Outpatient Civil Commitment Pilot Program

2025 Report

Health-General Article § 7.5–205.1(c)

November 2025

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Executive Summary

The Maryland Department of Health (MDH), Behavioral Health Administration (BHA) established the Outpatient Civil Commitment (OCC) pilot program under Health General Article (HGA) § 7.5 -- 205.1 in 2017. This program allows for the release of individuals involuntarily admitted for inpatient mental health treatment as outlined in Health General Article §10–632 and based upon specific conditions related to their admission into the pilot program. Per HGA §7.5-205.1 (c) and §2-1257 of the State Government Article, MDH is submitting a report on the OCC pilot program for Fiscal Year 2025 to the Senate Finance Committee and the House Health and Government Operations Committee on:

1. The number of individuals admitted into the pilot program during the immediately preceding 12-month period;
2. The number of applications for admission into the pilot program submitted during the immediately preceding 12-month period;
3. The cost of administering the pilot program for the immediately preceding 12-month period;
4. For individuals admitted into the program voluntarily and involuntarily:
    a. The percentage of individuals admitted into the pilot program who adhered to the treatment plan established for the individual under the pilot program;
    b. Treatment outcomes; and
    c. The type, intensity, and frequency of services provided to individuals admitted into the pilot program; and
5. Any other information that may be useful in determining whether a permanent outpatient civil commitment program should be established.

The program was developed as a follow-up to the 2016 SAMHSA Assisted Outpatient Treatment grant, and was locally administered by the Behavioral Health System Baltimore (BHSB), Baltimore City's Local Behavioral Health Authority (LBHA) over four federal fiscal years. The program's objective is to provide mental health recovery support, foster stability, engagement, and recovery by creating stable coordination of care between service providers and individuals before their discharge.

During this fiscal year, the program received a total of eight (8) applications to participate in the OCC program. Of the eight (8) applications received, four (4) individuals were admitted into the program voluntarily. All patients admitted during the reporting period adhered to and completed established individualized care plans (ICP) or Individualized Recovery Plan (IRP). Program activities were as follows:

1. One of four were successfully discharged (25%);
2. One of four (25%) enrolled in behavioral health services that included mental health and substance use support (25%);

3. Three of four participants were referred to somatic care (75%); and
4. Two of four (50%) were referred to and connected with permanent or stable housing.

The Certified Peer Recovery Specialist (CPRS) provided 27 cumulative peer support engagements to the four (4) participants over the course of the fiscal year; approximately nine (9) engagements per quarter; and/or an average of twice per week, as needed. Three of the four program participants (75%) were referred to and engaged with various community services, to include Assertive Community Treatment (ACT) services, (one individual); Outpatient Mental Health Center (OMHC) services (one individual); and Residential Rehabilitation Program (RRP) services (one individual). The fourth participant did not receive additional services and was discharged from the OCC program.

Introduction and Overview

Outpatient Civil Commitment (OCC) is a legal and clinical intervention designed to ensure that individuals with severe and persistent mental illness (SPMI) engage in treatment. It targets those who are unwilling or unable to participate voluntarily and often have a history of repeated hospitalizations, noncompliance with treatment, or interactions with the criminal justice system.[1]

OCC programs reduce hospitalizations, homelessness, and involvement in the justice system while enhancing public safety and improving individual recovery outcomes. The program is implemented using a structured, court-ordered approach that involves mandating participants to engage in outpatient treatment services and connecting them with coordinated care while living in their communities, promoting treatment adherence.

The typical treatment plan includes:

- Medication management;
- Individual or group therapy;
- Case management services; and
- Connections to community support and rehabilitation services.

The primary goals of the OCC program are to reduce repeated hospitalizations, homelessness, and involvement with the criminal justice system while promoting recovery, stability, and public safety. The Court monitors compliance with treatment, and treatment providers deliver coordinated services that address both clinical and social needs.

[1] Substance Abuse and Mental Health Services Administration. (2019). Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice. Rockville, MD: Office of the Chief Medical Officer, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/resource/ebp/civil-commitment-mental-health-care-continuum-historical-trends-principles-law

A 2019 SAMHSA report noted that there were 20 active OCC programs operating across the United States; more recent data from the Treatment Advocacy Center and others shows that 48 states operate some type of court-mandated outpatient treatment program.[2]

Individuals living with SPMI frequently encounter barriers to accessing consistent treatment, often resulting in frequent hospitalizations, emergency department (ED) visits, homelessness, or involvement with the criminal justice system. OCC programs offer a less restrictive alternative to inpatient care by ensuring access to necessary treatment within the community. According to SAMHSA, OCC is part of a broader continuum of care designed to decrease hospital utilization and enhance engagement in voluntary treatment services.[3]

Additional research studies of New York's Kendra's Law[4] (Assisted Outpatient Treatment, AOT) and other state's OCC programs show reductions in arrest rates, emergency department use, and criminal justice involvement.[5] It has also been demonstrated that combining OCC programs with intensive services, such as Assertive Community Treatment (ACT), can reduce further psychiatric hospitalizations and inpatient length of stay.[6]

The benefits of AOT/OCC programs include:

- improved treatment engagement by participants, who are more likely to attend appointments and adhere to prescribed treatment;[7,8] reduction in hospitalizations and emergency department use by participants who have lower rates of psychiatric readmissions, shorter inpatient stays, and improved treatment adherence, particularly in medication management and follow-up care[9]

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[2] Id. *See also*, Brain and Behavior Research Foundation. 2025. Study: Court-Ordered Assisted Outpatient Treatment (AOT) Improved Broad Range of Outcomes in People with 'Serious Mental Illness.' https://bbrfoundation.org/content/study-court-ordered-assisted-outpatient-treatment-aot-improved-broad-range-outcomes-people

[3] Id.

[4] N.Y. Mental Hyg. Law § 9.60.

[5] Swanson, J. W., Van Dorn, R. A., Swartz, M. S., et al. (2013). The cost of assisted outpatient treatment: Can it save states money? *American Journal of Psychiatry, 170*(12), 1423–1432. https://doi.org/10.1176/appi.ajp.2013.12091152

[6] Swanson, J. W., Swartz, M. S., & Elbogen, E. B. (2013). Effectiveness of assisted outpatient treatment in New York: Evidence from the pilot program. *Psychiatric Services, 64*(9), 876–882. https://doi.org/10.1176/appi.ps.201200469

[7] Johnson KL, Parish WJ, Theis E, et al. (2025). Clinical and Social Functioning Outcomes of Assisted Outpatient Treatment: Results From a Multisite Evaluation. Psychiatr Res Clin Pract, 7(3):174-181. https://pubmed.ncbi.nlm.nih.gov/40932844/

[8] Kisely, S., Campbell, L. A., & O'Reilly, R. (2017). Compulsory community and involuntary outpatient treatment for people with severe mental disorders. *Cochrane Database of Systematic Reviews, 2017*(3). https://doi.org/10.1002/14651858.CD004408.pub5

[9] Supra, note 4.

- reductions in homelessness, strengthened social supports, and improved continuity of care;[10,11]
- reduction in criminal justice involvement for participants, resulting in decreased arrests and incarceration;[12]
- participants report satisfaction with program supports, particularly peer services and case management;[13]
- participants engage in recovery with structured support, fostering hope and autonomy as a result of the trauma-informed, person-centered approach utilized for service provision;
- reduction in utilization of crisis and inpatient services by participants, which translates into measurable cost savings for the health system; and[14]
- more efficient use of behavioral health resources, supporting long-term recovery and reintegration into the community.[15,16]

These outcomes demonstrate how AOT/OCC enhances individual well-being, promotes community safety, and facilitates a more efficient allocation of behavioral health resources.

The Baltimore City Outpatient Civil Commitment (OCC) Pilot Program

The Baltimore City Outpatient Civil Commitment (OCC) pilot program was established on May 25, 2017, under Health General Article §7.5-205. The program facilitates the discharge of individuals from involuntary inpatient psychiatric care under Health General Article §10-632 and supports a successful reintegration into the community.

Program Structure and Services

The pilot program employs a person-centered, trauma-informed model of care that emphasizes collaboration, dignity, and autonomy. Each participant collaborates with a Certified Peer Recovery Specialist (CPRS), a trained professional with lived experience in mental health recovery, to develop ICP or IRP to assist in meeting treatment and recovery goals, accessing and navigating services, and maintaining stability in the community. During program participation, individuals received support one to three times per week, or more frequently as needed. Services are tailored to meet each individual's clinical needs that are provided by a licensed behavioral

[10] U.S. Department of Health & Human Services, Office of the Assistant Secretary for Planning and Evaluation (ASPE). (2024). *Evaluation of the Assisted Outpatient Treatment Grant Program for Individuals with Serious Mental Illness.* https://aspe.hhs.gov/sites/default/files/documents/098651399f829e0c4cd561157ec82e23/aot-grant-program-smi-outcome-report.pdf

[11] Treatment Advocacy Center. (2020). *Assisted outpatient treatment: An evidence-based tool for addressing serious mental illness*. https://www.treatmentadvocacycenter.org

[12] Supra, note 5.

[13] Supra, note 10.

[14] Supra note 4.

[15] Supra, note 1.

[16] Supra, note 1.

health professional, level of care, and recommendations from the CPRC, an ACTteam, and/or community treatment providers.

The Continuum of Care (CoC) includes:

1. ACT;
2. Targeted Case Management (TCM);
3. Integrated Dual-Diagnosis Treatment; and
4. Peer Support Services, including:
    a. consistent, assertive, trauma-informed outreach and engagement;
    b. supportive counseling; and
    c. linkages to housing, employment, somatic healthcare, entitlements, and mental health consumer support funding.

Program Implementation and Oversight

The program was implemented by Grace Medical Center in Baltimore City, under the oversight of Behavioral Health System Baltimore (BHSB). Grace Medical Center was chosen due to its successful integration and firmly established use of peer specialists, and dedication to trauma-informed, community-based care.

Oversight by Behavioral Health System Baltimore (BHSB)

As the Local Behavioral Health Authority (LBHA), BHSB takes the lead in coordinating programmatic oversight to maintain accountability among participating hospitals, community providers, and peer specialists. BHSB ensures that program participants receive timely, appropriate, and high-quality care through the following activities:

1. **Weekly Case Review Meetings:** These meetings are facilitated by the CPRS program staff to review and monitor individual participant progress, and address challenges in real time. BHSB meets regularly twice a month and adds additional meetings when complex cases require in-depth clinical review and intervention.

2. **Monthly Documentation Review:** This activity is conducted by the CPRS, with guidance and support from clinical staff as needed. This includes in-depth analysis of progress notes to evaluate participant engagement and the quality of service delivery.

3. **Hospital Discharge Planning:** Hospital discharge activities are collaboratively managed by hospital social work staff, and/or other medical staff. Referrals to community support and connection to legal representation and a CPRS are facilitated at the time of discharge.

4. **Progress Report Submission:** BHSB submits quarterly reports to the BHA to assist with monitoring trends which tracks changes in service utilization and provision, program

outcomes and population needs; accountability which helps to provide transparency to stakeholders, constituents, and oversight bodies; tracks program performance measures that help evaluate provider performance and quality of care. Below are some of the data metrics captured during the reporting period:

a. individuals admitted to the program **voluntarily;**
b. individuals admitted to the program **involuntarily;**
c. individuals enrolled in the program who were diverted from ED or inpatient hospital settings;
d. individuals connected to somatic care;
e. referrals made to the OCC program;
f. peer encounters conducted with enrolled participants;
g. outreach activities (e.g., presentations, training, etc.) conducted to hospitals or community programs;
h. individuals connected to permanent or stable housing upon discharge;
i. individuals linked to other recovery support services (employment, education, legal, etc.);
j. number of Consumer Quality Team (CQT) surveys conducted; and
k. discharges.

Through these activities, BHSB provides technical assistance (TA) to community stakeholders, and develops system-level recommendations to improve care quality, coordination, and responsiveness.

Oversight by the Behavioral Health Administration (BHA)

The BHA provides comprehensive programmatic, fiscal, regulatory, and compliance oversight for the OCC program. Each year, BHA reports program outcomes to external stakeholders, including advocacy organizations, service providers, and policymakers, to promote transparency and accountability. The BHA is responsible for compliance by:

1. Reviewing quarterly and annual program and expenditure reports;
2. Monitoring regulatory compliance; and
3. Identifying areas for strategic improvement based on participant and system-level data

Program Funding

In State Fiscal Year (SFY) 2025, the Baltimore City Outpatient Civil Commitment (OCC) Program received a total allocation of funds of $494,827 to support program operations.[17] This funding supported administrative functions, service delivery, peer support, outreach activities, program evaluation, and technical assistance (TA) as follows:

[17] As of August 12, 2025, $173,930.33 has been expended.

1. Behavioral Health System Baltimore (BHSB) - $217,733
2. Grace Medical Center - $197,094
3. Mental Health Association of Maryland (MHAMD) - $60,000
4. Consultant (Attorney) - $20,000

Program Implementation Activities

Throughout the year, the OCC program focused on providing intensive peer support and outreach to assist individuals to connect or remain connected to mental health services. Key activities included community engagement, system collaboration, and gathering participant feedback through CQT surveys.

I. During **community engagement**, the OCC team conducted presentations to community providers and hospitals, disseminated educational email blasts, and communicated via telephone to provide guidance and assistance for stakeholders interested in the OCC program. During the reporting period, there were a total of four (4) presentations conducted to area hospitals. These presentations provide potential referral agencies and behavioral health providers, with a synopsis of the OCC pilot program, which includes information about the history of OCC (i.e., a timeline regarding the proposal, approval, etc.), and the newly implemented regulatory changes. Additionally, the presentations provide an opportunity for the CPRS, to add value and context regarding their role and program goals. Lastly, the presentations provide an opportunity for stakeholders to ask questions and/or to share complex cases that may be eligible for OCC.

II. **System collaboration** involves collaboration of the OCC staff and potential referrals to support coordination of care between the program participant and their treatment team to discuss the individual's treatment goals.

III. **Quality monitoring** is conducted by the Mental Health Association of Maryland (MHAMD) and its CQT to administer quarterly confidential surveys with program participants, and incorporate participant feedback into program evaluations. The CQT provides quality oversight for service provision for individuals that participate in Maryland's PBHS through the facilitation of an oral interview with program participants about satisfaction with the services received. The information gathered from these interviews is aggregated and reported as indicators to be used to inform the overall quality of the program. Overall, the CQT helps to ensure system accountability to individuals referred to the OCC program. The confidential surveys are used to aggregate participant data that highlights:

- Service accessibility and satisfaction;

- Quality of engagement with peer support and treatment teams;
- Perceived barriers to care;
- Suggestions for program improvement; *and*
- Feedback that has been collected to inform ongoing efforts to identify service gaps, enhance the participant experience, and support a consumer-informed approach to system development.

IV. **Peer Support Services** are used by the OCCto provide recovery support services to adults and older adults with SPMI who reside in Baltimore City or a contiguous zip code and have not been served well by the existing PBHS. Intensive peer support and outreach is provided to assist participants in making meaningful connections with behavioral health providers and/or other community recovery support services (e.g., housing, social service entitlements, and benefits, etc.).

<u>Program Metrics</u>

The program collected both quantitative and qualitative data to evaluate participant outcomes and track program performance. The metrics for FY2025 include:

I. Applications and Enrollments
   - Applications received during the reporting period: Eight (8)
   - Individuals enrolled into the program during the reporting period: Four (4, 50%)
   - Individuals referred in to the program voluntarily during the reporting period: Four (4, 100%)
   - Individuals referred in to the program involuntarily during the reporting period: Zero (0)
   - Individuals admitted into the program that adhered to and completed an ICP/IRP: Two (2, 50%)
   - Successful discharges: One (1, 25%)

II. Service Engagement
   - Participants actively engaged in behavioral health services (mental health): One of four (25%)
   - Participants referred for somatic (physical) health care: Three of four (75%)
   - Participants that received referrals and connections to permanent or stable housing Two of four (50%)
   - Participants that left the program against medical advice (AMA): Zero

III. Referrals
   - Individuals referred to Assertive Community Treatment (ACT): One of four (25%)
   - Individuals referred to Outpatient Mental Health Centers (OMHC) : One of four (25%)

- Individuals referred to Residential Rehabilitation Program (RRP): One of four (25%)
- Individuals referred to American Society of Addiction Medicine (ASAM) Level of Care (LOC): Zero
- Cumulative engagements facilitated by a CPRS: 27

Stakeholder Collaboration

The OCC program operates under a collaborative oversight structure designed to ensure program fidelity, participant safety, and ongoing quality improvement. Additionally, an interagency stakeholder group advises and monitors the OCC program, providing policy guidance and recommendations. This multidisciplinary group ensures the program remains evidence and best practice based, rights-focused, and responsive to the community's needs.

Members include:

1. Maryland Department of Health/Behavioral Health Administration (MDH/BHA)
2. Behavioral Health System Baltimore (BHSB)
3. National Alliance on Mental Illness (NAMI)
4. Mental Health Association of Maryland (MHAMD)
5. Maryland Hospital Association (MHA)
6. Disability Rights Maryland (DRM)

2025 Regulatory Changes

In February 2024, BHA published draft regulations (Code of Maryland Regulations [COMAR] 10.63.07 et seq.) in the Maryland Register. The draft regulations received two comments: one from MHA and one from BHSB. Both entities supported the proposed changes to increase program participation, discussed below. The regulations were promulgated in February 2025.

The recent regulatory changes will enhance the overall effectiveness and accessibility of the OCC pilot program by:

1. **Expanding residency requirements**: By broadening the residency criteria to include not only Baltimore City, but also contiguous zip codes the program will be available to more individuals residing in a larger geographic area. . This change will permit the enrollment of individuals who previously met all other criteria but were excluded based on their residence.
2. **Broadening inpatient and ED admission criteria**: The inclusion of both voluntary and involuntary admissions to state hospitals, along with the addition of a new criteria—three (3) emergency department visits within the past calendar year for voluntary admission—broadens eligibility for the OCC program to individuals without recent inpatient admissions but with a demonstrated need for services.

3. **Streamline enrollment for voluntary participants**: The removal of the requirement for Administrative Law Judge (ALJ) endorsement for voluntary individuals not retained at the hospital accelerates the enrollment process. This not only removes a procedural barrier, but also facilitates faster access to care for voluntary participants who are ready to engage in services.

Challenges and Barriers

During the reporting period, the primary challenges experienced in the provision of services in the OCC program, were:

1. **Low Referral Rates:** A significant barrier was the requirement that individuals must be inpatient when referred to the program. Due to the fluid nature of the inpatient system, providers often are not aware that the OCC program is an option in the mental health continuum of care; as such, providers do not submit referrals for eligible program participants prior to discharge. Increasing referrals and enrollments into the program could improve treatment adherence by providing structured oversight that can help individuals stay engaged in treatment; reduce hospitalizations, ED visits, and crises by stabilizing individuals in the community; enhancing public safety with consistent treatment that may reduce behaviors associated with un- or undertreated SPMI; promote recovery and stability with the connection to community and natural supports; filling service gaps for individuals who have not traditionally been served well through the PBHS; providing more intensive support to family members, caregivers, and advocates.
2. **Difficulty with Continuity of Care**: Even when individuals are actively enrolled in the program their varying and complex behavioral, somatic, and health-related social needs may require more coordination then the CRPS has the capacity to provide or that the PBHS or other social systems is able to support. Unmet needs make it difficult for individuals and CRPS to ensure continuity of care.
3. **Delay in Promulgating Regulations: Regulations were submitted in 2022 but a hold was placed by the** Administrative, Executive, and Legislative Review (AELR) Committee. Subsequent regulations were submitted in 2024 and took effect in 2025.
4. **Workforce Recruitment and Retention:** Hospitals experienced challenges recruiting and retaining social workers As a result, caseloads were much higher. There was limited time to onboard and educate new staff to get them up to speed on the referral process, and benefits and requirements of the OCC program.
5. **Administrative Service Organization (ASO):** The former ASO that provided administrative, fiscal, and care coordination support to the PBHS was unable to support requests for reports, such as utilization management that would help to inform and identify eligible patients and support real-time access to frequent inpatient utilizer data.

Lessons Learned

During FY2025, the BHSB OCC team recognized the importance of increasing provider awareness regarding OCC services. With the promulgation of updated regulations,the program aims to increase referrals and enrollments, as well as, improve the referral process.

During implementation, a key lesson learned was a need to have a more streamlined referral process from the inpatient psychiatric hospital team, which had been identified as a program barrier. To address this, the OCC team created a concise informational/quick tip sheet. This sheet is strategically placed within the direct line of sight for provider and hospital staff to serve as a visual reminder to initiate OCC referrals. Providing such support serves as an immediate and visible reminder about the program, and the requirement that referrals must be submitted while individuals are still hospitalized.

Another lesson learned is the need for conducting ongoing presentations and outreach about the program to potential providers, and referral agencies. This level of stakeholder engagement has proven to be beneficial as critical staff turnover is common in the healthcare field. Regular engagement helps ensure that current teams remain informed and have a clear understanding of the program. It is also important to emphasize the program is an additional supportive service available to individuals who may already be connected to other services.

Finally, during the reporting period, the BHSB team focused on improving communication and continued engagement for individuals already enrolled in the OCC program. This aims to better understand and support an individual's identified goals, and address any challenges they may face while enrolled in the program. Improved communication also supported more family involvement which may lead to stronger treatment outcomes, provides emotional support, and increases understanding of the disease.

Conclusion

In FY2026, the Outpatient Civil Commitment (OCC) Pilot Project in Baltimore City will continue its mission to provide intensive peer recovery support to individuals admitted into the program either voluntarily or involuntarily. The goal of OCC aims to prevent unnecessary hospitalizations, and ensure low barrier access to mental health care. Through collaboration with behavioral health community providers and utilization of national best and evidence-based practices, the program remains committed to improving access to mental health treatment and recovery support services for individuals that utilize the Public Behavioral Health System (PBHS).

In addition, Chapter 704, Maryland Acts of 2024, requires the establishment of statewide Assisted Outpatient Treatment (AOT) programs. Some OCC program participants may meet the

eligibility criteria for AOT. Further details regarding AOT are included in the 2025 Report on Assisted Outpatient Treatment Programs.