients that are participating in the program; (2) prepare and execute treatment plans that include criteria for completion of court-ordered treatment and provide for monitoring of the patient's compliance with the treatment plan, including compliance with medication and other treatment regimens; (3) provide case management services that support the treatment plan; (4) ensure appropriate referrals to medical and social service providers; (5) evaluate the process for implementing the program to ensure consistency with the patient's needs and the state law; and (6) measure treatment outcomes, including health and social outcomes such as rates of incarceration, health care utilization, and homelessness.

[3] Based on current expenditures, the Department is charged $194.44 per hour by the Office of Administrative Hearings. One hour per case was used as an estimate as current involuntary admission cases are charged at half an hour per case. Since this would be a new type of hearing, additional time was allotted.

II. Proposal 2 - Enhance Access to Voluntary Outpatient Mental Health Services

Based on stakeholder input, proposal 2 was developed to enhance access to voluntary outpatient mental health services to improve access to: (1) Assertive Community Treatment teams; (2) peer support; (3) housing for the seriously mentally ill; and (4) crisis services. It should be noted that additional funding would be necessary to make these types of enhancements to the Public Behavioral Health System. The need for additional funding is supported by stakeholders. More specifically, stakeholders indicated funding should not be diverted from existing services to fund these initiatives.

Two of the seven workgroup meetings were devoted to the topic of voluntary outpatient services. Opportunities were provided for stakeholder input at both meetings, and there was a written comment period after each meeting. The workgroup's meetings devoted to voluntary outpatient mental health services are summarized below:

- May 20, 2014: At this introductory meeting, the Department reviewed the workgroup's mandate under its establishing legislation and summarized the process for stakeholder comment and participation. The Department provided stakeholders with an overview of outpatient services funded under Maryland's public mental health system. Dr. Anita Everett - Johns Hopkins Bayview, Division Director of Community and General Psychiatry provided the workgroup with an overview of Assertive Community Treatment, including variations of the program and capitated programs.

- June 24, 2014: The workgroup examined access to voluntary outpatient mental health services and discussed how existing services may be enhanced. The Department provided a presentation on crisis services in Maryland. A guest from On Our Own, Maryland – Denise Camp, Outreach Trainer/Coordinator – provided the group with a presentation on the importance of peer support. Finally, Lisa Kornberg, Executive Director of the Governor's Office of the Deaf and Hard of Hearing presented on working with individuals who are deaf or hard of hearing.

Stakeholder Input

This proposal incorporated stakeholder comments. The draft proposal was circulated to all workgroup participants and other stakeholders. There was a two week comment period and **Appendix 3** includes comments received, and the Department's response to comments, including whether comments were accepted and integrated in this final report.

Assertive Community Treatment

The Department currently provides Assertive Community Treatment services throughout Maryland, but on a limited basis. Assertive Community Treatment provides intensive, mobile, assertive mental health treatment and support services to individuals. Services are delivered by a multidisciplinary treatment team to adults whose mental health needs have not been met through traditional outpatient mental health programs. Treatment teams include psychiatrists, nurses, mental health professionals, employment specialists, and substance use specialists. Services may be delivered in an individual's home, where they work, or other community settings where assessment, intervention and support is needed.

Currently, Assertive Community Treatment teams serve individuals through 19 teams in Anne Arundel, Baltimore (two teams), Carroll, Frederick, Harford, Howard, Montgomery (two teams), Prince George's, and Washington counties as well as Baltimore City (six teams), and the Lower-shore and Mid-shore areas. Services are available 24 hours a day, 7 days a week.

Through the Outpatient Services Program's Workgroup, stakeholders also discussed the potential impact of an outpatient civil commitment program on access to voluntary mental health services in Maryland. The impact of outpatient civil commitment on New York's public mental health system was highlighted in New York State Assisted Outpatient Treatment Program Evaluation. Among other things, it was unclear whether resources were diverted away from other adults with severe mental illness as a result of outpatient civil commitment implementation. In New York, the implementation of outpatient civil commitment was supplemented by large increases in funding, which over time increased the availability of intensive services for all outpatient individuals, even those who did not receive outpatient civil commitment treatment. In the first few years when outpatient civil commitment was implemented, evaluators found that preference for intensive case management was given to outpatient civil commitment cases. This meant that individuals who were not under an outpatient civil commitment order were less likely to receive case management services than those under an outpatient civil commitment order. This especially held true outside of New York City.[4]

The expansion of Assertive Community Treatment is needed regardless of whether an outpatient civil commitment program is implemented in Maryland. However, if a program were established, the Department must consider the effects of an outpatient civil commitment program on access to voluntary outpatient mental health services. Based on findings in New York, it is recommended that if an outpatient civil commitment program is implemented in Maryland – that includes Assertive Community Treatment services – that the Department must increase funding to expand Assertive Community Treatment for individuals seeking services voluntarily.

In order to create an additional Assertive Community Treatment Team, $0.6 million would be required. This includes start up costs for the first year for one 50 consumer team ($0.5 million), and for training and technical assistance infrastructure ($0.1 million). When expanding Assertive Community Treatment, the Department should consider jurisdictional need and the demand for treatment teams as a result of outpatient civil commitment. The current eligibility for capitation programs should be examined to determine whether eligibility should be expanded to address high utilizers. Similarly, the Department should investigate and consider changes to regulations that currently preclude Federally Qualified Health Centers from participating in Assertive Community Treatment Teams and receiving reimbursement that recognizes the more intense service provision.

Peer Support Services

Peer support specialists are consumers with lived experience with behavioral health who are in recovery. Presently, peer support has been integrated into Assertive Community Treatment teams; however several stakeholders noted that that peer support should be further integrated into other outpatient mental health services. Moreover, the Continuity of Care Advisory Panel recommended that the use of peer support specialists in the public mental health system should be further studied by the

[4] Retrieved from: http://www.macarthur.virginia.edu/aot_finalreport.pdf

Department. Based on stakeholder input it is recommended that additional funding be appropriated to expand peer support services within each jurisdiction. Expansion should include the public mental health service delivery system, local detention centers, courts and primary care.

In order to fund one full time peer support specialist at each Core Service Agency, the Department estimates that this would cost approximately $0.6 million annually. This assumes a peer support specialist receives an annual salary of roughly $31,000.

Housing

Written comments submitted by stakeholders consistently identified housing as an area that needed enhancement in the public mental health system. Multiple stakeholders noted that housing is a key component to ensuring an individual is stable and can remain stable in the future. Similar input was solicited through the Continuity of Care Advisory Panel. Among other things, the Panel noted that care can be interrupted when there is inadequate access to needed behavioral health services. The Panel's workgroup's cited a number of areas where there is need for the expansion of specific services, including residential housing for the seriously mentally ill. It was recommended by the Advisory Panel, that within the context of behavioral health integration, the Department continue to monitor and evaluate its ability to enhance and expand services in this area.

Appendix 4 outlines housing programs administered by each Core Service Agency in the state. As the chart shows, there is variation in the number of individuals served by Core Service Agency as well as variation in the types of housing resources offered. Based on stakeholder input, and the Department's survey of Core Service Agencies, it is recommended that the Department increase funding for rental subsidies. The median cost associated with BHA's rental subsidies is $9,946. This ranges from a low of $6,720 per year per person to a high of $13,171 per year per person. Using the median point of $9,946, an additional 50 individuals would be able to receive rental subsidies for every $500,000 appropriated in accordance with this proposal.

Crisis Services

Crisis services serve as an alternative to traditional programs and can be viewed as a continuum of services. This continuum may include a 24/7 hotline, walk-in crisis services, mobile crisis teams, police-based Crisis Intervention Teams, urgent care clinics, emergency department psychiatric services, 23 hour holding beds, crisis residential beds, case management, and court-based diversion.

All jurisdictions offer crisis services; however services vary by jurisdictional need and funding sources. Through a supplemental budget bill in fiscal 2014, $3.5 million was appropriated to expand crisis services in the State. Of this amount, $2.0 million was provided to enhance or add to crisis services and $1.5 million was allocated to fund Crisis Intervention Team programs. **Appendix 5** outlines current crisis services administered by each Core Service Agency; enhancements that are being made through supplemental funding; and the implementation status of each enhancement. As shown in Appendix 5, while numerous enhancements are occurring in each jurisdiction, gaps remain in the crisis services continuum. Moreover, crisis services are not readily accessible to individuals who are deaf and hard of hearing due to a lack of training and staff fluent in ASL. It is recommended that additional funding be appropriated to further integrate and enhance crisis services, within each jurisdiction. Enhancing crisis

services for the deaf and hard of hearing should also be prioritized. If additional funding were appropriated, the Department would distribute funding to Core Service Agencies using inpatient bed utilization as a proxy for demand for crisis services, or allocate funding evenly amongst jurisdictions to increase core levels of funding for crisis services.

III. Proposal 3 - Define Dangerousness in Regulations and Provide Comprehensive Training Around the Dangerousness Standard

Senate Bill 882/House Bill 1267 of 2014 also required the Outpatient Services Programs Stakeholder Workgroup to evaluate the dangerousness standard for involuntary admissions and emergency evaluations of individuals with mental disorders, including: how the standard should be clarified in statute or in regulations adopted by the Department; and initiatives the Department should adopt and implement to promote the appropriate and consistent application of the standard by healthcare professionals, administrative law judges, the Office of the Public Defender, consumers, and other individuals. The Workgroup held one meeting to discuss this topic.

Background

This proposal draws upon observations and recommendations made by the Continuity of Care Advisory Panel. Following its review of the dangerousness standard, the Panel found that in practice, there was variance in how the dangerousness standard is interpreted across the healthcare system. This has led to inconsistent application of the dangerousness standard in various settings, including emergency evaluations.

Ultimately, the Panel recommended that the Department promulgate regulations defining dangerousness to promote consistent application of the standard throughout the healthcare system; and to further ensure consistency, the Department should develop and implement a training program for healthcare professionals regarding the dangerousness standard as it relates to conducting emergency evaluations and treatment of individuals in crisis. It was recommended that training should be extended beyond the emergency room to Administrative Law Judges, the Office of the Public Defender, consumers and family members to ensure consistent application of the standard statewide.

It is important to note that the Panel concluded that a gravely disabled standard was not needed to address inconsistencies in involuntary admission practices. Rather, the Panel found that dangerousness to self is included in the civil commitment criteria; variances in involuntary admissions are the result of other factors, including the application and interpretation of "dangerousness to self," failure of the State to define "dangerousness," and inadequate training of providers, first responders, and administrative and legal professionals on how to apply the dangerousness standard.

Current Law

Under current law, the dangerousness standard is only one of six criteria used when determining whether an individual may be admitted to a facility involuntarily. A health care facility or Veterans' Administration hospital may not involuntarily admit an individual unless (1) the individual presents a danger to the life or safety of the individual or of others; (2) the individual has a mental disorder (3) the individual needs inpatient care or treatment; (4) the individual is unable or unwilling to be admitted

voluntarily; (5) there is no available, less restrictive form of intervention that is consistent with the welfare and the safety of the individual; and (6) if the individual is 65 years old or older and is to be admitted to a State facility, the individual has been evaluated by a geriatric evaluation team, and no less restrictive form of care or treatment was determined by the team to be appropriate. As a matter of federal constitutional law, an individual may not be confined to a hospital involuntarily unless the State proves by clear and convincing evidence, that the individual is a danger to the life or safety of the individual or others.[5]

Proposed Definition of Dangerousness

Consistent with the Continuity of Care Advisory Panel's recommendation, the Department proposes the following definition of dangerousness to promulgate in regulations:

"Danger to the life or safety of the individual or of others" means, in consideration of the individual's current condition and, if available, personal and medical history, that:

(1) There is a substantial risk that the individual will cause harm to the person or others if admission is not ordered; or

(2) The individual so lacks the ability to care for himself or herself that there is a substantial risk of death or serious bodily injury if admission is not ordered."

Stakeholder Comments: Psychiatric Deterioration

This proposed definition was circulated to all workgroup participants and other stakeholders. There was a two week comment period. The majority of stakeholder comments supported the inclusion of psychiatric deterioration in the definition of "danger to the life or safety of the individual or others." These comments were considered, but the Department made the decision not to include psychiatric deterioration in the definition due to concerns that involuntary hospitalization may not always be the clinically appropriate level of care for all individuals at risk for psychiatric deterioration. For those individuals whose psychiatric deterioration that has not resulted in them presenting a current danger to themselves or others, inpatient hospitalization often is not clinically appropriate. To further illustrate this concerns, the Department offers the three scenarios below.

> **Scenario 1:** Mr. A is a 28 year old man who was emergency petitioned to the emergency department due to threatening behavior directed toward his family. He reports hearing voices telling him that his family is poisoning his food. He expressed frustration, thoughts of suicide and aggression toward those he views as his persecutors. He has a history of 3 prior psychiatric admissions over the previous 7 years, all in the context of psychotic, paranoid symptoms. Each hospitalization was brief, the longest lasting 12 days, during which he responded quickly to antipsychotic medications and psychosocial support. He reports that he stopped attending treatment at his outpatient program "a while ago" because "I was better and didn't need it

[5] In *O'Connor v. Donaldson*, 422 U.S. 563 (1975), the United States Supreme Court ruled that "a State cannot constitutionally confine, without more, a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends." In *Addington v. Texas*, 441 U.S. 418 (1979), the Court determined that the appropriate standard of proof of dangerousness is clear and convincing evidence. Neither case has been limited or overruled.

anymore." In the emergency department, his physical exam, lab values and tox screen are normal. He is in the quiet room, yet takes an aggressive stance on approach. He denies any intention to harm anyone specifically, saying "I just want to be left alone." Mr. A's active psychotic symptoms coupled with his poor frustration tolerance and aggressive posturing (impaired judgment) support the need of inpatient psychiatric treatment for crisis stabilization.

Scenario 2: Mr. B is a 28 year old man who was taken to the emergency department by family due to increasing frequency of panic attacks. He has a long history of panic disorder, dating back about 7 years. He works from home as a web designer. He has been followed as an outpatient by a psychiatrist and a therapist and has never been hospitalized. His panic symptoms were well managed until he stopped attending treatment "a while ago" because "I was better and didn't need it anymore." In the emergency department, he reports that from time to time he has been so paralyzed by his panic symptoms that he fears leaving his home. He orders food from a local supermarket which delivers his groceries to his home. His physical exam, lab values (including thyroid function tests and tox screen) and EKG are normal, suggesting that he has maintained adequate nutrition.

Scenario 3: Ms. C is a 28 year old woman brought to the emergency department by police after threatening a police officer who suggested that she should go into a code blue shelter. The police officer found her sleeping under a bridge in the middle of a snow storm. In the hospital, records indicate that she had been involuntarily committed six months previously. Her physical exam suggests that she is malnourished and is suffering from frostbite on her fingers. She acknowledged that she has not kept her appointments or followed up with her medication, and says that "the voices are getting louder." She vociferously declined the offer of a voluntary admission, yelling "you just want to lock me up and throw away the key" and then trying to run out of the emergency department.

Using the proposed definition of "danger to the life or safety of the individual or of others," the individual described in Scenario 1 and 3 could be admitted involuntarily, while the individual described in Scenario 2 would not:

- In scenario 1, the emergency department clinicians would likely diagnose Mr. A with a psychotic disorder. Attempts to treat his psychosis in the emergency department may be insufficient given his chronic history. If he continues to present with aggressive or threatening behaviors while in the quiet room, he could be certified in the emergency department for inpatient admission.

- However, in scenario 2, Mr. B almost certainly would not require admission, however serious his illness might appear initially. Emergency room treatment to address Mr. B's symptoms would most likely include the initiation of both pharmacological and psychotherapeutic treatment targeting his anxiety disorder. Depending on the location, these clinicians may have access to urgent care or walk in clinics. Even if they do not, it is reasonably likely that this individual could be referred back to his treating psychiatrist, who would reengage him in treatment. Even if this man were believed to be "gravely disabled" or "likely to deteriorate," very few clinicians would view this individual as someone who should be subjected to involuntary inpatient treatment as he does not pose a danger to the life or safety of himself or others.

- Finally, in scenario 3, Ms. C clearly is a person who requires inpatient care at the present time, involuntarily if needed.

If the proposed definition was altered to include psychiatric deterioration, all three individuals would be involuntarily admitted. This would not be clinically appropriate for Mr. B because he does not present as dangerous; thus he does not meet the standard for involuntary admission.

Much of the feedback received focused on the perceived need to include language within the dangerousness criteria regarding the risk of psychiatric deterioration. The Department does not believe that this is either necessary or wise. The dangerousness criteria, as revised, characterizes individuals suffering with mental illness who *in the present moment* pose a public safety risk, broadly defined to include substantial risk to themselves either affirmatively or passively. Thus, the language codifies what the Department believes to be the proper practice: liberty is to be infringed only when there is a current risk. It captures the concept, if not the language, of grave disability. Adding language to include risk of deterioration would create a vastly overbroad group of people who could be subjected to involuntary commitment, as most everyone could be considered at such risk at some point in time, regardless of their willingness to engage in treatment.

Stakeholder Comments: Statutory vs. Regulatory Change

Some stakeholders also noted that dangerousness should be defined in statute as opposed to regulation. Proceeding through regulations, as opposed to legislation, is recommended because if concerns are identified in the implementation of this definition of "dangerousness," then the regulations can be amended without requiring the passage of new legislation. Additionally, the regulatory review process would provide the Department with an opportunity to get further input from providers, consumers, and other interested stakeholders and incorporate that input into the amended regulations. The Department plans on posting the regulations for formal comment in early 2015.

Other Stakeholder Comments

A minority of stakeholders indicated that "danger to the life or safety of the individual or of others" did not need to be further defined. More specifically, stakeholders argued that the Department should implement training around the current standard to address its inconsistent application. The standard could then be further defined if training did not promote consistent application of the standard. The Department considered these comments; however Senate Bill 882/House Bill 1267 of 2014 requires the Workgroup to determine how the standard should be clarified in regulations and statute and the Department supports further clarification of the current standard.

Other stakeholders noted that terms that are used in the proposed definition, including "substantial risk" and "will cause harm," will make it more difficult to involuntarily admit an individual and suggested the use of a lower legal standard. After considering these comments the Department believes that the inclusion of these terms is necessary to sufficiently protect individuals' civil liberties. The use of a lower legal standard would not adequately address these concerns. Training modules created by the Department will be designed to ensure that these terms are adequately explained to ensure consistent and clinically appropriate application of the standard.

Training

The Outpatient Services Programs Stakeholder Workgroup was also required to develop initiatives to promote the appropriate and consistent application of the dangerousness standard. Once a new standard is adopted, training methodologies will include case-based training to illustrate questionable scenarios. Pre and post test training tests will be used to determine whether individuals met learning objectives.

Training modules will also be designed for specific audiences. The Department advises that the following audiences would benefit from training around the dangerousness standard:

- first responders,
- emergency department clinicians,
- inpatient psychiatric staff,
- including hospital presenters,
- Administrative Law Judges, and
- public defenders.

Implementation of these new training modules will require assistance from stakeholders including: EMS and law enforcement agencies, the Maryland Hospital Association, the Office of Administrative Hearings, the Office of the Public Defender, the statewide academic health centers, and professional organizations, such as the Maryland Psychiatric Society.

Training will be developed to target the needs of specific audiences. For example, the needs of clinicians working in emergency or crisis settings are quite different from the needs of Administrative Law Judges tasked with making decisions using civil commitment law - which includes a finding as to dangerousness. Thus, first responders and emergency clinicians must make rapid decisions based on limited information, so their training will focus on how best to make good decisions in the context of their work. By contrast, inpatient mental health staff have time to gather information, talk with the patient and his/her significant others, and gather prior records, and can make a more considered decision regarding the need for continued acute involuntary treatment. Administrative Law Judges and defense counsel are in a place to more strictly consider the legal standard as applied to the facts presented in evidence, and their role is to ensure that there is a proper balance between the patient's rights and public safety considerations. Through partnerships with the various stakeholders, trainings will be designed to meet each group's specific needs and ensure a full but targeted understanding of the standard as it is to be considered and/or applied by that group.

To ensure that the training modules have the widest possible distribution, they will be adapted as webinars suitable for distance learning. Webinars will be recorded to allow for later viewing by participants unable to join live training exercises. This will be especially important for workers on off-shifts, as is commonly the case for first responders and emergency clinicians.

The content of the training will include, as relevant to the specific audience, education regarding the dangerousness standard as it is to be applied during the "emergency petition" phase of a particular case and during the various civil commitment procedures and proceedings. In addition, examples will be incorporated into the trainings to allow participants to examine specific issues likely to arise during their work with people with mental illness. These examples will vary based on the audience targeted and based on the phase of the process being discussed.

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Criteria 2: This citation seems too general to subject an individual to outpatient commitment. A better definition for the population of interest may be those with “serious mental illness” as defined in COMAR 10.21.17.02.76. This item might read “The individual’s condition meets the definition of “serious mental illness” as detailed in COMAR 10.21.17.02.76.	The Department did not accept this recommendation. The definition of "serious mental illness" in COMAR 10.21.17.02.76 is too narrow and would exclude a number of people who would otherwise qualify for an outpatient civil commitment program. Instead, the Department used the term "mental disorder" as currently defined in Health - General § 10-101.	Tim Santoni
Criteria 4: I believe the criteria list is usable but (4) should be removed.	The Department did not accept this recommendation. The purpose of criteria #4 is to help ensure that an outpatient civil commitment order is not too far reaching. Generally, the Department supports an individual's right to make decisions about his/her medical treatment. An individual should be subject to an outpatient civil commitment order only if his/her nonadherence to outpatient treatment is likely to result in the individual presenting a danger to the life or safety of the individual or others.	Steven Gray
Criteria 4: What about the consumer who refuses treatment, lives with an elderly parent who has tolerated psychotic behaviors for years without accessing help. The parent dies and the individual is now left alone to fend for him/herself, but without a “history” of hospitalization? Can the 2 hospitalizations within 48 months criterion be disregarded in some circumstances?	No. In order to meet the criteria for outpatient civil commitment an individual would of had to been hospitalized involuntarily at least twice within 48 months.	Bette Stewart

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Criteria 4: A few aspects of DHMH's "2 in 48 months" proposal are more restrictive than similar criteria in other states. Specifically: no existing state OCC law requires qualifying past hospitalizations to have been "involuntary," as the DHMH proposal does. Other states typically allow for a broader range of facilities in which the person may have received past treatment. Other states typically allow for exclusion from the "lookback period" of time the person spent hospitalized or incarcerated.	The Department considered this comment and examined criteria used in a number of states. The decision was made to reject this recommendation due to concerns that broadening the criteria would make it more difficult for the program to target those most in need for outpatient civil commitment. The bill requires the Department to submit annual reports to the General Assembly on the implementation of the outpatient civil commitment program. If this review uncovers a need to expand the criteria, the Department would support such action. It is important to note that there are states, including Florida, that have a similar requirement. (See Fla. Stat. §394.4655(e)(1)).	NAMI Maryland
Criteria 4: This criterion should be changed from two "involuntary admissions" in 48 months to two civil commitments in 48 months.	The Department did not accept this recommendation. The existing statute uses the term "involuntary admissions." Our goal is to remain consistent, so the Department will use "involuntary admission" instead of "civil commitment."	Maryland Psychiatric Society and the Suburban Maryland Psychiatric Society

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Criterion 5: This criterion would dramatically reduce the number of people who could be served by OCC. A good model here is California's "Laura's Law," which requires a showing that voluntary services have been offered in the past, but allows OCC based on the person's continued "fail [ure] to engage in treatment." Laura's Law does not require a current refusal to accept voluntary services. The distinction is critical.	The Department considered this comment and examined criteria used in a number of states. The decision was made to modify this criteria to state: "The individual has been offered the opportunity to participate in recommended treatment but either declines to do so or fails to adhere to treatment recommendations." If an individual is willing to accept voluntary services, then an outpatient civil commitment order is not appropropriate. Such an order should be obtained only if an individual refussed to accept or adhere to voluntary services. It is important to note that Laura's Law has a similar requirement that the person has been offered an opportunity to voluntarily participate in treatment. See Cal. Welf. & Inst. Code § 5346(a)(5).	NAMI Maryland
Criteria 8: Using the term "feasible" will likely increase the racial and geographic disparities among civilly committed outpatients, as people in economically and geographically impoverished areas lack services available in other areas, making access to them less feasible (see 2014 HB1267, Section 1(a)(2)(iii));	The Department accepts this recommendation. The term feasible will be removed.	Maryland Psychiatric Society and the Suburban Maryland Psychiatric Society
Criteria 8: Using the word "feasible" will likely increase the imbalance of parity between public and private payers, as members of private payers that lack similar coverage for rehabilitative, residential, and ACT services, will find that these alternatives are appropriate, but not available to them and thus are not feasible (see 2014 HB1267, Section 1(a)(2)(vi));	The Department accepts this recommendation. The term feasible will be removed.	Maryland Psychiatric Society and the Suburban Maryland Psychiatric Society

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Criteria 8: The term “least restrictive” is poorly defined and may be comprised of many components including liberty, time, and degree of invasiveness.	The Department did not accept this recommendation. The term "least restrictive" is used throughout the current Maryland statute related to involuntary inpatient admissions. Using this term promotes consistency. This term is also used in California (See Cal. Welf. & Inst. Code § 5346(a)(7)) and Florida (See Fla. Stat. §394.5655(1)(i)).	Maryland Psychiatric Society and the Suburban Maryland Psychiatric Society
If the intention is to target individuals whose “mental illness”, conditions that lead to hospitalization in State facilities, then it is essential to exclude those with a primary substance use disorder and a mental illness which is not severe and persistent from those on whom a petition may be filed.	Only individuals who have a mental disorder and have been involuntarily admitted to an inpatient facility (at least two times over 48 months) will meet the minimum criteria for outpatient civil commitment under this bill. All others will be excluded.	Tim Santoni
Comments on Mandated Services		
There should be estimates of the costs to calculate what the total expenditures may be.	The final report submitted to the Maryland General Assembly will include cost estimates.	Nevett Steele, Jr.
What about the somatic needs of individuals not receiving mental health services prior to their civil commitment, should there be a nurse on the team to assess for illnesses that shorten the lives of individuals with SMI by 25 years of their peers?	An outpatient civil commitment program must focus on improving adherence to mental health treatment. However, the legislation will provide the flexibility to tailor treatment plans to meet the individual needs of the patient.	Bette Stewart
Because such a high percentage of the population at issue will have co-occurring SUD needs, and because many may have both drug and alcohol issues, it may be more emphatic to move the qualifying phrase to the end of this clause and to state: “alcohol and/or substance abuse treatment…”	The Department accepts this recommendation. 10-934(b)(6) will be changed to: COUNSELING, PERIODIC TESTS FOR THE PRESENCE OF ALCOHOL, ILLEGAL DRUGS, OR PRESCRIPTION DRUGS, OR ALCOHOL OR SUBSTANCE USE DISORDER TREATMENT IF AN INDIVIDUAL HAS A HISTORY OF A SUBSTANCE USE DISORDER.	Tim Santoni

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I believe that there should be housing and transportation for persons committed as outpatients. They should have these services if they are to succeed. Those costs should be considered.	Under the current proposal, a wide array of services, including housing and transportion, may be included in the treatment plan based on the needs of the individual.	Nevett Steele, Jr.
Specific language be developed to ensure that private payers provide the same level of rehabilitative, residential, and ACT services that are provided by public payers.	The Department did not accept this recommendation. If a treatment plan includes services that are not covered an individual's private insurance, such coverage will be provided by funds in the Department's outpatient civil commitment program.	Maryland Psychiatric Society and the Suburban Maryland Psychiatric Society
If a mandated outpatient treatment program is to be developed, this be a required benefit covered by private payers in the same manner that public payers cover the benefit.	The Department did not accept this recommendation. If a treatment plan includes services that are not covered an individual's private insurance, such coverage will be provided by funds within the Department's outpatient civil commitment program.	Maryland Psychiatric Society and the Suburban Maryland Psychiatric Society
I think there should be explicit attention to assigning individuals to a model that includes ACT like teams that are augmented with case rates to allow for highly flexible and individualized treatments and that include outcomes tied to incentives and risk. It is important to examine the results of the Baltimore Capitation Project as originally designed. They had an enormous success rate, without a mandate, of treating extremely heavy users in the community and dramatically reducing inpatient days while increasing positive outcomes.	The Department accepts this recommendation. These issues will continue to be explored by the Department if legislation passes establishing an outpatient civil commitment program in Maryland.	Deborah Agus, JD

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Intensive case management, as currently defined, may be insufficient to meet the needs of this population. Current reimbursement is limited to five visits per month. This may be inadequate for the needs of this population and the Department may want to use a different term or some modifier to indicate "a level of intensive case management, more intense than that currently reimbursed in the public behavioral health system"	This is not an exhaustive list of available services. Additional services may be provided based on the needs of the individual.	Tim Santoni
Comments on Civil Liberties		
Regarding the right to cross-examine adverse witnesses: If the person does not have the capacity to care for themselves, and their lawyer is only addressing the person's rights, then doesn't this put us back where we started? If two medical professionals, trained to assess capacity, are over ruled by the person's "rights", has civil commitment just added another layer of barriers to treatment?	The Department did not accept this recommendation. An individual who is the subject of a petion is entitled to a hearing and should have the ability to cross examine adverse witnesses.	Bette Stewart
Regarding non-adherance to treatment: What is Mental Health Service Providers' responsibility to work with the insurance company's refusal to pay for services, or connect the individual with MA to receive this level of service?	This is an issue that the Department will continue to explore should legislation pass to establish an outpatient civil commitment program in Maryland.	Bette Stewart
Regarding non-adherance to treatment: How will the mental health service provider collaborate with the Correctional Services to guarantee cooperation for mental health services (medications) are continued during incarceration?	Under the current proposal, an outpatient civil commitment order would no longer be in effect if the subject of the order is incarcerated.	Bette Stewart

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Regarding the right to receive notice of the Department's petition: Should not the subject of the petition be informed of the allegations that led to the filing of the petition as well as the identity of the initial requestor of the petition? While this is proposed as an executive process, those charged in the judicial system have those rights.	Under the current proposal, the subject of the petition will receive notice of the petition.	Tim Santoni
Should not "and the right, to the degree possible, to have any conditions and treatments stated in a petitioner's advanced directive for mental health treatment to be honored and included in the treatment plan order" be included?	The Department accepts this recommendation. That language will be added to the legislation.	Tim Santoni
Comments on Reporting		
An individuals living situation pre and post program participation - Is the interest in living situation or whether or not the individual was homeless at these points in time?	This would capture whether an individual is homeless. However, it is also the Department's intent to capture whether an individual is able to live more independently.	Tim Santoni
'Came in contact' is disturbingly general. Does this include those who may have been taken to a shelter because they were on the street and it was a bitterly cold evening? Does it include individuals who could be possible witnesses to a crime whom the police question? Or those against whom a crime may have been committed and who therefore had to approach the police to report the crime?	The report submitted by the Department will detail the type of contact between the individual and local law enforcement.	Tim Santoni
Regarding medication outcomes: While I am not a medical professional, I am not certain how to define or measure "medication outcomes". How does one know the changes which were cause by medication as opposed to those caused by other factors?	Data on medication outcomes will be provided by the service provider. The service provider will have primary responsibility for providing treatment to the subject of the order and can reasonably determine and measure medication outcomes.	Tim Santoni

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Regarding enforcement mechanisms: Given the discussion regarding the power (or lack thereof) of a finding from the OAH, I am uncertain what the "enforcement mechanisms" could be invoked much less how to measure their outcomes.	The proposal requires the Department to submit an annual report to the General Assembly on the outpatient civil commitment program. One of the reportable measures is the extent to which enforcement mechanisms are used and the outcome of the enforcement mechanisms. Enforcement mechanisms include efforts by service providers to reengage patients. In addition, if there is sufficient evidence to suggest the subject of the petition may meet criteria for inpatient admission, an individual may be transported to a facility for emergency evaluation under Health-General 10-622.	Tim Santoni
Missing from the list is the number of individuals found subject to outpatient commitment whose insurance was insufficient or unwilling to cover the costs of mandated treatment. Lack of cooperation on the part of private insurers and Medicare will have an impact on the effectiveness of the program.	The lack of health care coverage will not impact access to treatment under an outpatient civil commitment program. Unless funding is available, an individual will not be subject to an order.	Tim Santoni
Regarding program evaluation: Given the importance of this provision, it seems essential that the elements of cost, process measures, and outcomes all be well defined if not in the law itself then in a planned process. While the suggestion of using an external entity to collect and analyze the data, such a process would seem expensive and duplicative. A transparent process of data collection with an advisory committee overseeing the results on a regular basis may be a compromise which would assure transparency while maintaining efficiency.	The Department of Legislative Services - the state entity that conducts program evaluations - would conduct an evaluation of the outpatient civil commitment program using existing resources. Therefore, additional funding would not be needed.	Tim Santoni
The reporting described in the last paragraph should be monthly.	The Department will develop policies around reporting requirements for providers, including frequency of reporting.	Nevett Steele, Jr.

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Other Comments		
Please clarify who will be responsible for contacting the person to determine if they are willing to voluntarily participate in mental health treatment.	The Department, in conjuction with the appropriate treatment provider will ensure that treatment is offered voluntarily.	Bette Stewart
Will this emergency evaluation have the same 5-day expiration as the current emergency evaluation process if the person is not picked up within that timeframe?	The emergency evaluation process, set forth under HG 10-624(a)(1), provides for a five day deadline when the petition is endorsed by the court. However, there is no five day deadline when the petition is signed by a qualifying health care provider, health officer, or peace officer. Similiarly, the emergency evaluation process under this bill would require the petition to be signed by the Secretary, or the Secretary's designee, and there is no five day deadline.	Bette Stewart
Regarding the examination by two licensed mental health treatment providers: How are the service providers identified and when are they engaged to begin work with the person? It is not clear what the timeframe is for the treatment plan to be prepared, and in the meantime where is the person being held?	In response to other comments received, the Department has amended this section. An examination by one licensed mental health treatment provider is required before the Secretary may file a petition for outpatient civil commitment. The licensed mental health treatment provider will be designated by the Secretary, or the Secretary's designee.	Bette Stewart
Petitions: The persons described in footnote 1 on page 2 should have the right to petition directly to the OAH and not have to await the outcome of a preliminary investigation by the Secretary’s office. The people in categories (1) and (2) were among the ardent supporters of the proposal.	The proposal was developed with a single petitioning entity in order to adderss racial and geographic disparities in program implementation.	Nevett Steele, Jr.

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There is nothing in the proposal to guide the process addressing an individual's non-compliance with the court order. This is obviously a vital aspect of any OCC program, and we request an opportunity to learn and comment upon what DHMH has in mind for this part of its proposal.	Under this proposal, the process for addressing noncompliance will be similiar to that under California and New York's outpatient civil commitment programs. It will be the responsibility of the service provider to attempt to reengage non-compliant patients in treatment. However, if there is reason to believe that the non-compliant patient may be in need of involuntary admission to a hospital, the individual may be subject to a petition for emergency evaluation in accordance with HG § 10-622.	NAMI Maryland
Regarding investigations: It seems as if this would be more appropriate as a two step process, the first being a finding of whether or not the individual should be subject to outpatient commitment, and, if that finding is positive, then a second hearing that details the treatment plan for the course of the commitment; there is no mention of a "service provider" prior to this point, and it seems premature to put together a treatment plan prior to a finding having been made.	Under this proposal, the Department will submit a petition to the Office of Administrative Hearings. The recommended treatment plan will be included as part of the petition. OAH will hold a hearing and determine whether the individual meets the criteria for outpatient civil commitment. If OAH finds that the individual meets the criteria, then OAH will determine whether the proposed treatment plan meets the individual's treatment needs. OAH will not approve a treatment plan in the absence of finding that the individual meets the criteria for outpatient civil commitment.	Tim Santoni
Regarding the petitioning process: We believe that any person with a legitimate interest in the individual should be eligible to request a petition. However, at a very minimum, guardians and health care agents should be added to the list.	The Department will add guardians to the list of entities that may request an investigaton. However, health care agents were not added to this list. Once appointed, a guardian is obligated to file an annual report with the court. The report is meant to supervise the guardian's actions and to determine whether the guardianship should be modified or terminated. In comparison, health care agents are not supervised.	NAMI Maryland

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NAMI Maryland believes that families should be involved in the ongoing mental health treatment planning with the individual. For this reason, we recommend that the OCC proposal include services to the family of the individual similar to those outlined in Laura's Law	The Department agrees that families may play a roll in an individual's ongoing mental health treatment. However, the Department did not accept this recommendation as this proposal only addressed services for the individual.	NAMI Maryland
We suggest, that where possible, notification of an OCC request, an OCC petition, and an OCC hearing be sent to the individuals listed in Health-General §10–632. Additionally, we recommend that the individual who files the OCC request be notified that an OCC petition has been filed and when the hearing has been scheduled. Families and guardians are generally the most involved in the individuals past history with service providers, ER, outpatient, inpatient, corrections, homelessness, etc., and can often provide a more complete and lengthy history than any one examiner or service provider. There are several other requirements in Kendra's law relevant to individuals that should be notified during the OCC process.	The Department did not accept this recommendation as the proposal does not address specific hearing procedures.	NAMI Maryland

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Comments on criteria	**DHMH Response**	**Submitted by**
Since Maryland already allows testimony be given by the parent, guardian, or next of kin of an individual involuntarily admitted, we recommend that you include this requirement in the draft OCC proposal. Allowing these individuals to testify should not be dependent on being called as a witness or questioned by the person presenting the case for the petitioner. Family members have a compelling interest in requesting appropriate medical treatment be provided to the individual. While the vast majority of individuals coping with mental illness are not violent, there are cases that the safety of a family member is a concern. Involuntary evaluation and an OCC order is an effective way that the individual suffering with a severe mental illness can get needed treatment, which can help safeguard the family member from continued violent behavior.	The Department did not accept this recommendation as the proposal does not address specific hearing procedures.	NAMI Maryland
We strongly suggest that the OCC proposal include provisions for mandatory training, so that all professionals involved in the process are educated in how to carry out the requirements of the new law, including, judges, defense attorneys (public defenders, if applicable), mental health treatment providers, law enforcement officials, corrections officers, and homeless providers.	The Department did not accept this proposal as the workgroup did not examine training provisions needed for an outpatient civil commitment program.	NAMI Maryland

Appendix 2

RESPONSE TO THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE'S REPORT ON THE OUTPATIENT SERVICES PROGRAMS WORKGROUP

Submitted by:
Maryland Disability Law Center
Mental Health Association of Maryland
On Our Own of Maryland, Inc.

December 2014

Maryland Disability Law Center (MDLC) is the federally funded, non-profit legal services organization officially designated by the Governor of the State of Maryland as the Protection and Advocacy System for individuals with disabilities. Founded in 1977, MDLC's mission is to work with and for people with disabilities in defense of their legal and human rights. MDLC has been extensively involved with litigation, legislative, and policy work related to mandated community treatment in both the civil and criminal contexts; the statutory and constitutional limits on the involuntary administration of psychotropic medication; and the rights of individuals with mental disabilities to be free from coercion and to be fully integrated into the community.

Mental Health Association of Maryland (MHAMD) is a voluntary, nonprofit citizens' organization that brings together consumers, families, professionals, advocates and concerned citizens for unified action in all aspects of mental health and mental illness. Since 1915, MHAMD has been dedicated to promoting mental health, preventing mental disorders, and achieving victory over mental illness through advocacy, education, research, and service. MHAMD is an affiliate of Mental Health America and the National Council for Behavioral Health. MHAMD envisions a just, humane and healthy society in which all people are accorded respect, dignity and the opportunity to achieve their full potential free from stigma and prejudice. MHAMD supports person-centered recovery in the least restrictive environment, and opposes unnecessary restrictions on liberty, independence, choice and self-determination.

On Our Own of Maryland, Inc. is a statewide mental health consumer education and advocacy organization that promotes equality in all aspects of society for people who receive mental health services, and develops alternative, recovery-based mental health initiatives. The organization's goals are to support and to provide technical assistance to its affiliated organizations and their members; to encourage improvements and alternatives to the current mental health system; to promote self-help programs; and to advocate for the least restrictive setting for those undergoing treatment and provide the maximum degree of personal freedom. One of On Our Own of Maryland's many programs includes the Olmstead Peer Support Project. This project prepares consumers in the state's psychiatric facilities to leave these facilities by advocating their options in less restrictive settings, such as community placements.

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EXECUTIVE SUMMARY

During the 2014 legislative session, two legislative approaches were put forward to address the longstanding need for better engagement of a discrete population of individuals with serious mental illness. An outpatient civil commitment bill was introduced, accompanied by a substantial amount of misinformation put forward by a national lobbying group. House Bill 1267/Senate Bill 882 was also introduced to establish a voluntary program designed to engage individuals at risk for disruptions in continuity of care – the same population targeted by supporters of outpatient civil commitment. While there was no opposition to House Bill 1267/Senate Bill 882, proponents of outpatient civil commitment argued that involuntary treatment was still needed. In an effort to resolve disputed claims about the necessity and potential effectiveness of each approach, the Legislature amended House Bill 1267/Senate Bill 882, to direct the Department to engage stakeholders in an evidence-based examination of a broad range of potential programs, voluntary and involuntary, and to address potential critical disparities in implementation.

Consumers, family members, advocates and providers alike are in complete agreement that a solution is needed to improve continuity of care. The interim study offered an opportunity to build consensus around a proposal that could be supported by all. Rather than leading an unbiased examination and allowing stakeholders to potentially choose a voluntary program of services as the best model to reach at-risk individuals – and as an *alternative* to involuntary treatment – the Department pre-determined that involuntary treatment would be proposed to the Legislature in the required Final Report.

While we were distressed by the Department's unilateral decision, we are stunned by the inadequacy of the final proposal for outpatient civil commitment. The Department makes broad assumptions about the target population and asserts that outpatient commitment would "improve continuity of care," yet provides no evidence-base to support its assumptions or conclusion. Because outpatient civil commitment deprives individuals of the constitutional right to make their own treatment decisions, however, the Department must demonstrate that involuntary treatment is necessary because it produces sufficiently superior outcomes to voluntary services to justify the infringement of rights. The Department could not make this showing, because the weight of the research evidence is against the effectiveness of outpatient civil commitment.

Moreover, the Department fails to adequately address potential racial, economic and geographic disparities, and instead merely states that having a single petitioning entity will resolve these issues. The Legislature, the mental health community, the general public, and most certainly the individuals who would be targeted for expanded coercion, deserve a full analysis on these critical

points. We offer this response to provide the Legislature with the required evidence-based examination of outpatient civil commitment and to offer our proposal for an alternative voluntary program.

Summary of the key findings:

•Six independent systematic reviews of the body of outpatient civil commitment research concluded that there is **little or no evidence** that people court ordered to community treatment have better outcomes than those receiving voluntary services. Conducted by teams of independent researchers with expertise in the topic area, a systematic review is regarded as the highest level of research evidence, as all qualified studies are identified, collected and analyzed. The six independent systematic reviews of outpatient civil commitment research included two meta-analysis studies, in which primary data from existing randomized, controlled trials is pooled and analyzed. As compared to any single study, this pooling of data increases statistical power and reduces potential bias. A quality meta-analysis thus provides the most accurate analysis of existing randomized controlled research trials.

Consultants, hired by the Department to review only three selected studies, came to a different conclusion on only one domain, finding *moderate* evidence that people on court orders have fewer hospital admissions. The Department's consultants rated the strength of evidence on all other claims as "weak" or unconfirmed.

•According to Maryland data, 503 individuals were identified as having high emergency department or inpatient care utilization rates in fiscal year 2012. In the following fiscal year, 89% of that population was receiving voluntary services. It is unknown whether the remaining 53 individuals were offered enhanced and coordinated services and refused, or if they were simply discharged with no follow-up. In addition, 50% of the at-risk population no longer met the high utilization criteria the following year, demonstrating the effectiveness, to some unknown extent, of voluntary services in reducing hospital and emergency department admissions. Nearly three-quarters of the high-risk population were diagnosed with substance use disorder, indicating that substance use, not mental illness, may be the primary cause of high inpatient admissions.

While this data is incomplete, it calls into question the Department's hypothesis that "many individuals" having frequent contact with a psychiatric facility will refuse voluntary services and that coercion is necessary to reduce hospital admissions. More information is required before a reasonable conclusion can be made about the nature and cause of disengagement from community services – in other words, whether it results from a fragmented system, poor quality of care

experienced by the individuals, the impact of substance use, or the symptoms of a severe mental illness.

•Studies on outpatient civil commitment conducted in North Carolina and New York revealed that people of color and those living in poverty are disproportionately impacted by involuntary community treatment orders. In North Carolina, two-thirds of individuals court-ordered to community treatment were African American, despite only representing approximately 22% of the total state population. In New York, African Americans were subjected to court orders **five times** more frequently than whites, while Latinos were **two and a half times** more likely than whites to be under a court order. The study authors observed that states targeting the "revolving door" population – those involuntarily hospitalized and concentrated in the public mental health system – will "inevitably select a greater proportion of African Americans than their share in the general population, because that is the racial distribution of the target population, for historical reasons."

•Although it is frequently reported that forty-five states have civil outpatient commitment, only ten states have the type of "preventive commitment" law proposed by the Department. Preventive commitment targets people who do not meet the state's inpatient commitment criteria; in other words, they are not presently dangerous or gravely disabled. Thus, the Department's proposal is a radical departure from the well-established concept that people who have the capacity to make treatment decisions are free to do so absent a clinical prediction of reasonably imminent harm to self or others.

Regardless of the specific type of outpatient civil commitment law, few states use it widely and it appears that only New York has developed a comprehensive program to implement its law. Undoubtedly, cost is a major factor in the decision by most mental health authorities not to use outpatient civil commitment. New York spends approximately **one hundred and fifty-eight million dollars annually** to support its outpatient civil commitment program. Despite this massive influx of additional annual funding, intensive voluntary services were dramatically reduced during the initial three-year implementation period. Accessibility to voluntary services remains vulnerable due to flat funding.

Without significant additional funding attached annually to any outpatient civil commitment program proposed for Maryland, it will either be rarely used or it will result in "queue jumping," in which people court-ordered to treatment will be prioritized for intensive services, shutting out those who voluntarily seek such services. Given the lack of empirical research support for the proposition that a court order offers any benefit above and beyond voluntary services, passing a

civil commitment law does nothing more than promote stigma against persons with a serious mental illness while effectively punishing those seeking help.

•In contrast to the lack of evidence supporting the need for mandated community treatment, there is clear evidence supporting the efficacy of intensive community services in significantly improving outcomes for people at risk for disruptions in continuity of care. For example, Assertive Community Treatment (ACT) is one of the most extensively researched models of community care for people diagnosed with severe mental illness who have been disengaged from mental health treatment. Systematic reviews of over fifty-five studies, including twenty-five randomized controlled trials of ACT, conclude that it is highly successful in engaging clients in treatment, substantially reduces psychiatric hospital use, lowers rates of substance use, increases housing stability and moderately improves psychiatric symptoms and subjective quality of life. Enhancements to the traditional ACT model have been used in pilot programs in Maryland, resulting in significant reductions in hospital admissions and improvements in other outcomes for the same population that would be targeted under a civil outpatient commitment program. Moreover, New York's experience with mandated community treatment demonstrates that creating a single point of entry to a coordinated system of care and having provider and administrative oversight are the key elements to improving outcomes for people with histories of disengagement from traditional services.

A court order is simply **not** necessary to create a well-designed program to engage people in treatment and significantly improve outcomes for the at-risk population. Moreover, a voluntary program avoids the significant problems attendant to outpatient civil commitment – discrimination and deprivation of civil liberties, racial/economic/geographic disparities, and unnecessary legal, court and enforcement costs.

Recommendation

As introduced, House Bill 1267/Senate Bill 882 provided for a voluntary program to engage individuals at risk for disruptions in continuity of care and as an alternative to outpatient civil commitment. The legislation was developed with input from representatives from Maryland's advocacy and provider community, current and former Maryland mental health system administrators, and a former New York mental health administration official with experience implementing and overseeing an outpatient civil commitment program. The proposed program included Assertive Community Treatment as the service delivery model with enhancements such as peer support, unlimited outreach efforts, and financial incentives for providers. The program also

incorporated elements of the New York program, such as a single point of entry and service provider and systems accountability for outcomes.

In light of the lack of current evidence that a court-order offers any benefit above and beyond voluntary services, we believe that a reasoned approach to this divisive issue would be to establish a five-year pilot to design and implement a voluntary program in selected jurisdictions based on the elements found in the 2014 legislation. Such a pilot would afford Maryland the opportunity to accurately assess the effectiveness of a well-designed targeted voluntary program without the significant additional funding necessary to implement a comprehensive program throughout the state. It would also provide an opportunity to collect the data and other information needed to determine whether some people would still remain disengaged from services and, if so, whether there are any common characteristics of that population so further enhancements to the program could be strategically developed and implemented.

SECTION I. Outpatient Civil Commitment

A. Few States Have The Type of "Preventive Outpatient Commitment" Law That The Department Is Proposing

Legally mandated treatment in the community is known by a variety of titles that are frequently used interchangeably, including "Assisted Outpatient Treatment," "Outpatient Civil Commitment," "Involuntary Outpatient Treatment," "Preventive Outpatient Commitment" and "Compulsory Treatment Orders." The Department has chosen to use "Outpatient Civil Commitment." Titles, however, do not convey the criteria or requirements of the particular laws[1] that have been enacted outside of Maryland, which fall under one of three[i] categories:

(1) Less Restrictive Alternative to Inpatient Admission. Thirty-three states permit a court or administrative hearing officer to order an individual to adhere to community treatment in lieu of involuntary inpatient admission. Thus, this type of Outpatient Civil Commitment is restricted to situations in which it has already been proven by clear and convincing evidence that the individual meets the inpatient commitment criteria, i.e., is a current danger to self or others, or currently gravely disabled.

(2) Conditional Release From Inpatient Hospital. Forty states permit mandated community treatment as a condition of discharge for persons who have been involuntarily admitted on an inpatient basis.

(3) Preventive Outpatient Commitment. Ten states[2] permit mandated community treatment for individuals who do not currently meet the inpatient commitment criteria, but are believed to need mental health treatment to prevent "likely" future hospitalizations.

In their repeated assertion that Maryland is sorely out of step with the rest of the nation because 45 states have Outpatient Civil Commitment ("OCC") laws, proponents fail to disclose that the "Preventive Outpatient Commitment" model is squarely in the minority. The vast majority of states currently only authorize OCC for individuals who already meet the inpatient commitment criteria, and thus it is truly a "less restrictive alternative" to inpatient hospital care. The Department, however, is urging the Legislature to instead strip civil liberties from persons who are not dangerous (or gravely disabled), based on the belief that at some undetermined point in the future, they *may* meet the inpatient commitment criteria. This is, in fact, a quite radical proposal that

[1] Several states have passed more than one type of outpatient civil commitment law.
[2] Current as of October 2013.

contravenes long-standing legal and policy principles of individual liberty and self-determination in the absence of an objective prediction of a reasonably imminent threat of harm to self or others.

Proponents often characterize preventive OCC as a benign tool that merely "assists" individuals to reach their maximum potential, and argue that there is little impact on civil liberties because individuals may still live "freely" in the community. We strongly disagree. The Department proposes that treatment orders may mandate that a person live in supervised housing, take prescribed medications, submit to blood tests and urinalysis, attend day programs, group therapies, specified educational or vocational activities, and accept any and all other services that may be contemplated in the future.[ii] In sum, individuals will have no independent choice in where they live, their personal and social relationships, their own healthcare and how they spend their waking hours. Worse, they could be subjected to the compulsory drawing of their blood – a bodily intrusion from which other citizens who are neither accused nor convicted of a crime are protected under Maryland's Declaration of Rights and the U.S. Constitution.

Given the civil liberty implications of a preventive OCC model, the Legislature directed the Department to examine the evidence supporting involuntary and voluntary programs, and to address potential disparities in implementation. As outlined below, the Department chose not to comply with this directive.

B. The Department Provides No Evidence to Support Its Underlying Assumptions About The Causes Of Disruptions in Continuity of Care

As a preliminary matter, it is necessary to reasonably identify the population described by the Legislature as being at high risk for disruptions in continuity of care. In 2013, the Department advised the Continuity of Care Advisory Panel (COC Panel)[3] that high emergency room and inpatient utilization are two measures used in medicine as indicators of challenges in coordination of care, and provided data[iii] showing that, during fiscal year 2012, 503 people in the Public Mental Health System were admitted to emergency departments six times or more or had psychiatric hospital inpatient admission costs that exceeded $69,900.[4] The Department defined this cohort as the basis for investigating continuity of care challenges leading to frequent contact with the State's psychiatric facilities.[iv]

[3] The Department established the Continuity of Care Advisory Panel in 2013 to review and recommend potential solutions to disruptions in continuity of care.

[4] Assuming a hospital rate of $1,000 per day, the inpatient population had approximately 70 total hospital days during a twelve-month period.

In its proposal, the Department similarly describes the target population for preventive OCC as "individuals who have frequent contact with the State's psychiatric facilities."[v] We would therefore expect that the Department would further define this "frequent contact" population in line with the "high-utilization" cohort of 503 individuals considered by the COC Panel. Instead, and without discussion, the Department defines "frequent contact" with a psychiatric facility quite broadly, proposing a preventive commitment criteria of a mere two involuntary admissions within the past 48 month period. The Department then casts "treatment refusal" as the *cause* of frequent hospital admissions, stating that:

> While hospitalized and adherent to treatment, these individuals' conditions improve. However, when they return to the community, many refuse to engage in treatment, and their condition deteriorates. Consequently, individuals with serious mental illness who refuse to engage in treatment may experience homelessness, frequent hospitalizations, increased contact with law enforcement, and incarceration.[vi]

The Department fails to provide any support for this sweeping statement, including any evidence that the unspecified "many" individuals it claims refuse treatment have actually been provided reasonable access to comprehensive and coordinated community services, or that refusal of mental health treatment is the cause of repeated hospital admissions.

Indeed, data presented to the COC Panel calls into question the Department's underlying assumptions. This data reveals that, during the following year (FY13), 450 out of the 503 individuals in the high utilization population - 89% - were accepting community-based services.[5] In other words, nearly nine out of ten individuals in the target pool will, in fact, voluntarily accept services. It is unknown whether these 450 individuals had previously refused care – and if so, what motivated them to subsequently accept services – or whether they had instead slipped through the cracks of a system that failed to provide coordinated community care upon discharge. Either way, coercion is clearly not necessary to engage the vast majority of individuals identified as being at risk for multiple hospital admissions.

With respect to the remaining 53 individuals not receiving community services in FY13, it is unknown whether they were offered enhanced services, such as Intensive Case Management or Assertive Community Treatment, but refused, or whether they were instead simply discharged to standard care with no follow-up care coordination. Without further investigation into what actually occurred in these cases, it is grossly unfair to simply assume, as the Department does, that the fault lies with the individuals. In addition, demographic data on the Maryland "high risk" cohort

[5] For unknown reasons, the Department chose not to publish this data.

revealed that three out of every four individuals have a substance use disorder diagnosis, but less than one-third received substance use treatment during the fiscal year in which they had multiple hospital and emergency department admissions.[vii] This data suggests that untreated substance use, not untreated mental illness, may be the single most significant characteristic driving high-utilization rates for emergency department and hospital admissions.

Finally, the Department provided the COC Panel with data revealing that 50% of the 503 people "at-risk for disruptions in continuity of care" in FY12 did not appear in the at-risk categories in FY13. More data is necessary to determine whether these individuals were provided standard care or whether enhanced strategies were employed, how effective each approach was in reducing hospital-based care, and by how much admissions and bed days were reduced. Nevertheless, the data demonstrates that *voluntary* services reduced hospital admissions and emergency department visits. This outcome is consistent with systematic reviews of OCC studies, outlined in Section I.C. below, which conclude that voluntary services are as effective as court orders in improving outcomes, including reduced hospital admissions.

C. There Is Little or No Evidence That Outpatient Civil Commitment Produces Better Outcomes Than Voluntary Services

In its report, the Department merely asserts that OCC would "improve continuity of care by decreasing interruptions in treatment, stabilizing the individual in the least restrictive environment, and reducing preventable hospitalizations, including inpatient civil commitment."[6][viii] As the Department should know, this is *not* a legally sufficient basis for an OCC law. Because preventive OCC restricts the civil liberties of individuals who do not currently meet the involuntary inpatient treatment criteria, there must be compelling evidence that court ordered community treatment has such significantly better outcomes, *as compared to voluntary services*, that it is necessary to achieve the stated purpose of the proposed law.

It is a daunting task to assess the entire body of research on whether OCC results in better outcomes than what can be achieved with voluntary services. The research is generally classified into two generations of studies, based not on when the study was conducted, but on the sophistication and rigor of the design.[ix] First generation studies consist of case reports and observational studies that are characterized as being "plagued by significant methodological limitations," that undermine their validity.[x] Second-generation studies include randomized controlled trials and nonrandomized observational studies that employ sophisticated strategies to

[6] The Department also states that homelessness, increased contact with law enforcement, and incarceration are negative outcomes associated with untreated mental illness. However, the Department provides no evidence that OCC would have any impact on those areas, and makes no attempt to connect its target population to those experiencing these negative outcomes.

overcome the problems inherent in first-generation studies. A randomized controlled trial (RCT) is considered the best method for ensuring equivalence between the intervention (OCC) and control (voluntary services) groups on both known and unknown factors.[xi] Nevertheless, any individual RCT or observational study may be poorly designed and thus its purported outcomes are of limited value in accurately assessing an intervention's effectiveness. Further, even under the most rigorous study design conditions, a single study rarely provides definitive results.[xii]

To date, RCT studies have been conducted in England (2013),[xiii] New York (2001),[xiv] and North Carolina (1999).[xv] The England and New York RCTs concluded that there is no evidence that OCC is more effective than voluntary services in improving outcomes. The North Carolina RCT had conflicting results, depending on whether a bivariate or multivariate analysis was used. The North Carolina study authors also conducted a non-randomized comparison and concluded that orders lasting greater than six months resulted in significantly greater outcomes for the OCC group. In addition to these RCTs, there have been several longitudinal observational studies using two large data sets from Australia[xvi] and New York.[xvii] The Australian studies produced conflicting conclusions, but most found that the OCC group had more admissions and longer lengths of hospital stays than the voluntary group, while the New York studies found better outcomes for the OCC group across a variety of domains.[xviii]

Viewed in total, the studies present conflicting conclusions about the effectiveness of OCC as compared to voluntary services. Individually, each study has been criticized for various reasons, including flawed methodology or the lack of valid comparison groups. However, a few of the researchers involved with one or more of these studies are media savvy and have published or been interviewed in multiple articles touting their own flawed research outcomes. This inflated volume of articles creates the perception that research has settled the issue in favor of the effectiveness of OCC. Unsurprisingly, proponents selectively trumpet results that appear to favor their position, while refusing to acknowledge contrary findings or criticisms about a study's methodology. Perception, however, is not fact. For example, the North Carolina RCT is frequently cited as proof that OCC is effective. The results of this study, however, are of dubious value, as reflected in the following critique:

> Study populations in these reports were sometimes poorly specified and, being subject to missing data and losses to follow-up, the analyses often involved smaller numbers of highly selected patients than would have been used in the original studies. Therefore, many of the datasets might not have been properly representative of the source population. Most of these reports present the findings of multiple, sometimes post hoc, analyses, often involving complex models which looked at the effects of multiple explanatory variables

> (often categorized in several different ways), and the interactions between these, on multiple outcomes . . . . Multiple analyses of this kind are at increased risk of resulting in false positives (Type I Errors). Furthermore, in regression analyses, all observed associations should be seen as observational and potentially confounded by other unknown or unmeasured factors and, even though attempts might have been made to limit the possibility, confounding by other factors may still have been possible. The need for cautious interpretation of these data cannot be over-emphasized. These analyses can be seen as exploratory and potentially hypothesis-generating only."[xix]

It is clear that without knowing the reported outcomes of <u>all</u> second-generation research, the strengths and weaknesses of study design, and validity of published findings, it is impossible to accurately assess the effectiveness of OCC as compared to voluntary services. To navigate this terrain and arrive at a well-informed conclusion, it is critical to review the results of the highest level of research – the systematic review.[xx] A systematic review is an independent "high-level overview of primary research on a particular research question that tries to identify, select, synthesize and appraise all high quality research evidence relevant to that question in order to answer it."[xxi] Quality systematic reviews provide the most accurate overall assessment of the effectiveness of an intervention.[xxii]

As summarized below, there are six independent systematic reviews that collectively have synthesized and analyzed all qualified OCC studies to date. These six systematic reviews, including two meta-analyses, are consistent in their conclusion that there is little or no evidence that court orders are more effective than voluntary services in improving outcomes**.** One additional review of three selected studies conducted by consultants contracted by the Department differed only in concluding that there is "moderate" evidence that court orders may reduce hospital admissions.

<u>Kisely & Hall</u>: In 2014, researchers at the University of Queensland School of Medicine[xxiii] conducted an updated meta-analysis of the three existing RCTs conducted in England, New York, and North Carolina. Considered the highest level of systematic review, a meta-analysis collects, combines and analyzes the primary data, giving it greater statistical power.

<u>Conclusions</u>: OCC orders did **not** result in a greater reduction in hospital readmissions or bed days, and there were no significant differences between the study and control groups in social functioning or psychiatric symptoms.

Maughan & Molodynski, et al: In 2013, researchers published a systematic review of the 18 qualifying studies published between January 2006 and March 2013, including the England RCT and the observational studies using the New York and Australian data bases. [xxiv]

Conclusion: There is now a strong level of evidence that OCC orders have **no** significant effect on hospitalization outcomes or community service use.

Maryland Department of Health and Mental Hygiene: In 2013, the Department hired consultants to review three studies – the New York and North Carolina RCTs and the New York observational study.[xxv]

Conclusions: There is a **moderate** amount of evidence that OCC reduces hospital admissions, but not days. There is emerging evidence on greater engagement in treatment, but these studies have considerable limitations, and the only RCT in this area found no effect on medication adherence. There is **little solid** evidence on reductions in criminal justice interactions or on costs (i.e., that OCC reduces system costs).

Churchill, Owen, Singh & Hotopf: In 2007, researchers published the single most comprehensive systematic review of the OCC research conducted through 2005.[xxvi] All data based empirical studies were included in the review, including the New York and North Carolina RCTs and the Australian nonrandomized observational studies. There were no restrictions on language, year, study-quality or study sample size. In total, there were 72 data-based empirical studies, 47 conducted in the U.S., 10 in Australia, five in New Zealand, four in Canada, three in the UK, two in Israel and one was world-wide.

Conclusion: There is **very little** evidence to suggest that OCC orders are associated with any positive outcomes.

Kisely, Campbell & Scott: In 2007, researchers conducted a systematic review of five studies, including New York, North Carolina and three controlled before and after studies using the Australian database.[xxvii]

Conclusion: The evidence for involuntary outpatient treatment in reducing either admissions or bed days is **very limited**, and the effects on other outcomes uncertain. It therefore cannot be seen as a less restrictive alternative to hospital admission.

Cochrane Collaboration: In 2005 and updated in 2010, the Cochrane Collaboration

(Cochrane) conducted a meta-analysis of the North Carolina and New York RCTs.[xxviii]

Conclusions: Compulsory community treatment results in **no significant difference** in service use (hospital admissions and medication compliance), social functioning or quality of life compared with standard care. People receiving compulsory community treatment were, however, less likely to be victims of violent or non-violent crime. It is unclear whether this benefit is due to the intensity of treatment or its compulsory nature.

In addition, Cochrane used a methodology that enables "numbers needed to treat" (NNT) to be calculated from the statistically non-significant results. Used to assess the effectiveness of an intervention, NNT is the average number of patients who need to be treated for one to benefit compared with a control. Based on its NNT calculation, Cochrane found that it would take 85 OCC orders to prevent one hospital admission and 236 orders to prevent one criminal arrest.[xxix] As the reviewers aptly stated:

> "It is difficult to conceive of another group in society that would be subjected to measures that curtail the freedom of 85 people to avoid one admission to a hospital or of 236 to avoid one arrest."[xxx]

RAND Corporation: In 2001, RAND Corporation (RAND) conducted a systematic review of studies on the effectiveness of OCC, including the New York and North Carolina RCTs. [xxxi] Twenty-two articles reporting outcomes of OCC studies met the criteria for review.

Conclusion: Studies reviewed "[did] **not** prove that treatment works better in the presence of coercion or that treatment will not work in the absence of coercion."

RAND also analyzed peer-reviewed, published literature on evidence-based reviews of voluntary alternatives to OCC and found "strong evidence of the effectiveness of ACT (assertive community treatment)."[xxxii] Thus, RAND also concluded that "evidence-based reviews prove that alternative interventions such as assertive community treatment have similar positive effects" to OCC.[xxxiii]

In summary, six independent systematic reviews, including two meta-analyses, uniformly concluded that there is little or no evidence that OCC orders result in better outcomes than voluntary services. One limited review, contracted by the Department, concluded that there is "moderate evidence" that OCC has a greater effect on reducing hospital admissions, but not on any other outcome. All review teams highlighted the urgent need for well-designed studies. It is possible that a body of future studies will be created that withstand systematic review scrutiny and

lead to a different conclusion about the effectiveness of OCC as compared to voluntary services. Until such time, there is simply no evidence-based support for enacting such a law, most particularly the radical preventive OCC program proposed by the Department.

D. A Fully Implemented Outpatient Civil Commitment Program Is Costly And Reduces The Availability Of Voluntary Services

Basing its estimate on New York and California, the Department states that it would cost an additional $3.0 million per 100 individuals served under its proposed OCC program, excluding defense counsel and Office of Administrative Hearing costs.[xxxiv] California is a curious choice as a model for comparison given its very limited experience with OCC implementation. Nevada County is the only county in the state to have authorized and implemented OCC and, to date, only 30 unduplicated individuals have been placed under court order.[8][xlii] New York courts, by contrast, have placed 12,129 people under OCC since the November 1, 1999 implementation of "Kendra's Law,"[xliii] making it a more useful comparison in a cost analysis. New York spends approximately $32 million dollars annually for direct support of its OCC program, excluding associated defense counsel and court costs, equaling approximately $40,000 annually per individual under court order. The Department's per person cost estimate of approximately $30,000 annually ($25,000 in service costs, plus administrative support costs) thus appears low in light of the proposed program's similarity to New York's program.

Of greater concern, however, is the Department's failure to adequately address the significant impact that OCC would have on the availability of voluntary services. New York provides approximately $126 million annually in *additional* funding for enhanced community-services under its public mental health system, to serve those on OCC as well as those voluntarily seeking such services.[xliv] Despite this annual influx of dollars, New York experienced a 50% reduction in the availability of voluntary intensive case management and ACT services state-wide during the three-year period following implementation of Kendra's law.[xlv] There are concerns that the service capacity created during the early years of the program with the massive influx of additional funding is now fully utilized and, coupled with flat funding over the program's fifteen-year history, voluntary services may once again become unavailable for many mental health consumers.[xlvi]
The Department only mentions the potential service capacity issues under its proposal to enhance access to voluntary services. The Department states in that section that it was "unclear whether resources were diverted" in New York as a result of OCC, while at the same time acknowledging

[8] Neighboring Yolo County established a pilot program in 2013, designed to serve a total of four individuals, and Los Angeles (Orange County) established a pilot program in 2010, designed to serve approximately ten individuals per year. Although both counties, along with San Francisco, have recently authorized full implementation of OCC, it has not yet gone into effect in these locations.

that "preference for intensive case management was given to outpatient civil commitment cases," meaning that "individuals who were not under an outpatient order were less likely to receive case management services."[xlvii] Giving individuals on treatment orders preference in access to services *is* diverting resources from voluntarily those seeking such services.

The Department does at least recognize that it must increase funding to expand ACT services if an OCC law is enacted, but fails to estimate the overall cost and how expansion would be accomplished state-wide. Instead, the Department simply states that it would cost $600,000 to create one ACT team.[xlviii] However, an individual team only serves mental health consumers residing in the specific county or city in which it is located and, therefore, one team cannot serve people across the state placed on OCC orders. The Department fails to address current regional disparities in the availability of ACT, stating simply that it "should consider jurisdictional need,"[xlix] and fails to address deficits in the availability of mental health professionals that comprise ACT teams in those regions, particularly psychiatrists. Finally, the Department fails to acknowledge the impact on voluntary accessibility to the services provided via ACT, including housing. Certainly, given the difference in population totals, it would not cost Maryland $158 million a year to implement OCC, as it does in New York. However, we believe that the Department's apparent suggestion that OCC could be implemented for a mere $3.6 million per year, while at the same time keeping voluntary services intact, is wildly inaccurate.

Moreover, while the New York program evaluators claimed that OCC results in overall cost-savings due to reduced hospital and jail admissions, the Department's own consultant rated this evidence as "weak."[l] Thus, it is clear that OCC is costly, would likely not generate overall savings and that, without significant additional annual funding, it would greatly reduce the availability of voluntary services. Based on the current lack of evidence that OCC is necessary to improve outcomes for individuals at risk for disruptions in continuity of care, we urge that Maryland instead focus on fully funding community-based services and creating an enhanced voluntary program to engage the at-risk population.

E. Studies Reveal Significant Racial, Insurance And Geographic Disparities In The Implementation Of Outpatient Civil Commitment

House Bill 1267/Senate Bill 882 required that a program proposal address the potential for racial, geographic and insurance disparities in implementing a recommended program. The Department's OCC proposal fails to adequately address *any* of these critical issues.

1. Racial Disparities

The single comment the Department makes on potential racial disparities is its assertion that having an OCC program administered by a singly petitioning entity will "help avoid health disparities and racial bias in program implementation."[li] The Department's lack of analysis, and concern, is puzzling, given that available information strongly predicts that minorities, and African Americans in particular, will experience disparate rates of coercion should OCC be enacted and implemented in Maryland.

North Carolina and New York are among the few states that have the type of "preventive" commitment law proposed by the Department. Studies in those two states show that African Americans are grossly overrepresented in the pool of OCC order recipients. In North Carolina, **two-thirds** of persons subjected to a mandated treatment order in the study were African American, despite only representing approximately 22% of the total state population.[lii] The evaluation of the New York OCC program[liii] revealed that disparate rates based on race/ethnicity have plagued the program since its implementation in 1999:

	Subject to Court Orders	Total State Population
Blacks	34%	17%
Hispanics	30%	18%
Whites	34%	61%

African Americans are subjected to court orders **five times** more frequently than whites, while Latinos are **two and half times** more likely than whites to be under a court order.[liv] The New York program evaluators concluded that there is no proof of intentional racial bias in the selection of individuals placed on OCC, finding that the overrepresentation of African Americans is a "function of [their] higher likelihood of being poor, higher likelihood of being treated by the public mental health system (rather than by private mental health professionals), and higher likelihood of having a history of psychiatric hospitalization."[lv] The evaluators further state that the "underlying reasons for these differences in the status of African Americans are beyond the scope of the report."[lvi]

The institutional racism infecting the mental health system must be of paramount concern, however, precisely because it greatly contributes to the overrepresentation of African Americans in

the target population for OCC. The historical roots trace back to the waning days of Slavery and the decades of oppression that followed, as summarized in this historical account:

> According to the 1840 US Census, insanity was 11 times more likely among African Americans living in Northern free states than in the South. Slavery proponents claimed that the 'burdens of freedom' drive African Americans insane and that slavery saves them from certain 'mental death.' Between 1860 and 1880, the incidence of insanity rose five-fold among African Americans. The 1886 New York Medical Journal concluded that 'African Americans lack the biological brainpower to live in freedom.' During this period, African Americans were incarcerated in increasing numbers in mental institutions, jails and poorhouses. At the turn of the century, African Americans in the United States were diagnosed with schizophrenia in numbers that far outpaced whites. The 1921 American Journal of Psychiatry provided the rationale that "African Americans are not sufficiently biologically developed and thus are prone to psychotic illnesses."[lvii]

The same distressing state of affairs continues, with African Americans being disproportionately diagnosed with the severest forms of mental illness and disproportionately subjected to involuntary inpatient treatment. Nationwide, African Americans are up to four times more likely to receive a schizophrenia diagnosis than whites – even after controlling for all other demographic variables[lviii] – and are more than twice as likely as whites to be involuntarily committed to state psychiatric hospitals.[lix]

The impact of these historical factors is not confined to New York alone, and the New York program evaluators acknowledged that, "insofar as outpatient commitment by statute targets a 'revolving door' population, that of involuntarily hospitalized patients who are concentrated in the public mental health system, it will inevitably select a greater proportion of African Americans than their share in the general population, because that is the racial distribution of the target population – for historical reasons . . . ".[lx] The Department is proposing to target precisely this "revolving door" population,[lxi] and available Maryland data shows that African Americans comprise 46% of the Public Mental Health System, while representing only 30% of the state's total population.[lxii] Thus, as in New York, African Americans are overrepresented in the insurance category from which the target pool for OCC is most likely to be drawn.

By failing to closely examine racial and ethnic minority disparities, an opportunity was lost to develop a thoughtful and comprehensive approach to better engage and serve these populations in a culturally sensitive manner. We are disappointed that the Department proposes instead that Maryland use the sledgehammer of coercion against historically oppressed and disadvantaged groups.

2. Insurance Disparities

The Department failed to address the potential for disparity based on insurance status and instead simply recommends that, "an inability to obtain access to appropriate treatment because of inadequate health care coverage or an insurer's refusal or delay in providing coverage for the treatment" should not be considered a "refusal to comply."[lxv] Thus, while the Department does not explicitly limit the target population to those eligible for Maryland's Public Mental Health System, it appears to recognize that OCC would likely only be effectively implemented with this population.

3. Geographic Disparities

The Department failed to adequately address the potential for variance in program implementation among urban and rural jurisdictions, again simply declaring that such variances would be eliminated with a single petitioning entity. Geographical disparity is an extremely critical concern, however, given the experience with OCC in New York where 82% of all mandatory treatment orders originated in New York City and Long Island.[lxvi] The regional variation in New York is believed to be a function of available resources and differing attitudes about service engagement approaches.[lxvii] In more rural jurisdictions, there are fewer resources and additional funding provided under Kendra's law is used to beef up the available voluntary services. Thus, in those counties, a person thought to meet the OCC criteria is first provided with enhanced voluntary services ("EVS"), with OCC being used as a last resort. County mental health officials and providers expressed a very different attitude than their urban counterparts with respect to use of coercion, as captured by the following quotes from the program evaluations:

> "We don't do it like downstate or OMH wants. We use the voluntary order first. We don't approach it in an adversarial way."[lxviii]

As a result, only 16% of OCC orders originate outside of New York City and Long Island. By contrast, New York City and Long Island are better funded and take a far more impersonal and adversarial approach:

> "If you meet the criteria, it would be foolish to do less [than a court order]."[lxix]

Thus, few if any attempts are made to voluntarily engage people, with OCC orders being routinely issued for people as part of their "discharge plan" from hospitals.

The Department is proposing the same requirement found in New York's law that the "individual has been offered an opportunity to participate voluntarily in treatment but declines to do so."[lxx] The concern is that, as in New York, the manner in which this "opportunity" is presented may vary greatly among jurisdictions, based both on community attitudes and the availability of resources. While community attitudes may or may not be as sharply divided in Maryland, there are existing urban/rural disparities with respect to where people eligible for the Public Mental Health System (PMHS) are concentrated and where resources are allocated. For example, Baltimore City represents 33% of those receiving PMHS services, while representing just 11% of the total State population, and its expenditures account for 35% of total PMHS expenditures.[lxxi]

In sum, it is reasonable to expect that racial and ethnic minorities concentrated in urban areas and living in poverty would populate the ranks of people under OCC orders, yet the Department made no effort to acknowledge or address these disparities.

F. People Under Outpatient Civil Commitment Orders Lose The Right to Make Decisions About Psychiatric Medications That May Be Ineffective Or May Pose Serious Risks To Their Health

The Department states that there was support to have program eligibility criteria include consideration of an individual's capacity to make treatment decisions, and then proposes the criterion that an individual "fails to adhere to treatment recommendations."[lxxiii] We are troubled by the Department's failure to explain whether this "fails to adhere to treatment" criterion encompasses lack of capacity to make treatment decisions and, if so, how it envisions implementing such a standard. There are many critical issues, including who has oversight to ensure that the individual's health and interests are protected;[9] whether a finding that an individual lacks capacity with respect to decisions about psychiatric treatment would extend to all medical decisions and other personal life decisions, such as housing and finances; and whether there would be any impact on the terms of the OCC order should the individual regain capacity.

We are also concerned that the Department's recommendation may be reflective of a growing trend among ardent proponents of involuntary treatment to make refusal of psychiatric treatment the equivalent of lacking the capacity to make informed decisions about the risks and benefits of psychotropic medication. For example, these proponents claim that 50% of people with

[9] Under current Maryland law, an individual found by a court to lack capacity to make treatment decisions must be appointed a guardian of the person. A guardian, along with continuing court monitoring, ensures that a person's interests are protected. The Department appears to be proposing that a person who lacks capacity to make treatment decisions will be ordered to comply with a treatment plan designed by a treatment provider, with no monitoring by an independent person or entity. This is would be another radical departure from existing law.

schizophrenia and 40% of people with bipolar disorder have "anosognosia," a neurological condition associated with stroke and brain-injury victims. According to this theory, people with anosognosia refuse treatment because they are literally unable to recognize the symptoms of their mental illness due to brain damage.[lxxiv] To date, anosognosia has not been established or widely accepted as a medical condition related to severe mental illness,[lxxv] and it is not a diagnosis identified in the most current edition of the Diagnostic and Statistical Manual (DSM-V), which is used by clinicians to diagnose and treat mental disorders. Nevertheless, these proponents argue that people who refuse treatment have anosognosia and therefore lack capacity but, only with respect to accepting a psychiatric diagnosis and agreeing to take prescribed medications.

Fundamentally, of course, proponents of OCC are concerned with medication compliance, regardless of the reason a person may refuse prescribed medication. There is, however, increasing public acknowledgment of significant limitations in the diagnosis and treatment of mental illness. Dr. Thomas Insel, Director of the National Institute on Mental Health, is a strong supporter of the medical model of psychiatry, yet is also an honest critic of its limitations. He recently characterized the state of psychiatry as lacking "biomarkers to identify who should get which treatment," and lacking "effective treatments for many aspects of mental illness."[11][lxxvii] For example, research on long-term outcomes for individuals with schizophrenia indicates that those who did not use antipsychotic drugs actually experienced *better* outcomes than their counterparts continuously taking medications.[lxxviii] In light of this research, Dr. Insel correctly observed that, "we need to ask whether in the long-term, some individuals with a history of psychosis may do better off medication."[lxxix] Indeed, physicians in Switzerland, Sweden and Finland have developed programs that involve minimizing use of antipsychotic drugs, and are reporting much better results than what is being obtained in the United States.[lxxx] One such program reports that five years after initial diagnosis, 82% of psychotic patients were symptom free, 86% returned to jobs or school, and only 14% were on antipsychotic medication.[lxxxi] Furthermore, poor medication outcomes are not restricted to classes of antipsychotics. According to the National Institute of Mental Health's STAR-D study, the largest and longest study ever conducted to assess the effectiveness of depression treatment, only one in three individuals achieves remission on the first trial of antidepressants. By the time an individual is on his or her fourth medication trial, there is a one in ten chance of remission through medication use.[lxxxii]

In addition to growing doubts about diagnostic accuracy and the long-term benefits of medication, there are many serious, sometimes fatal, side effects of these drugs. All antipsychotic medications increase the risk of sedation, sexual dysfunction, postural hypotension, cardiac arrhythmia, and

[11] Dr. Insel also called on psychiatry to atone for its lack of humility because "so much of mental health care is based on faith and intuition, not science and evidence."

sudden cardiac death.[lxxxiii] Older antipsychotic medications are associated with movement disorders, including tardive dyskinesia, a neurological disorder causing involuntary, abnormal movements, particularly of the face and neck.[lxxxiv] Second generation drugs are associated with metabolic problems, including obesity and diabetes. Weight gain, often rapid and significant, is a common side effect, and antipsychotic drugs "can contribute to a wide range of glycemic abnormalities, from mild insulin resistance to diabetic ketoacidosis."[lxxxv]

In response to these findings, some psychiatrists have started to voice concern over the appropriateness of long-term use of antipsychotic drugs. For example, Dr. Sandra Steingard recently wrote in an editorial in the Washington Post that, reviewing longitudinal studies and witnessing the severe side effects that many people experience prompted her to support a client's choice to discontinue medication.[lxxxvi] Unfortunately, and with potential tragic consequences, the Department is proposing a mandatory community treatment regime that dismisses the experiences and valid concerns of people diagnosed with a mental illness, and which may actually impede the formation of therapeutic alliances with mental health professionals.

In summary, there is no evidence to date that OCC is necessary to reduce hospital admissions – the stated goal of the Department's proposal – and implementation of such a law is costly and fraught with racial, economic and geographic disparities. Worse, it may cause significant harm to the health of many individuals due to side effects, while not being effective for an unknown number of those who will be mandated to adhere to prescribed medications. As detailed in Section II below, Maryland must choose instead to address disruptions in continuity of mental health care by establishing a voluntary program that targets at risk individuals for outreach and engagement, and provides individualized and evidence-based services while increasing provider and system accountability for outcomes. In other words, the program would "commit the system, not the individual."

Section II. A Voluntary Alternative to Outpatient Civil Commitment

The Department recommends increasing funding to expand the availability of voluntary ACT services. The Department further recommends that additional funding should be appropriated or increased to (a) expand peer support services; (b) further integrate and enhance crisis services within each jurisdiction; and (c) increase funding for rental subsidies. We support additional funding and expansion of all of these services. However, we strongly believe that enhanced services should not be expanded *in addition* to an OCC program, but should instead be integrated into a voluntary services model that serves as an *alternative* to involuntary treatment.

During the 2014 session, House Bill 1267 and Senate Bill 882, originally entitled Assertive Community Treatment – Targeted Outreach, Engagement and Services (ACT-TOES) were introduced to implement a comprehensive voluntary service program developed by a team of stakeholders, including advocates, former mental health department officials from Maryland and New York, and representatives of agencies currently responsible for overseeing the administration of mental health services in local jurisdictions. The team reviewed the non-coercive elements of New York's program, Maryland pilot programs using innovative practices, and a previous unfunded proposal for a comprehensive voluntary program to serve as an alternative to OCC, called Individual Options. Essential components of a successful program were identified as including (a) having specific eligibility criteria and a matching program to connect services to need; (b) a single point of access where family members and others could go when they recognized that a person had a need for intensive services; (c) financial restructuring to allow for ongoing engagement efforts; and (d) a system of accountability with regular quality assessments.

The legislation was then developed incorporating these essential components. First, eligibility was limited to a similar target pool found under current preventive OCC laws in other states, and Assertive Community Treatment (ACT) was identified as the service delivery model. ACT is an evidenced-based practice and one of the most extensively researched models of community care for people diagnosed with severe mental illness. Systematic reviews of over 55 studies, including 25 randomized controlled trials[lxxxvii] of ACT, conclude that, compared to usual community care, it is highly successful in engaging clients in treatment, substantially reduces psychiatric hospital use (50%-76%), lowers rates of substance use, increases housing stability, and moderately improves symptoms and subjective quality of life.[lxxxviii]

Second, ACT-TOES enhanced the traditional ACT model by requiring peer support, a feature that has demonstrated positive outcomes. For example, Baltimore City conducted a peer support engagement pilot to determine whether enhanced peer support would enable consumers who are at high risk for repeated hospitalization to be served and supported in the community and thus avoid inpatient care. An analysis of outcomes for the consumers participating in the pilot showed that it reduced emergency department visits by 24%; inpatient hospital admissions by 53%; inpatient days by 42% and public mental health system costs by 18%.[lxxxix]

Third, ACT-TOES required the Department to identify individuals who may currently meet the eligibility criteria and to establish a process for family members and other specified individuals to file a petition for enrollment in the program, i.e., a single access point. Fourth, ACT-TOES incorporated provider incentives and accountability. Providers would be reimbursed for ongoing efforts to engage individuals so that trust can be built over time, if necessary. In addition, the

circumstances under which providers may involuntarily discharge clients would be limited, and alternative providers would have to be identified prior to discharge to ensure continuity of care. Persons who voluntarily terminate services would remain eligible for immediate reinstatement should they need that level of care and service coordination. Support funds would be provided for housing, food and other basic necessities and are attached to the individual to maintain stable living conditions as the person moves from more to less intensive care and service needs. Finally, ACT-TOES would build-in system accountability by requiring the Department to engage in continuous quality improvement efforts by improving existing accountability and outcome systems.

We had anticipated that, during the review process envisioned by the Legislature, the ACT-TOES model would be strengthened and that the broader stakeholder workgroup would have the opportunity to ultimately determine that this voluntary approach, based on sound empirical research, should be the recommended program for Maryland. We are deeply disappointed that the Department chose not to allow review of ACT-TOES as an alternative to OCC. We remain confident, however, that the Legislature will recognize that this model has the potential to generate better outcomes than those produced in clinical trials involving voluntary and involuntary groups receiving traditional services, while avoiding the controversy, costs and civil rights implications attendant to an OCC program.

Section III. Definition of Dangerousness

We support the Department's recommendation to promulgate regulations, rather than propose a statutory amendment, to define "danger" for purposes of detention for psychiatric evaluation and involuntary admission to a facility, and to provide necessary training to law enforcement, emergency department physicians, judges and administrative hearing officers. We also support the Department's decision to exclude "psychiatric deterioration" in its proposed definition. Simply because a person's symptoms of mental illness may be worsening, does not equate to a need for inpatient treatment, and including "psychiatric deterioration" would violate the constitutionally-required present dangerousness standard for involuntary confinement. As noted by the Department, the Supreme Court held forty years ago that states may not confine a "non-dangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends."[xc]

Predictions of future dangerousness are notoriously unreliable. Studies have consistently found that unstructured clinical assessments of future dangerousness are "accurate in no more than one out of three predictions"[xci] and only "slightly more reliable than chance."[xcii] Adding the variable of "deterioration" and extending the potential "event" date (danger to self or others) to an unspecified

distant future will increase the already high error rates of involuntary detention and commitment. And certainly, if trained and experienced mental health professionals would struggle with accurately predicting distant future dangerousness based on "psychiatric deterioration," it seems reasonable to assume that law enforcement and lay persons would perform exponentially worse. While police officers may be able to assess, based on direct observation, whether a person is currently acting in a dangerous manner, they have no expertise to form a reasonable basis that someone is experiencing "psychiatric deterioration" which will result in future dangerousness. With respect to lay persons, a petition for a psychiatric evaluation currently requires a description of the dangerous behavior that is believed related to mental illness, which enables a judge or district court commissioner to determine whether there is an objectively reasonable basis for involuntary detention. This review provides at least some minimum level of due process protection against speculative subjective opinions rendered by non-professionals. Under a "psychiatric deterioration" standard, however, petitions would have to be approved based precisely on such subjective speculation that a person's mental health *is* declining and that this decline *will* eventually result in dangerousness to self or others.

While detention in an emergency department is seen as an acceptable intrusion on liberty when based on reasonable belief that a person is presently a danger to self or others, the entire process can be a traumatic and humiliating experience. The individual is handcuffed by law enforcement and led out of his or her residence, often in full view of their neighbors, for transport to the emergency department. Upon arrival, she is under guard by police or hospital security, ordered to remove clothing and, if she refuses, may be forcibly stripped by security. Protestations may be met with physical or chemical restraints or periods of isolation. Widening the net of potential victims of such iatrogenic trauma to include virtually all persons diagnosed with a mental illness would be unconscionable.[12]

Finally, complying with a "psychiatric deterioration" standard for psychiatric evaluations would also exert tremendous pressure on the healthcare system and significantly increase costs. Increasing demand would overwhelm the capacity of emergency departments to conduct assessments in a timely manner as well as the current inpatient bed capacity, leading to overcrowding and lengthy emergency department stays before an inpatient bed becomes available. This would potentially leave the State vulnerable to lawsuits for "psychiatric boarding," in which individuals are illegally detained in emergency departments beyond the statutory limit of 30 hours.[xciii] With respect to

[12] Recovery is not linear. People who faithfully take prescribed medications may, over the course of lifetime, experience periods in which their symptoms reappear or worsen. Many will not, however, need hospital level care before their symptoms abate. In other instances, situational stressors, such as the loss of a loved one, may be the culprit, not lack of treatment. But again, symptoms can and do abate without medical intervention, yet a "psychiatric deterioration" standard would leave everyone vulnerable to being picked up for evaluation and involuntary admission at some point in time.

costs, during the 2014 session legislation was introduced to change evaluation and involuntary admission standards to include "psychiatric deterioration," and the Department estimated that, if bed days for psychiatric inpatient care increased by 5% to 10%, total expenditures for psychiatric care in the State would increase by $20 million to $40 million annually. The Office of the Public Defender, the Office of Administrative hearings and the Judiciary would also face increased costs to respond to petitions and involuntary admission hearings.

For all these reasons, we urge that the Legislature reject any proposal to include a "psychiatric deterioration" standard for the purposes of evaluation and involuntary inpatient admission.

IV. Conclusion and Recommendations

Despite the lack of empirical evidence that mandated treatment orders are more effective than voluntary services in improving outcomes for individuals at high risk for disruptions in continuity of care, proponents continue to strenuously lobby legislatures across the country and internationally to adopt preventive OCC laws. These proponents continue to believe, despite overwhelming evidence to the contrary, that a court order, in and of itself, is the essential ingredient of OCC, due to the "black-robe effect." According to this theory, the judicial process and a judge's "imprimatur" increase the likelihood that the individual will comply with prescribed medication.[13][xciv] We urge that the Legislature not consider depriving people of their civil liberties based on a hope that a magical "black-robe" effect will solve the complex problem of engaging at-risk individuals. Yet perhaps the most distressing aspect of some OCC proponents' advocacy is that it promotes pseudo science about "brain damaged" people who are somehow less worthy of civil protections and reinforces ugly stereotypes about mental illness and violence. As one team of researchers summarized the issue:

> There is strong evidence that liberty is being substantially curtailed without any obvious clinical benefit to justify it . . . if we believe that psychiatry should be an evidence based profession and clinical trials are a worthwhile exercise, than we should not ignore the findings . . . we believe that there should be a moratorium on further imposition of [OCC] . . . unless and until convincing evidence of their effectiveness is obtained. It may be time to cease pursuing risk-based coercive interventions (which lack evidence) and refocus our efforts into restoring enduring and trusting relationships with patients."[xcv]

[13] To the extent that there is a "black-robe effect," it requires a judge in a black robe and a formal courtroom. See, e.g., Chase, O., Thong, J. (2012), Judging the Judges: The effect of courtroom ceremony on participant evaluation of process fairness-related factors. Yale Journal of Law & Humanities, Volume 24: Issue 1, Article 10. We note that in an administrative process, as proposed by the Department, hearings would take place in ordinary conference rooms with hearing officers in business attire.

We strongly agree with this assessment. Certainly there are people who have frequent contact with psychiatric facilities and other negative outcomes due to disengagement from community services and supports. However, it is time to recognize and address the inescapable fact that the mental health system often guarantees failure by not requiring outpatient providers to make contact with these individuals in the hospital, assertively follow-up post discharge or coordinate care across systems. Financing mechanisms discourage collaboration and coordination between inpatient and outpatient care and do not allow for the financial flexibility necessary to meet the needs of these individuals. As one former New York official involved with implementing Kendra's law stated: "[t]he increasing use of the courts reflects not only the desire for simple answers to complex problems but reflects our failure as a mental health community."[xcvi] Unfortunately, the appeal for many elected officials in passing an OCC law is that it is viewed as solving these problems. As noted by the Cochrane Collaboration researchers, however, the reality is that "such initiatives give the impression the legislators are addressing the needs of patients and carers while actually doing very little at all."[xcvii]

We applaud the Legislature for recognizing that complex issues demand more than simplistic responses and for directing the Department to oversee a process to develop an evidence-based program that minimizes or avoids deprivations of civil liberties and racial, economic and geographic disparities. Unfortunately, the proposed program lacks supporting evidence of efficacy and is based on unsupported declarations about the nature and cause of disengagement from community services. Worse, it does absolutely nothing to address current gaps and failures in Maryland's mental health system. As detailed in this report, existing evidence supports the development of a voluntary program that identifies the high-risk population, provides ongoing outreach and engagement efforts, and delivers high-quality individualized services and supports.

We therefore make the following recommendations:

1. Reject proposals for outpatient civil commitment in the absence of compelling future evidence, confirmed by the weight of systematic reviews, that treatment orders are necessary to reduce hospital admissions and bed days, or any other asserted significant state interest. Further, require that any such future proposals provide a detailed cost analysis, including the impact on voluntary services, and specifically outline how racial, economic and geographic disparities will be eliminated.
2. Recognizing that there is a significant projected state budget deficit that may not allow for full implementation of a comprehensive voluntary program, require the Department to develop, implement and study outcomes of a five-year pilot of a voluntary program

in selected jurisdictions. The program design shall be based on ACT-TOES and developed with input from stakeholders.

3. Require the Department to report annually on the pilot program outcomes, including: (a) number of eligible individuals identified; (b) number of outreach attempts and narrative summary of engagement techniques and outcomes; (c) number of enrolled participants and narrative summary of services provided; (d) outcomes including pre-enrollment and post-enrollment data on hospital and jail admissions, hospital bed days, service use, social functioning (housing, law enforcement contact, psychiatric symptoms), and participant satisfaction.

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December 9, 2014

Continuity of Care is paramount to ensuring individuals with serious mental illnesses have every opportunity to live lives of value and meaning in the community of their choice. Continuity of care includes a service continuum of hospitals, short-term acute inpatient and intermediate care facilities, crisis services, outpatient and community-based services, peer support services, and independent living options. Interruptions in an individual's treatment can have devastating and long-lasting effects on both physical and mental well-being and can reduce long-term recovery.

In 2013, Governor O'Malley directed the Department of Health and Mental Hygiene (DHMH), to convene an Advisory Panel to "examine barriers to continuity of care and make recommendations to strengthen the behavioral health system and improve health outcomes." DHMH Secretary Sharfstein appointed state and national experts to the Advisory Panel. The panel encouraged extensive stakeholder input from a diverse range of professionals and community advocates.

On January 21, 2014 the Advisory Panel released 25 recommendations to address areas where continuity of care was found to be deficient. One of the findings concluded that "there is evidence of the effectiveness of a well-designed outpatient civil commitment program" and the panel "recommends moving forward to define such a program in Maryland." Maryland is one of five states that do not have an outpatient civil commitment program.

Outpatient Civil Commitment (OCC) provides a viable option for a small subset of individuals with serious mental illness who have not benefited from voluntary services because they lack an understanding of the impact of their symptoms and the need for continued treatment to reduce that impact. These individuals, often cycle in and out of hospitals, jails and homelessness; OCC provides a less restrictive treatment alternative to institutionalization or incarceration, and it supports an individual's overall physical and mental health, safety and dignity in the community.

In 2014, legislation (SB822/HB1267) passed the Maryland General Assembly that required DHMH to convene an Outpatient Services Programs Stakeholder Workgroup to examine outpatient services, including OCC, and to develop a program proposal. DHMH was also tasked to recommend draft legislation as necessary to implement the program included in the proposal.

We strongly supported the process that DHMH developed for the Outpatient Services Programs Workgroup; it was open and transparent with opportunities for extensive stakeholder input. At multiple workgroup meetings, DHMH presented information about OCC programs in other states and facilitated respectful dialogue among stakeholders about the development of an OCC program in Maryland. Meetings focused on criteria for an OCC program including eligibility, demographics, fiscal impact, the services provided and data collection to enable program monitoring, evaluation and effectiveness.

The same process was undertaken regarding the proposal for voluntary services. Information was presented on programs Maryland currently offers for individuals with mental illness. This helped pinpoint the areas that are in need of expansion and increased funding, such as housing, assertive community treatment (ACT), peer support and crisis services, in order to prevent disruption in continuity of care.

We support the administration's efforts to establish an outpatient civil commitment program in Maryland. Our support of the proposal is contingent on a continued collaborative approach with the State. Without this alternative, a small subset of people with severe mental illness will continue to cycle in out of hospitals, jails, prison or homelessness or die by suicide. The OCC proposal will benefit the individual, family and the community.

To be clear, OCC is not a solution for all that impedes continuity of care in Maryland. The population currently facing gaps and disruptions in services is far larger than that which would qualify for OCC under DHMH's proposal, and - as evidenced by the 24 other recommendations of the 2013 Advisory Panel - more still needs to be done to improve the system for all. But there can be little doubt that, through no fault of their own, the subset who would qualify for OCC consumes a grossly disproportionate share of the resources currently available. Addressing the needs of those who struggle with accepting effective treatment will benefit not only these individuals and the families who love them; it will also free up community-based resources that can serve others with severe mental illness.

Our belief in the promise of OCC to improve treatment outcomes and reduce costs is supported by an overwhelming body of research. Studies performed in Arizona, Ohio, North Carolina and New York affirm that if properly implemented, OCC significantly reduces risks of hospitalization, incarceration, homelessness, self-harm and violence for its target population. A 2013 cost analysis of OCC by faculty of the Duke University School of Medicine reported that treatment costs for participants in New York City declined by 43% in the first year of OCC and another 13% in the second year.

Further, we applaud the state's commitment to enhance access to outpatient voluntary services. It is essential and preferable that people with mental illness have a continuum of services necessary to keep them stable and living well in their own community. Every Marylander deserves the opportunity to be productive and healthy. To have that opportunity, access to high quality and effective mental health care must be available.

These proposals are well-researched and thought out. We want to thank Secretary Sharfstein and Deputy Secretary Jordan-Randolph for supporting the recommendations provided to DHMH by the Continuity of Care Advisory Panel. We look forward to working with the Department in developing the legislative proposals and ensuring that these programs are adequately funded. It is our hope that in 2015 these proposals will become bills, find favorable support from members of the General Assembly and ultimately signed into law by the incoming Governor.

Signatories:

Armel Inc.
Bethesda Cares, Inc.
Grassroots Crisis Intervention Center, Inc.
Help in the Home, LLC
Johns Hopkins Medicine Department of Psychiatry
National Alliance on Mental Illness Maryland (NAMI Maryland) and 13 NAMI affiliates
Sheppard Pratt Health System
Alliance, Inc.
Family Services, Inc.
Mosaic Community Services
Way Station, Inc.

Appendix 3 - Stakeholder Comments on Voluntary Services Proposal and DHMH Response		
Comment	**DHMH Response**	**Submitted by**
Create a funding mechanism for ACT teams to conduct in-reach and engagement services for individuals who are hospitalized or incarcerated. The current reimbursement arrangement does not cover the cost of in-reach services, which can be critical to establishing a relationship prior to discharge, thereby decreasing the risk of losing the individual once he or she is discharged.	While this recommendation was not included in the proposal for voluntary services, the Department plans to continue to look for ways to improve access to assertive community treatment.	Lori Doyle
Increase the number of residential crisis beds. Given the pressure hospitals are under to reduce readmissions, the demand on our crisis beds has grown dramatically. Unfortunately, we must turn a number of referrals away due to the lack of vacant beds. Residential crisis beds more than pay for themselves by diverting inpatient admissions and reducing the length of inpatient stays. Our stats show that we are quite successful in stabilizing the psychiatric crisis, addressing somatic and addiction treatment needs, finding stable housing, and assisting the person in applying for eligible benefits, all in an average stay of less than ten days.	The Department did not accept this recommendation. Under this proposal, CSAs would be able to dedicate additional funding to residential crisis beds based on jurisdictional need.	Lori Doyle
Consider funding arrangements beyond fee-for-service and expand eligibility for the current capitation programs.Our capitation program has been highly successful in serving some of the most challenging individuals in the public mental health system. Much of that success can be attributed to the service flexibility capitated payments allow. In addition, the capitation programs reward outcomes (and punish lack of same), allowing providers to reinvest in services and staff that prove most successful. The same flexibility should be extended to other services. Additionally, expansion of eligibility for the current capitation programs would allow us to intervene before an individual becomes a high-cost user (which are the only individuals eligible for capitation programs at present).	The Department accepts this recommendation and will consider expanding eligibility for the current capitation programs.	Lori Doyle
Expand the use of telemental health services, particularly in residential crisis programs and other outreach services.It is becoming increasingly difficult to attract and retain prescribers, not only in outpatient clinics, but particularly in crisis and outreach programs (such as ACT and residential crisis programs). Expanding telemental health would allow us to stretch the reach of our prescribers in areas where they are most needed.	The workgroup did not examine the use of telemental health services. However, the Department has initiatives outside of this proposal to addres the expansion of telemental health.	Lori Doyle

Appendix 3 - Stakeholder Comments on Voluntary Services Proposal and DHMH Response		
Comment	**DHMH Response**	**Submitted by**
Expand intensive RRP beds and reimburse at a level that would allow for nurses and other medical support staff.We are finding that many of the individuals who are most challenging psychiatrically are also challenging somatically. In fact, now that we have access to CRISP data we have found that many of the individuals we serve have had more frequent admissions for somatic issues than for psychiatric. While this may not seem like an outpatient commitment issue, the reality is that once these individuals reach the emergency department they are quickly "coded" as a psychiatric patient. Their somatic issues may not be adequately addressed and they spend time inappropriately in the ED, tying up services that would be better used addressing a true crisis. The health outcomes for the population we serve are deplorable. This issue should be at the top of any debate regarding major systems change.	The role of RRP was not discussed in the voluntary services proposal. While the Department acknowledges that resources must be available for individuals with co-occuring behavioral health and somatic conditions, we did not accept this change.	Lori Doyle
Does this mean that peer services will be MA reimbursable?	No. Under this proposal, grant funds would be provided to local jurisdictions to build peer support into their existing service delivery system.	Arleen Rogan
In the second full para. on p.1 , I suggest that we add transportation to the items that will improve access and stabilize the rendering of services.	While the Department agrees that transportation can improve access to services, DHMH did not accept this change.	Nevett Steele
The 3rd full para. on p.2 seems to consider that an outpatient civil commitment may not be implemented in Maryland. The enhancements discussed in the paper could obviate the need for involuntary commitment.	Whether an outpatient civil commitment program is implemented in Maryland is dependent on the passage of legislation.	Nevett Steele
Our members do urge a word of caution, however, with regard to the Workgroup's proposal: increased services must be accompanied by increased funding to support those resources. We urge the Department, in pursuing the recommendations of the Workgroup, to implement increased access to services only when there is adequate funding to support it. The Department should be cautious not to dilute the already strained finances for outpatient services by potentially entering more patients into the mental health system without additional funding appropriations.	The Department accepts this recommendation and does not intend to divert current funding to finance this proposal.	Maryland Psychiatric Society and the Suburban Maryland Psychiatric Society

Appendix 3 - Stakeholder Comments on Voluntary Services Proposal and DHMH Response		
Comment	**DHMH Response**	**Submitted by**
Establish additional community treatment teams specifically for mental health only to include an intensive program. Two examples in our community that service non mental health conditions are Med Star and Patient First. Both have over 20 locations to service individuals with heart disease, cancer, diabetes, dental care, aches, pain, fever, abdominal pain, hypertension, work injury – just to name a few. The ratio between volume of individuals with a mental illness and mental health services is unbalanced and the individuals needing mental health care are suffering due to lack of assertive community treatment.	This recommendation was not accepted as outpatient services for somatic issues were not examined within the workgroup. However, the Department's Health Homes program assists individuals with co-occuring somatic and behavioral health disorders. The Department is also assessing the expansion of Community Integrated Medical Homes through other funding streams.	Shantelle Stroman
Create an Oversight Commission at the DHMH state level to review government funds that are given to housing providers who give eviction notices to individuals that are mentally ill – the individual becomes homeless with this harsh decision making and the government is allocating $2,200 to $3,500 a month per client to ensure the welfare and care of this person…… Where is the accountability plan or accountability team (Inspector General's Office) to ensure that these funds are utilized as they were appropriated? If a client is evicted for lack of medical treatment then the funds should definitely cease and a credit should be given back to the state and the client's account for his/her residential cost.	The voluntary services proposal did not address the oversight of providers who receive state funding for housing services. Therefore, this recommendation was not accepted.	Shantelle Stroman
Implement a transition care unit (mobile team) to assist home care providers to help a person get medical treatment prior to eviction and allow individuals to maintain their same residence to prevent them from being homeless.	This recommendation was not accepted as the workgroup did not examine outpatient treatment for somatic services.	Shantelle Stroman
Expand training in the community to mental health providers and the police department to enhance the knowledge base of mental health across our community and continue the 24/7 hotline it is a great resource during an emergency.	The voluntary services proposal did not address training of mental health workers and the police. Rather, the workgroup developed a proposal to expand access to voluntary outpatient mental health services. Therefore, this recommendation was not accepted. It is important to note that police training is being addressed at the jurisdictional level through other avenues, including Crisis Intervention Teams.	Shantelle Stroman

Appendix 3 - Stakeholder Comments on Voluntary Services Proposal and DHMH Response		
Comment	**DHMH Response**	**Submitted by**
In addition to expansion funds, there needs to be further review of additional funds to enhance traditional ACT.	While the Department reconginzes the benefits of enhancing Assertive Community Treatment, it did not accept this recommendation.	Dale Meyer
Outreach and Engagement is a separate and defined service with a specific skill set and competencies that must be funded as a separate service. ACT teams do not have the capacity to conduct ongoing outreach and engagement in the fee for service financing structure. It is critical that the proposal fund a separate service for this to occur which is grant funded.	This recommendation was not accepted. The workgroup did not study the financing of outreach and engagement services.	Dale Meyer
Flexible Housing & Needs Funds must be attached to this population to achieve success. This proposal must provide a housing fund which pays for housing and housing needs to support the consumer in the community. Funding must be flexible above and beyond a rental subsidy to meet the needs of consumers. The success of this initiative will depend on this item being available.	The Department acknowledges that housing outside of rental subsidies may be necessary for individuals with serious mental illness. However, the Department did not accept this recommendation.	Dale Meyer
Two areas that I think need more service are; transitional housing for homeless and treatment of inmates in correctional institutions with mental health issues. These populations will require and benefit from Assertive Community Treatment over the long term. There also needs to be programs that recruit mental health professionals to staff these initiatives.	Under the proposal, rental subsidies would be available to both the homeless and to those exiting correctional institutions. The workgroup did not discuss initiatives to recruit mental health professionals as it was outside of the workgroup's mandate. Therefore, the Department did not accept this recommendation.	Patricia Ranney
DORS concern with the role of the employment specialist as a part of the team. It has been our expereince that successful employment outcomes are difficult to acheive as the employment specialists is often called upon to fill many of the ancillary roles in support of a consumer's related needs, rather than focusing on employment. If the access to ACT teams is expanded statewide, it is DORS suggestion that the role of the employment specialist, as part of the ACT team, be further defined and preserved as a specialty unto itself. Furthermore, the employment specialist, when possible, should be co-supervised by an individual who coordinates the provisoin of employment services (when an agency has both ACT and supported employment (i.e. trandtional and/or evidence based) to provide an opportunity for that professional to continue to develop job placement and support skills.	This recommendation was not accepted. The workgroup did not have time to throughly examine the various positions, including employment specialists, under an ACT team.	Suzanne R. Page

Appendix 3 - Stakeholder Comments on Voluntary Services Proposal and DHMH Response		
Comment	**DHMH Response**	**Submitted by**
Recommended Report Language to Be Added: In support of its efforts to expand Assertive Community Treatment, enhance behavioral health integration, and strengthen Patient Centered Medical Homes, the Department should investigate and consider changes to regulations that currently preclude Federally Qualified Health Centers from participating in Assertive Community Treatment Teams and receiving reimbursement that recognizes the more intense service provision.	The Department accepts this recommendation and will investigate reimbursement of Assertive Community Treatment services by Federally Qualified Health Centers.	Health Care for the Homeless
Recommended Report Language to Be Added: In order to support integration and funding of peer support services, the Department should consider pursuing a Medicaid waiver, state plan amendment, or other option that would permit the inclusion of peer support among the services reimbursable through Medicaid.	This recommendation was not examined during the stakeholder workgroup process and was not including in the voluntary services proposal. However, the Department will continue to explore ways to increase funding sources for peer support.	Health Care for the Homeless
Recommended Report Language to Be Added: Over the past 15 years, the "housing first" model of permanent supportive housing has demonstrated both cost-and outcome-effectiveness - particularly for people with serious behavioral health disorders. Because Medicaid offers a reliable and sustainable funding source for the majority of people experiencing homelessness, the Department should investigate and consider ways to use Medicaid funding to expand access to permanent supportive housing.	The housing first model was not examined during the stakeholder workgroup process. However, the Department will continue to explore ways to enhance housing services.	Health Care for the Homeless
Enhance peer support using the Clubhouse model.	The Clubhouse Model was not examined during the stakeholder workgroup process. However, the Department will continue to explore optimal ways to integrate peer support into the public behavioral health system.	B'more Clubhouse, Inc.
Expansion of ACT should not be tied strictly to outpatient civil commitment.	The Department agrees with this recommendation. The proposal to expand access to ACT is not dependent upon the establishing of an outpatient civil commitment program.	Mental Health Association

Appendix 4
Housing Resources by Core Service Agency
June 2014

	Housing Resources	**Notes**
Allegany County	CoC	21 rental subsidy units including single individuals and families. All units are in the tenant's name. 14 (1BR) 4 (2BR) 3 (3BR)
	RRP	30 beds – 0 General level of care (LOC), 30 Intensive LOC
	Supported Housing	4 units, 5 individuals
Anne Arundel County	CoC	28 rental subsidy units including single individuals and families. All units are in the tenant's name. 14 (1BR) 8 (2BR) 6 (3BR)
	RRP	271 beds – 75 General LOC, 196 Intensive LOC
	Supported Housing	58 units, maximum of 105 individuals
Baltimore City	CoC	99 Shelter + Care units
	RRP	357 beds – 175 General LOC, 182 Intensive LOC
	Supported Housing	80 units, 100 individuals
	Transitional Housing	164 transitional beds at 5 different programs, length of stay (LOS) between 3 months – 2 years
Baltimore County	CoC	58 rental subsidy units including single individuals and families. All units are in the tenant's name. 23 (1BR) 16 (2BR) 19 (3BR)
	RRP	352 beds – 117 General LOC, 235 Intensive LOC
	Supported Housing	25 units, 35 individuals

	Housing Resources	Notes
Calvert County	CoC	17 rental subsidy units including single individuals and families. All units are in the tenant's name. 9 (1BR) 4 (2BR) 4 (3BR)
	RRP	19 beds – 12 General LOC, 7 Intensive LOC
	Supported Housing	No supported housing other than CoC.
Carroll County	CoC	13 rental subsidy units including single individuals and families. All units are in the tenant's name. 11 (1BR) 1 (2BR) 1 (3BR)
	RRP	67 beds – 14 General LOC, 53 Intensive LOC
	Supported Housing	13 units, 18 individuals
	Transitional Housing	One program with 44 beds
Cecil County	CoC	13 rental subsidy units including single individuals and families. All units are in the tenant's name. 4 (1BR) 4 (2BR) 5 (3BR)
	RRP	38 beds – 6 General LOC, 32 Intensive LOC
	Supported Housing	17 individuals, no unit # reported
Charles County	CoC	43 rental subsidy units including single individuals and families. All units are in the tenant's name. 20 (1BR) 7 (2BR) 7 (3BR) 9 (4BR)
	RRP	19 beds – 3 General LOC, 16 Intensive LOC
	Supported Housing	Rental Assistance program (grant funded) 13 slots for individuals in the Public Mental Health System (PMHS) Additional Supported Housing 2 units serving maximum of 7 individuals (3 are w/Rental Asst program currently)

	Housing Resources	Notes
Frederick County	CoC	25 rental subsidy units including single individuals and families. 21 of the units are in the tenant's name and four are sponsor-based. 19 (1BR) 5 (2BR) 1 (3BR)
	RRP	180 beds – 98 General LOC, 82 Intensive LOC
	Supported Housing	13 units, 17 individuals Additional 10 units, 14 individuals served by ACT
Garrett County	CoC	None
	RRP	6 beds – 0 General LOC, 6 Intensive LOC
	Supported Housing	30 units through HUD-SHP program
	Transitional Housing	Transitional Housing through Public Housing Authority 9 beds
Harford County	CoC	23 rental subsidy units include single individuals and families. All units are in the tenant's name. 8 (1BR) 10 (2BR) 5 (3BR)
	RRP	59 beds – 17 General LOC, 42 Intensive LOC
	Supported Housing	2 units, 6 individuals 11 Supportive housing units*, individual has lease but agrees to support by program staff.
	Transitional Housing	21 units of permanent housing for former homeless individuals served by the PMHS.
Howard County	CoC	10 units single individual, all units are sponsor based in the tenants' name.
	RRP	106 beds – 41 General LOC, 65 Intensive LOC
	Supported Housing	12 units, maximum 26 individuals

	Housing Resources	Notes
Mid-Shore Counties (Caroline, Dorchester, Kent, Queen Anne's, Talbot)	CoC	16 rental subsidy units include single individuals and families. All units are in the tenant's name. 11 (1BR) 2 (2BR) 3 (3BR)
	RRP	58 beds – 9 General LOC, 49 Intensive LOC
	Supported Housing	49 units, 65 maximum individuals
Montgomery County	CoC	52 single units
	RRP	382 beds – 215 General LOC, 167 Intensive LOC
	Supported Housing	34 units, 75 individuals 155 units, 260 individuals (Public Housing Authority)
	Transitional Housing	2 programs serving 15 homeless men and 8 homeless women
Prince George's County	CoC	29 rental subsidy units include single individuals and families. All units are sponsor based in the tenant's name. 7 (1BR) 14 (2BR) 8 (3BR)
	RRP	398 beds – 76 General LOC, 322 Intensive LOC
	Supported Housing	34 units, 107 maximum single individuals 35 Single Family units – HUD and TAY grant funded
St. Mary's County	CoC	12 rental subsidy units include single individuals and families. All units are in the tenant's name. 5 (1BR) 6 (2BR) 1 (3BR)
	RRP	39 beds – 11 General LOC, 28 Intensive LOC
	Transitional Housing	One program serving homeless persons with behavioral health issues, assisting movement to permanent housing 10 units – 4 for women w/children, maximum 20 individuals 6 for men, maximum 24 individuals

	Housing Resources	**Notes**
Washington County	CoC	32 rental subsidy units include single individuals and families. All units are in the tenant's name. 19 (1BR) 8 (2BR) 4 (3BR) 1 (4BR)
	RRP	33 beds – 7 General LOC, 26 Intensive LOC
	Supported Housing	16 units, 21 individuals
Wicomico/Somerset Counties	CoC	25 rental subsidy units include single individuals and families. All units are in the tenant's name. 15 (1BR) 7 (2BR) 3 (3BR)
	RRP	74 beds – 32 General LOC, 42 Intensive LOC
	Supported Housing	48 units in Wicomico Co, 48 individuals (33 one bedrm, 10 two bedrm, 5 three bedrm) 9 units in Somerset Co, 9 individuals (5 one bedrm, 3 two bedrm, 1 three bedrm)
	Transitional Housing	Transitional Housing – 15 units (Wicomico only) women & children only
Worcester County	CoC	6 rental subsidy units include single individuals and families. All units are in the tenant's name. 2 (1BR) 3 (2BR) 1 (3BR)
	RRP	10 beds – 4 General LOC, 6 Intensive LOC
	Supported Housing	22 units, 34 individuals (includes 1, 2, 3 bedrm units – all HUD funded) 1 one bedroom unit for homeless veteran served in PMHS

CoC = Continuum of Care (the former Shelter Plus Care)

The CoC is a grant funded program through HUD that provides rental assistance for permanent housing to individuals and families with an adult member who has a mental illness or co-occurring disorder.

RRP = Residential Rehabilitation Programs

RRP is psychiatric rehabilitation connected with program housing. Persons learn independent living skills, self management of mental health care and recovery in a residential setting in order to graduate to independent living of their own choice.

General Level of Care = minimum of 13 face to face services in the residence monthly
Intensive Level of Care = minimum of 19 face to face services in the residence monthly, with staff on site 7 days per week. Both levels of care have 24 hour/day on call staff available.

RRP is accessed by application to the Core Service Agency (CSA) of the county of residency. Eligibility is determined by the CSA using the Behavioral Health Administration priority population definition and medical necessity criteria applied by the Administrative Services Organization (ASO). The CSA reviews applications, tracks vacancies, maintains waiting lists if necessary, and refers applications when bed availability occurs.

Supported Housing = housing for individuals served by the Public Mental Health System (PMHS) where the person is the leaseholder. Most supported housing units are subsidized or affordable. Services are available but not required.

Transitional Housing = housing that assists persons to move from homelessness to permanent housing. Services are included, including accessing benefits, referral to behavioral health resources, life skill training, etc.

*Harford County “supportive housing” where individual has lease but services are connected/required.

Appendix 5 – Maryland Crisis Services by Jurisdiction

Jurisdiction	Current Level of Crisis Services.	Enhancements from Grants	Implementation Status
Allegany County	• 24/7 Hotline • Crisis Residential Beds • emergency psychiatric services	• hire a part time mental health professional and a part time law enforcement officer to function as Crisis Intervention Team (CIT) liaisons to carry out planning and implementation. • promote Mental Health First Aid (MHFA) by training 12 trainers and then training 100 individuals, focusing on human service settings and school campuses.	• part-time mental health staff has been hired to function as CIT liaison. Initial meeting of Crisis Intervention Advisory Board is scheduled for February 13. A part time law enforcement officer to function as Crisis Intervention liaison will be identified following that meeting. • MHFA Train the Trainer Courses for both the Adult and Youth Curriculums are scheduled for March 2014. To Date, 18 individuals have been identified and have agreed to participate in the trainings. • during fiscal year ’14, 22 individuals have completed MHFA and the 3 additional classes scheduled for spring have 71 participants already enrolled. • Urgent Care Coordinator has been identified and providers have been approached and are willing to create urgent care slots. The first slot is expected to start around February 1. The other slot has been delayed temporarily as a result of loss of psychiatric time by the county’s largest PMHS provider.
Anne Arundel County	• 24/7 Hotline • Mobile Crisis Team (MCT) 8AM - midnight/7 days per week (on-call available for other hours); serves all ages. • Crisis Residential Beds • emergency psychiatric services • urgent care	• hire a part time law enforcement officer to be trained in CIT and become the primary trainer. CIT training will include all law enforcement and corrections agencies. • hire 1 licensed mental health professional to enhance the existing hospital diversion program.	In process of: • identifying CIT curriculum • working with Police Dept. to identify staff to be trained & ongoing training process.

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Jurisdiction	Current Level of Crisis Services.	Enhancements from Grants	Implementation Status
Baltimore City	• 24/7 Hotline • Child MCT - 9AM - 5PM/ Adult MCT 7AM - midnight; entire city covered • Crisis Intervention Team (CIT) - in place 12 yrs. • Crisis Residential Beds • 23 Hr. Holding Beds • emergency psychiatric services	• expand adult MCT availability during hours of high demand by adding additional 4PM to midnight team. • hire 1 licensed mental health professional to manage, coordinate and enhance the BEST/CIT program.	• crisis provider has additional team in place responding to requests for services. • recruiting process for BEST/CIT position has been initiated and initial screening of candidates has begun.
Baltimore County	• 24/7 Hotline • MCT 9AM - 1AM/7 days per week • CIT - in place 10 yrs. • Crisis Residential Beds • emergency psychiatric services • urgent care	• hire a care coordinator specialist that will provide case coordination for complicated cases and work with individuals who have been admitted to the emergency room by the mobile crisis team. • hire a full time peer recovery counselor to focus on co-occurring mental health & substance abuse issues & to participate in CIT training. • increase hrs. of part time psychiatrist with specialty in child/adolescent care for the urgent care clinic.	• grants received were approved by Baltimore County Council. • the vendor, Affiliated Sante Group is in the process of hiring.

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Jurisdiction	**Current Level of Crisis Services.**	**Enhancements from Grants**	**Implementation Status**
Calvert Tri County	• 24/7 Hotline • Crisis Residential Beds • emergency psychiatric services • urgent care	• provide or contract with a vendor to develop a regionalized mobile crisis response team for Calvert, Charles, and St. Mary's Counties. • provide BHA a copy of the regionalized crisis response plan. • provide or contract with a vendor to develop or expand the core components of the crisis response team (CIT). The CSA will pool these funds with the funds awarded to Charles and St. Mary's CSAs to conduct an area needs assessment regarding crisis needs and available resources. • provide or contract with a vendor to conduct trainings on issues unique to Charles County based on the results of the needs assessment. • work in collaboration with Charles and St. Mary's Counties Core Services Agencies (CSAs) to hold regionalized trainings. MHFA Training may be a part of either county or regional trainings.	• see Charles County

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Jurisdiction	Current Level of Crisis Services.	Enhancements from Grants	Implementation Status
Carrol County	• Crisis Residential Beds	The CSA will provide or contract with a vendor to develop or expand core components of its CIT. The CSA will use funds to: • assist in the continuation of training with local law enforcement personnel in MHFA by offering a small stipend towards overtime as an incentive to train the staff. • secure training site and purchase MHFA training materials. • hire a part time mental health professional as well as a part time law enforcement officer to work on a Crisis Intervention Team • training of personnel hired The CSA will provide or contract with a part-time nurse for care coordination, case management, service navigation and linkages to services for those who are awaiting a psychiatrist. • if time permits nurse will assist with Crisis Residential Beds	• CSA has received a proposal for consultant work to assist in the establishment of CIT in Carroll with a time line of February 2014 through June 2014. This time frame will be used to develop an MOU, meet with Community Partners, establish policies & procedures. • Law Enforcement MHFA is being offered in February 2014 and we have offered a stipend to township attendees. • MHFA materials and location have been secured. • CSA has advertised and conducted interviews for this position. The individual selected declined due to salary. We will continue to interview. • CSA continues to work with the County and the vendor on the Crisis beds and the linkages to services in the community until this position is filled.
Cecil County	• 24/7 Hotline • MCT - 10AM - midnight/7 days per week; serves all ages • emergency psychiatric services • urgent care	• hire a consultant to develop & implement CIT with community partners. A total of 50 officers will be trained. • work with a caseload of 10-15 families who are in crisis to develop a prevention plan, provide crisis intervention to avoid hospitalization, & coordinate referrals for wraparound services for children at risk of long-term care.	• identified the Crisis Intervention Team sub vendor (Affiliated Santé) to provide these services. Currently finalizing the contract to start CIT services by March 2014. • Affiliated Santé /Mobile Crisis is currently providing crisis prevention, Care Coordination AND wraparound services. Three families are currently enrolled for Care Coordination, with 12 additional children/adolescents seen by the mobile crisis team.

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Jurisdiction	Current Level of Crisis Services.	Enhancements from Grants	Implementation Status
Charles Tri County	• 24/7 Hotline • Crisis Residential Beds • limited emergency psychiatric services • limited urgent care	• collaborate with local law enforcement and stakeholders to develop partnership, identify training needs and develop curriculum of CIT for So. MD TriCounty (Charles, Calvert & St. Mary's) • hire a mental health professional 4 hrs/wk and fund 4 hrs/wk for law enforcement officer to co-facilitate development of partnerships, develop curriculum, implement trainings and track outcomes. • contract with a provider to develop some form of regionalized MCT to collaborate with local law enforcement and serve as liaison and provide linkage to behavioral health services for individuals coming into contact with law enforcement.	• all three CSA's, local police, local Sheriff and local law enforcement training academy have begun meeting to evaluate needs and develop plan for developing CIT curriculum, as well as community wide process for collaboration. • all three CSA's have agreed to develop and release an RFP to solicit a vendor to provide MCT and liaison services in collaboration with local law enforcement.
Frederick County	• 24/7 Hotline • MCT - 1PM - 9PM/5 days per week; separate team for children (24/7) & adults • Crisis Residential Beds • emergency psychiatric services	• hire a full time coordinator for CIT to review & expand the present training program of all law enforcement agencies. • plan & implement an urgent care facility to increase accessibility to the behavioral health system for law enforcement dealing with individuals in crisis. • expand the current MCT 5 days, 8 hrs./day to 7 days, 8 hrs./day.	• contract awarded to provider who is doing a staff search at this time. Training scheduled with the City Police Academy in February being developed to meet the CIT principles. • Mobile Crisis Team services to be expanded by February 14 to include weekends.

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Jurisdiction	Current Level of Crisis Services.	Enhancements from Grants	Implementation Status
Garrett County	• 24/7 Hotline • Crisis Residential Beds • urgent care • limited emergency psychiatric services	• hire and/or reassign existing mental health professional staff for CIT responsibilities in consulting with police personnel prior to, during and after an event which involves behavioral health issues. • maintain the operation of a Collaborative Planning and Implementation Committee (CPIC). • develop a referral protocol for individuals presenting at the local emergency department to have follow-up behavioral health services within 72 hours (urgent care) if hospitalization is not required.	• pre-contract meetings for the CIT and Enhanced Crisis Services have been completed with final revisions being made prior to implementation. • the CPIC has met on two occasions and there continues to be support from law enforcement to enhance their de-escalation ability for when dealing with individuals who are experiencing behavioral health crises.
Harford County	• 24/7 Hotline • MCT - 8AM - Midnight M-F & 8AM - 4PM Sat. & Sun.; responds to children & adults • CIT - in place 5 yrs. • emergency psychiatric services	• help fund Harford County Sheriff to hire a manager to coordinate & oversee the County's CIT Program & coordinate with other behavioral health services • increase hrs. of operation of MCT by 40 hrs. • increase contract with hospital for 1-2 psychiatric hours for MCT referrals • pilot program for urgent care	• CIT Coordinator started 12/23/13 • new MCT Coordinator began on 1/15/14. She has interviewed for staff to take on additional 40 hours. Should be operational by end of February 2014 • hospital hours are being carefully reviewed as they are being required to charge HSCRC rates. Looking to combine with Urgent Care • OMHC for Urgent Care has been selected and should be operational by 3/1/14.

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Jurisdiction	Current Level of Crisis Services.	Enhancements from Grants	Implementation Status
Howard County	• 24/7 Hotline • MCT - 9AM - 11PM/7 days per week; serves all ages. • Critical Incident Response • CIT - in place 4 yrs. • emergency psychiatric services	• contribute to staffing a CIT Coordinator position within Howard County Police • provide a minimum of 2 CIT trainings/year • provide additional training through conferences for CIT officers • provide start-up for residential crisis beds • increase hrs. of MCT to 24/7	• hired CIT Coordinator 11/25/13 who is a full-time mental health professional embedded within the police department who will be resource for patrol officers and will address issues such as linkage to community MH resources for individuals for whom repeated Emergency Evaluation Petitions are written but do not follow up with community treatment services. • sent 6 CIT trained officers to the National CIT conference in October 2013. • CIT class is scheduled for the week of 6/16 to 6/20/14. • Fiscal year 2014 Funds will be used as start-up funds to develop Crisis Beds within the county, which has been a missing piece within the crisis continuum. An RFP is under development to select a provider. Any additional funds will be used to expand the operations of the Mobile Crisis Team (MCT).

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Jurisdiction	Current Level of Crisis Services.	Enhancements from Grants	Implementation Status
Mid-Shore (Caroline, Dorchester, Kent, Queen Anne's, Talbot Counties)	• 24/7 Hotline • MCT - 9AM - midnight/7 days; 2 teams serve 8 counties - Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, & Worcester; 3rd team added in 3rd Q of fiscal 2013 • Crisis Residential Beds • limited urgent care	• the third Mobile Crisis Team (MCT) added in the 3rd quarter of fiscal year13 implemented to serve Caroline and Dorchester specifically in partnership with the Health Enterprise Zone (HEZ) grant. This is being sustained with funding with the new crisis services special allocation from last legislative session. • additionally, MSMHS is able to sustain the Crisis Intervention Team (CIT) training process initiated in fiscal year 2013 in the mid-shore region with start-up funding from the region's five (5) Local Management Boards.	• Call Center has experienced an increase in incoming call volume of 72% in the first half of fiscal year 2014 from fiscal year 2013 (1,806 incoming calls from July to December, 2013; 1,051 incoming calls for same time period in 2012). • the number of Mobile Crisis Teams (MCT) that serve eight of the nine counties on the Eastern Shore has doubled in the first quarter of fiscal year 2014, from two to four. The majority of new MCT dispatches are initiated by the Call Center after the Call Center worker has talked to the caller, assessed for safety, ascertained the crisis, provided support, completed a comprehensive clinical evaluation, triaged the options, and determined that an MCT dispatch is the appropriate intervention for the caller. • during the first six months of fiscal year 2014, MCT responded to 520 new dispatches initiated by the Call Center, up 154% from fiscal year 2013 when MCT responded to 205 new dispatches from the Call Center for the same time period.

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Jurisdiction	Current Level of Crisis Services.	Enhancements from Grants	Implementation Status
Montgomery County	• All crisis services 24/7 • hotline • walk-in/urgent care • emergency psychiatric services • MCT - responds to all ages • 6 crisis residential beds • Critical Incident Response • CIT - in place 13 yrs.	• add two part-time Community Health Nurses at the Montgomery County Crisis Center to work with providing support to medically complex cases and to provide basic medication follow up and monitoring for consumers who are using either our transitional services or our crisis beds. • as necessary, utilize PRN therapist to assure 24/7 crisis coverage at the Montgomery County Crisis Center. This will assure walk in and phone in availability. • ensure that the supplemental crisis services are connected or coordinated with existing crisis response services. • because MCT teams often respond to a variety of situations where bio-hazards exist (e.g. blood, vermin/infestations, toxins in hoarding situations) the teams will be provided with protective clothing to minimize risk during MCT responses. • provide support for CIT trainers and selected graduates to attend the national CIT training conference. In addition the CIT program will begin to develop workshops for CIT graduates on critical and emerging behavioral health issues.	• continuing planning and preparation efforts as we evolve our crisis and CIT efforts.
Prince George's County	• 24/7 hotline • MCT - 24/7, serves all ages; currently has 3 teams • Crisis Residential Beds • 23 hr. holding beds • emergency psychiatric services • urgent care • Critical Incident Response	• hire a licensed clinician to divert consumers from local EDs through onsite assessments and telephone screenings and referrals to community providers. • hire a CIT trainer/training coordinator to provide CIT training to public safety entities.	• contractual amendments for these new enhancements are currently going through the County's administrative review process. Approval should be received shortly.

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Jurisdiction	Current Level of Crisis Services.	Enhancements from Grants	Implementation Status
St. Mary's County	• 24/7 hotline • Crisis Residential Beds serving St. Mary's, Calvert, Charles, Prince George's, & Anne Arundel Counties • emergency psychiatric services	• Please see tri-county efforts with Calvert and Charles counties.	• Please see tri-county efforts with Calvert and Charles counties.
Washington County	• 247 hotline • emergency psychiatric services	• Law Enforcement and Mental Health Task Force will engage in identifying, planning and implementing a CIT curriculum which is responsive to local needs. • secure CIT for officers at State, County and City law enforcement departments. • provide additional training through conferences for CIT officers. • develop MCT staffed with CIT trained officers and Mental Health professionals. • create a system of urgent appointments to respond to those individuals identified through CIT.	• Task Force functioning as a CPIC • secured involvement of Training Officers at respective departments • reviewing CIT curriculum for appropriate model.
Wicomico/Somerset Counties	• 24/7 hotline • Crisis Residential Beds • MCT - 9AM - midnight/7 days per week • urgent care	• hiring two coordinators for CRT to directly work with referrals from Law Enforcement. • implementing CIT with law enforcement agencies in Somerset and Wicomico Co. • develop 40 hour training locally and policies that are consistent for each agency.	• attended National Conference in Oct. 2013. • team established & first met on November 8, 2013; Team consists of SA, MHA, DDA, PRMC, DSS, DJS, State's Attorney, Police Academy, and 11 law enforcement agencies. • Chief's meeting Nov 2014. • December and January created mission, goals, responsibilities, assets and barriers; police procedure meeting scheduled for 2/4/14 (canceled on 1/29/13 due to weather); 5 Officers attending training in Mont. Co; arranging strategic planning in Memphis. • public announcement 1/29/14; hired first CRT and 2nd still pending.

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Jurisdiction	**Current Level of Crisis Services.**	**Enhancements from Grants**	**Implementation Status**
Worcester County	• 24/7 hotline • MCT - 24/7 with 1 team; serves all ages; serves both mental health & substance use • Residential Crisis Beds • limited urgent care	• hire a full time coordinator for CIT to develop and implement CIT in Worcester County. Implementation to include training to MH professionals, law enforcement, and correction officers. • supplement MCT budget to fully fund the team. Budget currently funds approximately 75% of the team.	• staff has been included in developing statewide standards for CIT • staff has been discussing CIT with local law enforcement and correction officers through advisory meetings • CSA is in the process of hiring CIT coordinator. • CRT is now fully funded