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WRITTEN TESTIMONY IN OPPOSITION OF
House Bill 1160: Mental Health Law - Reform of Laws and Delivery of Service
Health and Government Operations Committee, House
March 9, 2022

Thank you Chair Kelley, Vice-Chair Feldman, and committee members for your dedication to improving the quality and accessibility of healthcare services for all Marylanders. On Our Own of Maryland (OOOMD) is a statewide behavioral health (BH) education and advocacy organization, operating for 30 years by and for people with lived experience of mental health and substance use challenges. Our network of 20+ affiliated peer-operated Wellness & Recovery Centers throughout the state offer free, voluntary recovery support services to 5,000+ community members with mental health and substance use challenges.

On Our Own of Maryland strongly opposes HB 1160, which would expand the criteria for involuntary admission to a psychiatric facility from the current "presents a danger to the life or safety of the individual or others" to also include 'psychiatric deterioration' and predictions of future safety concerns. These suggested criteria are overly broad, with serious implications for anyone experiencing significant BH symptoms, or who declines treatment for reasons that another may claim are not "rational and informed."

Maryland has well-established protocols for involuntary psychiatric treatment through an Emergency Petition (EP) for evaluation, involuntary hospital admission (IVA), and civil commitment (ICC). In 2021, BHA convened a workgroup of diverse stakeholders on this topic, including OOOMD. Participants broadly agreed that the EP process is too often inconsistently applied, resulting in inappropriate utilization. Echoing a preceding 2014 workgroup's findings, the primary recommendation produced was to implement training for all involved parties (i.e. peers and families, clinicians in multiple settings, law enforcement, judicial representatives), with data collection and analysis of EP-IVA-ICC utilization to assess effectiveness and account for any potential disparate impacts. To the best of our knowledge, no real effort has yet been made to follow through on these reasonable (and repeated) recommendations.

Involuntary interventions are inherently traumatic for the person already experiencing a BH crisis, and should only be used as a last resort in cases of genuine safety concerns. Unfortunately, we hear from too many peers that in their hour of need, they were instead subject to painful and punitive consequences when admitted to an inpatient setting:

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

- "I've been receiving psychiatric care since I was 17. There were always times when my ability to make decisions was disregarded. There were multiple occasions where I was forced to remove my clothing in front of male guards and be forcibly medicated, without my consent or my knowledge of what the medication was. [During one hospitalization] they wanted to put me on lithium. I have a pre-existing thyroid condition and my psychiatrist had never prescribed it to me because of this. I declined and reminded them that I was not supposed to take Lithium…staff informed me that my options were to take Lithium or to do electroshock treatment. I was exhausted…and agreed to take the Lithium. After release, my psychiatrist immediately took me off it because of how it would affect my thyroid."
- "The police came to my house [for a wellness check after speaking about suicide to a friend]. They handcuffed me roughly. I had no shoes on when they took me outside to the car. At the hospital, they put me in a small room with two other handcuffed men. I was afraid. The staff ignored us. They strapped me to a stretcher and took me to another hospital. I was in restraints for at least 24, maybe 32 hours. They treated me like I was a criminal or a wild animal. It was horrible and embarrassing."

Forced treatment increases panic, retriggers trauma, and destroys trust between peers and providers. Involuntary commitment can have long-term health, economic, and legal consequences for individuals and families. For these reasons, treating clinicians should always carefully consider the expressed needs, self-care skills, and specific context of the individual, as well as available alternative, voluntary, lower-intensity, and more cost-effective supports, such as peer support, warmlines or crisis hotlines, Mobile Crisis/Response Teams, and Urgent Care and Crisis Stabilization Centers, before filing an EP.

The broader criteria added by this bill would shift the expected use of EPs from a rare, live-saving intervention to a first response to mitigate liability whenever there are assumed potential future safety or self-care challenges. More individuals will be forcibly restrained by police for transport, and wait for hours in crowded ERs to be evaluated or admitted, instead of receiving the timely support they need and deserve. Worse, they will leave the hospital facing the same scarcity of accessible community-based services that could have otherwise supported, prevented, or diverted them from crisis.

Over-reliance on involuntary measures creates fear and mistrust of the BH system, and directly contradicts best practice models for BH crisis response, which research shows can effectively resolve safety concerns without resorting to hospitalization.[1] Given how stigmatizing attitudes and implicit bias can lead responders to misinterpret distress as dangerousness, especially for some diagnoses and demographic groups (ex: people experiencing delusions, people with a schizophrenia diagnosis, BIPOC men), the too-early deployment of an EP, which requires police involvement, is at best disruptive and at worst deadly.

We don't need to change the 'dangerousness standard' to improve care. We need to enhance and expand the availability of community-based, trauma-informed, and culturally competent support services that actually help people stay out of the crisis cycle and move forward in their recovery.

For these reasons, we strongly urge an unfavorable report on HB 1160. Thank you for hearing us.

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[1] *Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies*, HHS Publication No. SMA-14-4848. Substance Abuse and Mental Health Services Administration, Rockville, MD (2014)