Testimony_JPC_SB0398.pdf
Uploaded by: Carter, Jill
Position: FAV

JILL P. CARTER
Legislative District 41
Baltimore City

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THE SENATE OF MARYLAND
ANNAPOLIS, MARYLAND 21401

Testimony of Senator Jill P. Carter
In Favor of SB398 - Mental Health Law – Petitions for Emergency Evaluation – Procedures
Before the Finance Committee
on February 9, 2021

Madam Chairwoman, Mr. Vice Chair, and Members of the Committee:

This bill alters current law concerning emergency evaluation petitions. It does so by authorizing behavioral health professionals to transport individuals to emergency facilities for evaluation rather than law enforcement officers ("officers").

Today, the law only authorizes officers to transport evaluees to emergency facilities. Typically, this will involve an officer placing an individual who is believed to be suffering from a mental disorder, in handcuffs and in the back of a police vehicle. And according to data analyzed by the Treatment Advocacy Center, it also involves officers using deadly force disproportionately against these individuals.

According to the data, less than four percent (4%) of adults in the United States live with severe mental illness.

Unfortunately, at least 25 percent of all fatal law enforcement encounters involve individuals with severe mental illness, meaning that members of this population are 16 times more likely to be killed by an officer than the general population.

Everyone would agree that this is unacceptable. When a person is in crisis and someone files a petition for their wellbeing, the last thing we want to do is force anyone into an unsafe situation. Introducing an armed police officer into a situation that requires a skill set outside of their training, no matter how well-intentioned, can and does lead to tragic outcomes.

This bill seeks to reduce the probability of these outcomes by giving behavioral health professionals - persons best equipped to understand the dynamics of a given situation - the discretion to include or exclude the presence of law enforcement from the matter if they deem appropriate. Not only would this bill take the burden off of officers, it would also save lives.

Given this, I urge the committee to give a favorable report on Senate Bill 398.

Respectfully,

Jill P. Carter

Health Care for the Homeless - SB 393 FAV - Behavi
Uploaded by: Diamond, Joanna
Position: FAV

HEALTH CARE FOR THE HOMELESS TESTIMONY
IN SUPPORT OF
SB 393 – MARYLAND MEDICAL ASSISTANCE PROGRAM AND HEALTH INSURANCE - COVERAGE AND REIMBURSEMENT OF TELEHEALTH SERVICES

Senate Finance Committee
January 27, 2021

Health Care for the Homeless strongly supports SB 393, which would make permanent a number of telehealth expansions that have existed under the public health emergency. Among the changes enumerated in the bill are, for Medicaid, effectively removing originating and distant site provisions so both the provider and patient may be off-site for a clinical setting, and requiring reimbursement for audio-only services. Telehealth has been a lifeline for Marylanders as they access mental health (MH) and substance use disorder (SUD) care during the pandemic. Telehealth coverage must be expanded permanently in private and public insurance to help address the skyrocketing need for MH and SUD care as result of COVID-19 and as Maryland recovers from the pandemic.

Audio-only telehealth is lifesaving

Telehealth has immensely increased access to care for people experiencing homeless. While this increased access occurred during the public health emergency, the benefits are so concrete that we strongly believe increasing access to telehealth permanently is critical. **Make no mistake: the ability to provide phone-only services to our clients is lifesaving**. While we support the bill in its entirety, we would like to focus our testimony on the most vital aspects of the bill: maintaining access to audio-only services.

A collection of case studies based on interviews with staff at 17 Health Care for the Homeless programs throughout the country about their experience implementing telehealth demonstrates why increasing access to telehealth permanently is beneficial. Cases specific to Health Care for the Homeless in Maryland are highlighted below.

Contrary to prior belief, telehealth, particularly audio-only telehealth, works well for people experiencing homelessness. With our client population, we have generally found that phones are ubiquitous and inexpensive. Conversely, high speed internet access and video screens are exceedingly inaccessible. Allowing patients to receive services via audio-only telephones can make up for the lack of broadband access in many parts of the State and the lack of affordable internet and computer technology among lower-income families.

Currently 60% of our visits are through telehealth and 97% of those telehealth visits are phone only. Since implementing audio-only telehealth, we found our missed appointment

rate, which was previously around 30%, fell in the first two months of use to 10%.[1] We widely attribute this to the fact that we are meeting our clients where they are and breaking down barriers to care, such as an onerous public transportation system. Importantly, keeping our clients connected to care is pivotal, especially during the pandemic when overdose, suicide and depression rates have increased.[2] Telehealth has been essential to delivering MH and SUD services during the pandemic, and utilization for behavioral health care has far exceeded utilization for other health conditions.

Some clients experiencing homelessness report that telehealth feels safer and more accessible. Policies related to reimbursements and ongoing ability to conduct audio-only visits are likely to determine the ongoing use of telehealth. In other words, phone-only telehealth is the only type of telehealth accessible to the vast majority of our clients. If the ability to conduct phone-only visits goes away, so will our ability to provide any level of lifesaving telehealth care.

Audio-only telehealth is just a tool to deliver health care; all clinical standards and expectations still apply.

We believe there are widespread misconceptions about audio-only telehealth. At its core, audio is just another tool for delivering the same type of and level health care. No clinical or medical requirements, regulations, or standards have changed under audio-only telehealth. We provide the same quality therapeutic and medical services as we always have – whether in person, on video or by phone. The requirements to meet billable standards are robust and nothing about the way we practice is relaxed just because they are over the phone. As highlighted in the examples below, checking in with clients by phone on various issues is a valuable service but not always a *billable* service. There continues to be a distinct set of criteria for a service to be billable. The distinctions between what is a billable phone telehealth visit versus a non-billable phone call are exemplified below.

We urge a favorable report on Senate Bill 393.

Health Care for the Homeless is Maryland's leading provider of integrated health services and supportive housing for individuals and families experiencing homelessness. We work to prevent and end homelessness for vulnerable individuals and families by providing quality, integrated health care and promoting access to affordable housing and sustainable incomes through direct service, advocacy, and community engagement. We deliver integrated medical care, mental health services, state-certified addiction treatment, dental care, social services, and housing support services for over 10,000 Marylanders annually at sites in Baltimore City, and in Harford, and Baltimore Counties. For more information, visit www.hchmd.org.

[1] While our missed appointment rate has increased slightly to slightly over 15%. However, this rate represents nearly half of our pre-telehealth missed appointment rate.

[2] For instance, the number of overdose deaths from drugs and alcohol in Maryland increased 12% in the first three quarters of 2020 compared to the same time period in 2019. *See* https://beforeitstoolate.maryland.gov/opioid-operational-command-center-department-of-health-release-opioid-and-intoxication-fatality-data-for-third-quarter-of-2020/.

2021 NASW SB 398 Senate Side.pdf
Uploaded by: Faulkner, Rachael
Position: FAV

NASW MARYLAND CHAPTER
National Association of Social Workers

****SUPPORT WITH AMENDMENT****

February 9, 2021
Support for SB 398
Senate Finance Committee

Mental Health Law – Petitions for Emergency Evaluation - Procedures

On behalf of the National Association of Social Workers, Maryland Chapter (NASW-MD), we would like to express our support for Senate Bill 398- Mental Health Law – Petitions for Emergency Evaluation – Procedures

This bill would repeal the requirement that a peace officer be involved in the emergency petition process and leaves that choice up to the mental health professional who has done the evaluation. It is often very helpful to have the aid of a peace officer in these difficult situations. However, there have been a number of unfortunate cases where the involvement of law enforcement has made the situation worse rather than better. NASW support the bill's intent to reduce/remove police involvement in accessing mental health treatment.

While considering this legislation we reached out to our clinicians who have been involved in the EP process and here are some of their comments:

"As someone who does 4-6 EP per year, I would support this bill. Very often my families of color do not want the police called to their homes or to assist with their loved ones under any circumstance. Even to the point that they will underreport or hide information that they know may result in EP (even when they desperately want help!)"

"This would be great for ACT teams and mobile crisis teams as well. While some mobile crisis teams work with police (officer goes out to every one of the mobile crisis teams calls), some do not. The clinicians go out on their own to assess intervene and call police in if needed (for EP or if situation is acutely dangerous). ACT teams and other forms of mobile intensive treatment, are used to seeing their clients in the community and often transport to many other places."

In spite of our support for the overall bill, NASW-MD does have some concerns about the implementation; including hand off at the hospital in the absence of a police officer and interpretation. For example, we have a question about the legal process. The EP itself is involuntary and cannot become voluntary. It means that the person is a danger to the life or safety of themselves or others and cannot or will not agree to be evaluated voluntarily. If the person agrees to be transported by the clinician does the EP become voluntary?

NASW-MD would be happy to work with the committee and other stakeholders to find solutions to the concerns above.

Thank you,

Daphne L. McClellan, PhD, MSW
Executive Director
NASW-Maryland Chapter

5750 Executive Drive, Suite 100, Baltimore, MD 21228
(410) 788-1066 · Fax (410) 747-0635 · nasw.md @verizon.net · www.nasw-md.org

Mike Hilliard MD SB398 testimony 2021.pdf
Uploaded by: Hilliard, Michael
Position: FAV

LAW ENFORCEMENT ACTION PARTNERSHIP
ADVANCING JUSTICE AND PUBLIC SAFETY SOLUTIONS

121 Mystic Avenue, Suite 9
Medford, Massachusetts 02155
T: (781) 393.6985

Date: February 9, 2021

Re: SB 398 - Mental Health Law - Petitions for Emergency Evaluations - Procedures

Position: SUPPORT

To: The Maryland Senate Finance Committee

Distinguished Members of the Committee,

Thank you for the opportunity to testify today. As a retired Major with the Baltimore Police Department and as a speaker for the Law Enforcement Action Partnership (LEAP), I am here to support SB 398. This bill would allow us to improve public safety by shifting some mental health responsibilities from police to mental health professionals.

During my 27 years of service with the Baltimore Police Department, I began as a patrolman in East Baltimore, I ran 911 and police dispatch, I served as assistant to the Chief of Patrol, and I retired as a Major in the Communications Section.

As a patrolman, I remember getting a call about a muscular young man who was off his medication, throwing bottles in an alley at anyone who approached him. My partner arrived first and the kid threw a bottle, and then picked up another, so my partner began preparing to use force. I arrived and just called out the kid's name, and he put the bottle down and let me handcuff him for an emergency petition. My partner was shocked to see his much smaller sidekick swiftly resolve the situation. But I had responded to the same kid before on a similar call, so we had an existing relationship.

Requiring police to handle mental health issues can be a recipe for escalation. When someone in crisis sees flashing lights and a police uniform, they become more agitated. I was not surprised to see in a report from the Treatment Advocacy Center that individuals with mental illnesses account for more than 25 percent of all police-involved shootings.

Many mental health-related calls are better handled by specially trained behavioral health clinicians, paramedics, and peer counselors. Several cities already send civilians to appropriate 911 calls rather than police. They have never had a death or injury at one of these calls, because the trained civilians are skilled at de-escalation.[1] Over time, they develop existing relationships that make their work even easier, as I found with the young man throwing bottles.

I support SB 398 because it would stop requiring emergency petitions for mental health evaluations to be handled by law enforcement. It would allow people trained in mental health issues to handle these situations without calling in the police. It would free up police to focus on calls related to serious crime, for which we have been trained.

I believe this bill would help improve public safety in general by strengthening police-community trust. When police use force against someone in a mental health crisis, their family and community are likely to turn against the police. We rely on these families to report crime and collaborate with our officers. Community distrust has become one of the greatest barriers to improving safety on our streets. One of the best ways to avoid poisoning the well of community trust is to remove police from mental health-related situations where we are not necessary.

SB 398 would pave the way for Maryland to improve our crisis response system. We can equip skilled civilian responders to handle a large share of 911 calls currently on the shoulders of police. SB 398 is an important first step.

In sum, I believe that it is critical to allow people trained in mental health crises to handle emergency petitions without involving police. A career in policing has taught me that police cannot protect and serve alone -- our society needs to stop putting everything on our shoulders and start allowing partners to step in and help.

Thank you for the opportunity to share my experience in support of this bill.

Major Mike Hilliard (Ret.)
Baltimore Police Department, Maryland
Speaker, Law Enforcement Action Partnership

1. "The Community Responder Model - Center for American Progress." 28 Oct. 2020, https://www.americanprogress.org/issues/criminal-justice/reports/2020/10/28/492492/community-responder-model/. Accessed 3 Feb. 2021.

SB398 - Petitions for Emergency Evaluation.pdf
Uploaded by: Lowe, Lisa
Position: FAV

F.A.C.E. ADDICTION MARYLAND

FAMILY ADVOCATES COALITION TO END ADDICTION IN MARYLAND

Testimony to Support SB 398:

Mental Health Law - Petitions for Emergency Evaluation - Procedures

Senate Finance Committee
February 9, 2021

For Further Information, Contact: Lisa Lowe

heroinactioncoalition@gmail.com / 301-525-6183

I raised two boys in Montgomery County, one of which has severe mental health / substance use (MH/SUD) co-occurring disorders –bi-polar, unspecified mood disorder, chronic depression, anxiety disorder, oppositional defiant disorder, substance-use disorder, including opioid addiction, exacerbated by poly-drug use and alcoholism. This is a dangerous combination of disorders and without support and training for parents –which, of course, is often non-existent and/or difficult to access in this state, parents are at times left to deal with a very volatile and violent situation on their own with very little support or knowledge of best practices for addressing their child's issues. Unsafe situations often occur without warning –when some unidentified trigger ignites the fuse attached to this behavioral time bomb and suddenly a peaceful household erupts into chaos, violence and danger.

When this occurs, the need for family members to call for external assistance to restore safety becomes a priority. Unfortunately, often the only person who is designated to arrive to provide this assistance are the police. Even in Montgomery County, where mobile crisis has been in existence longer than other counties and jurisdictions, this service is typically unavailable. I have called for a mobile crisis response team on several occasions –only to be told that the mobile crisis unit is responding to other calls and it will take a couple hours for them to get to me –as if I can push a pause button on the dangerous and violent meltdown occurring before me. Even though there is a special police unit trained in responding to behavioral health calls of this nature –often those trained officers are also unavailable.

Family members, like myself, have been hit with heavy blunt objects, witnessed furniture thrown through glass windows and doors, woken up in the middle of the night with a knife being held to their throat, watched small pets being punted across the room, stood helplessly by as decorative ornaments, electronic equipment, and household appliances are kicked and smashed, and cowered in fear until the family members' episode has subsided. These individuals, diagnosed with a mental health disorder, fueled by substance use, can often spiral out-of-control for several hours at a time.

Police, unfortunately, often exacerbate the problem –inaccurately perceiving that the only way to deal with the situation is by a display of brute force and by exhibiting a higher degree of violence than the MH/SUD impacted individual in order to overcome them. With no surprise to the by-standing parent, this course of action typically only serves to further rile the would-be patient into an increasingly anxious, combative, and aggressive state.

One father described a situation where the officer tased his burly high-school linebacker and wrestling champion son, who then pulled the taser out of his arm and leaped upon the officer, pinning him to the floor. An accompanying officer pulled his gun, and the Dad actually had to jump in front of the gun demanding that the officer lower it, until he (not either of the officers) could talk his son down into a relatively calm state, where he then left peacefully with the officers to the hospital.

I once heard a Mom speak at a Keep the Door Open Rally, right here in Annapolis, about her experience calling for emergency assistance for her son. She described a situation where several squad cars pulled up to her home, hopped out of their cars and an officer with a bullhorn ordered everyone inside to come outside –which they did. Upon witnessing the MH/SUD impacted son stomping around and yelling on the front porch, officers aimed their firearms at the porch, and ordered the entire family including small children, to lie down. When the out-of-control teenager refused to follow the police directive, continuing to rant and scream at the SWAT team on the front lawn, the police then decided that tear gas was the best option, and tear-gassed the entire family, as well as the entire suburban block.

Similarly, at a Montgomery County homeless shelter for women, one schizophrenic resident began talking to her imaginary partner during the night, waking up other residents. A SWAT team showed up and about a dozen armed officers in combat gear poured into the women's bedroom, where about twenty women were in their cots wearing pajamas. The officers formed a line down the entire length of the room in the space between the cots. As they debated what should be done, it became clear that not one of the officers had any experience at all in de-escalating the situation or resolving it. Some officers began to make jokes about the woman, while another officer, presumably tired of standing, sat down at the foot of a resident's bed. The officers refused to allow anyone to exit or enter the room –meaning that some of the County's most vulnerable citizens –some with unaddressed mental health issues and poor coping skills, were subjected to this blatant example of mental health ineptitude, for more than an hour. The officers finally decided that because the woman was not a danger to herself or others, they were not going to yank her out of bed and take her to the ER by force.

Or police may take the opposite route –in my case, police showed up in response to a call when my son had lost control, was delirious and had obviously been using substance(s). Despite the blood streaming out of a deep gash in my head and trickling down my face, and both my other son and myself imploring the officer to invoke an emergency petition order and take him to the nearest hospital, they simply took him outside in the middle of the night, and told him that he could not re-enter our home until he "sobered up". But at 3:00 o'clock in the morning, with nowhere else to go, and out-of-his mind on substances, he came in through an upstairs window and jumped on top of his sleeping brother, threatening to kill him. Once again, the police arrived and took him back out of the house, advising him not to re-enter. This scenario continued repeatedly, all night long, until my son was finally exhausted and whatever concoction of drugs had worn off. Only then could I safely allow him back into the house where he collapsed on the floor and slept until I could get an emergency petition filed by the Commissioner and a new unit of officers to come pick him up. When he awoke later that day, he remembered none of the prior night's events.

These harrowing scenarios could be prevented, as well as the profound harm perpetrated on both the caller and the MH/SUD-impacted individual by untrained police officers, if behavioral health specialists arrived instead to assist in dealing with the very scenarios that they have been professionally trained, credentialed, and experienced in dealing with.

SB0398 submit.pdf
Uploaded by: muhammad, sabah
Position: FAV

Name: Sabah Muhammad | Treatment Advocacy Center|
muhammads@treatmentadvocacycenter.org
Date of Hearing: Tuesday February 9th, 2021 at 1pm
Committee: Finance
Sponsored by: Senator Jill Carter
Bill Number: SB0398
Full Bill Title: Mental Health Law - Petitions for Emergency Evaluation - Procedures
Position: In Support of Passing HB0537/SB0398

I appreciate the opportunity to submit testimony today. My name is Sabah Muhammad. Not only do I serve as Legislative and Policy Counsel with the Treatment Advocacy Center (TAC), I am a family member of a loved one diagnosed with paranoid schizophrenia.

The Treatment Advocacy Center is a national 501(c)3 nonprofit organization dedicated to eliminating legal and other barriers to the timely and effective treatment of severe mental illness (SMI).

We live in a country where our loved ones can deny a shot of long-term antipsychotic medication as a liberty right, then be shot and killed by police during a psychotic episode in the name of justice. None of us should sleep well at night knowing that individuals diagnosed with SMI are 16 times more likely to be killed in a police encounter than other citizens.

Steps taken to remove police as sole responders to a mental health crisis are steps in the right direction, therefore SB0398, which aims to mitigate police response to a mental health crisis by allowing medical workers to serve a first responders is a step in the right direction.

However, as long as volunteer required resources for individuals too sick to tell reality from delusion are the primary resources offered, we will continue to require police. The emergency begins when an individual is too sick to provide their basic needs like food, clothing and shelter. Waiting for that inability to turn suicidal or homicidal is negligent, inhumane and contradicts the desire to remove police from the medical crisis equation.

- Adults with severe mental illness account for one in four people killed in police encounters.
- Individuals with severe mental illness, account for just 3% to 5% of violent acts and they are 10 times more likely than the general population to be victims of violent crime.
- TAC found that about one-fifth of total law-enforcement staff time and 10% of law-enforcement agencies' total budgets in 2017 went toward responding to and transporting people with mental illness.

Thank you for your time and attention. I appreciate the opportunity to highlight the importance of SB0398. It is a step in the right direction for families and communities in need of early intervention, long term well-being, and treatment before tragedy. I urge you to support SB0398.

HB 537_SB 398 FAV BHRC Emergency Petitions.pdf
Uploaded by: Smith, Harriet
Position: FAV

February 9, 2021

The Honorable Delores Kelley
Chair, Senate Finance Committee
Miller Senate Office Building, 3 East Wing
11 Bladen St., Annapolis, MD 21401

RE: SUPPORT of Senate Bill 0398 (Mental Health Law –Petitions For Emergency Evaluation–Procedures)

Dear Chairwoman Kelley and Senate Finance Committee members,

Baltimore Harm Reduction Coalition (BHRC), an advocacy organization that mobilizes community members for the health, dignity, and safety of people targeted by the war on drugs and anti- sex worker policies, supports Senate Bill 396 (Mental Health Law -- Petitions for Emergency Evaluation--Procedures).

We support giving clinicians more discretion for ensuring patient safety. We offer this support as healthcare providers and because of our experiences as patients. I offer my experience below as testimony for the need to allow clinicians choice.

About four and a half years ago I experienced a particularly difficult episode of depression. Thanks to the help from a caring therapist I entered a day program where I could participate in activities and be checked on for most of the day, Monday through Friday. During one of our daily check-ins I mentioned that I was feeling much worse and the staff suggested that I consider hospitalization. I agreed. Since the program was located at a hospital all I had to do was walk across the street to enter the Emergency Department to wait for a bed in the inpatient section.

Unfortunately, the program had a rule that they needed to issue an emergency petition for any program participant who was a danger to themselves -- even if said patient was agreeable to hospitalization. As I understand it, they made this rule because of concerns regarding liability. By law in Maryland, when an emergency petition is issued the police must be called and they are required to transport the patient. The law leaves no room for the clinician's judgement about the specific scenario at hand.

Thankfully, the entrance to the Emergency Department was so close to the program that it was more cumbersome for the police to handcuff me and put me in the back of the transport wagon. They agreed that the brief walk across a minor street -- under their watchful eyes, hands resting on their holsters -- could be achieved without the wagon. When I hear of other people's experiences of being zip tied, alone, in a metal cage in one of the worst moments of their lives, my heart sinks into my stomach. Adding those layers of trauma to someone's experience, especially when they are at their most vulnerable, especially if they have had scary interactions with police before, and especially if there is a safe alternative, is not healthcare.

I ask that you trust clinicians' discretion and give them more options. In my case a program staff member walked with me, kept making eye contact, and we chatted about the weather to help alleviate my fear and embarrassment. We could have done without the police altogether.

It is possible that most emergency petitions will continue to be carried out as they have been. But a few less traumatic experiences are worth the effort. Those few matter.

As a director with BHRC, I appreciate the opportunity to share my experience and comment on this legislation and **BHRC respectfully requests the Committee give this measure a favorable report. Thank you for your consideration.**

For more information about BHRC or this position, please contact Harriet Smith at Harriet@BaltimoreHarmReduction.org.

SB 398 - SWA - MPS WPS.pdf
Uploaded by: Tompsett, Thomas
Position: FWA

February 4, 2021

The Honorable Delores G. Kelley
3 East - Miller Senate Office Building
Annapolis, Maryland 21401

RE: Support with Amendments – SB 398: Mental Health Law - Petitions for Emergency Evaluation - Procedures

Dear Chairman Kelley and Honorable Members of the Committee:

The Maryland Psychiatric Society (MPS) and the Washington Psychiatric Society (WPS) are state medical organizations whose physician members specialize in diagnosing, treating, and preventing mental illnesses, including substance use disorders. Formed more than sixty-five years ago to support the needs of psychiatrists and their patients, both organizations work to ensure available, accessible, and comprehensive quality mental health resources for all Maryland citizens; and strives through public education to dispel the stigma and discrimination of those suffering from a mental illness. As the district branches of the American Psychiatric Association covering the state of Maryland, MPS and WPS represent over 1000 psychiatrists and physicians currently in psychiatric training.

MPS and WPS support the intent of Senate Bill 398: Mental Health Law - Petitions for Emergency Evaluation – Procedures. Some very good programs, such as Baltimore Crisis Response Inc. (BCRI), bring patients into the emergency department themselves when they deem it safe. MPS and WPS recognize, however that the bill could use some refinement and we have worked with the sponsor as to why and how.

Under Health-General §10-622, only specified mental health practitioners are authorized to complete and submit a petition for emergency evaluation without judicial review. A non-mental health professional, such as a family member, a physician assistant, or a nurse who is not a psychiatric nurse practitioner or a psychiatric nurse clinical specialist, may obtain a petition for an emergency evaluation only by going before a district court judge. If granted, the court directs local law enforcement to locate and transport the respondent to the nearest emergency facility. The law enforcement professional must then complete a Return of Service form to be filed with the court that issued the petition.

A qualified petitioner, such as a psychiatrist or other mental health professional, may on rare occasions transport a respondent to an emergency facility if they are working as part of a mobile treatment or assertive community treatment team that provides services directly to the individual in his home. More commonly, the qualified petitioner completes the petition while working in a community clinic or inpatient service and then contacts law enforcement to pick up and serve the petition on the respondent.

SB 398 modifies transport procedures for emergency evaluees. While MPS and WPS agree with the intent to reduce potentially deadly conflicts between the police and people with mental illness, the emergency evaluation process does pose potential personal safety risks to clinicians who elect to serve the petition themselves while working as part of a mobile treatment team. Law enforcement should be required to respond to provide security to these clinicians at any point in this process. These clinicians should also be protected from civil or criminal liability. In addition, nothing in this bill should imply, or directly state, that a qualified petitioner must locate and transport the respondent without the help of law enforcement.

MPS therefore asks the committee to consider the following amendments in light of the above:

1. On page 4, in line 10 strike "shall" insert "MAY";

2. On page 4, in line 11 after "facility" strike "If the" insert ". (2) A";

3. On page 4, in line 15 strike "OR" and insert "WHO DOES NOT TRANSPORT THE EVALUEE SHALL PROVIDE THE EMERGENCY PETITION TO A"; in that same line after officer strike "HAS A PETITION";

4. On page 4, in line 22 after "(2)" insert (I)

5. On page 4 after line 29 insert "(II) A PHYSICIAN, PSYCHOLOGIST, CLINICAL SOCIAL WORKER, LICENSED CLINICAL PROFESSIONAL COUNSELOR, CLINICAL NURSE SPECIALIST IN PSYCHIATRIC AND MENTAL HEALTH NURSING, PSYCHIATRIC NURSE PRACTITIONER, LICENSED CLINICAL MARRIAGE AND FAMILY THERAPIST, HEALTH OFFICER OR DESIGNEE OF A HEALTH OFFICER, WHO TRANSPORTS AN EMERGENCY EVALUEE TO THE EMERGENCY FACILITY MAY REQUEST ASSISTANCE FROM A PEACE OFFICER TO AID IN THE TRANSPORT AT ANY TIME; (III) A PEACE OFFICER FROM THE APPROPRIATE JURISDICTION SHALL RESPOND TO A REQUEST FOR TRANSPORT ASSISTANCE."

6. On page 5 after line 18 insert "(C) ANY PHYSICIAN, PSYCHOLOGIST, CLINICAL SOCIAL WORKER, LICENSED CLINICAL PROFESSIONAL COUNSELOR, CLINICAL NURSE SPECIALIST IN PSYCHIATRIC AND MENTAL HEALTH NURSING, PSYCHIATRIC NURSE PRACTITIONER, LICENSED CLINICAL MARRIAGE AND FAMILY THERAPIST, HEALTH OFFICER OR DESIGNEE OF A HEALTH OFFICER, WHO TRANSPORTS AN EMERGENCY EVALUEE TO THE EMERGENCY FACILITY, WHILE ACTING IN GOOD FAITH, SHALL BE IMMUNE FROM CIVIL OR CRIMINAL LIABILITY FOR ANY INJURIES SUSTAINED DURING TRANSPORT."

Finally, MPS and WPS would ask the committee to resist any amendment that includes physician assistants or non-psychiatric nurses to the list of authorized health care providers for transport as this would be internally contradictory in the law as these professions are not qualified petitioners.

With the amendment adopted, MPS and WPS would then ask the committee for a favorable report of SB 286. If you have any questions with regard to this testimony, please feel free to contact Thomas Tompsett Jr. at tommy.tompsett@mdlobbyist.com.

Respectfully submitted,
The Maryland Psychiatric Society and the Washington Psychiatric Society
Joint Legislative Action Committee

3 - SB0398 - Mental Health Law – Petitions for Eme

Uploaded by: Bennardi, Maryland Department of Health /Office of Governmen
Position: UNF

Maryland
DEPARTMENT OF HEALTH

Board of Nursing

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Dennis R. Schrader, Acting Secretary

February 9, 2021

The Honorable Delores G. Kelley
Chair, Finance Committee
3 East Miller Office Building
Annapolis, MD 21401-1991

RE: Senate Bill 398 – Mental Health Law – Petitions for Emergency Evaluation – Procedures – Letter of Opposition

Dear Chair Kelley and Committee members:

The Maryland Board of Nursing ("the Board") respectfully submits this letter of opposition for Senate Bill (SB) 398 – Mental Health Law – Petitions for Emergency Evaluation – Procedures. This bill requires a petitioner for emergency evaluation to take an emergency evaluee to the nearest emergency facility. The petitioner is required to notify the emergency facility in advance that the petitioner is bringing an emergency evaluee to the emergency facility. Additionally, this bill provides that a petitioner who brings an emergency evaluee to an emergency facility is not required to stay with the emergency evaluee.

In current practice, clinical nurse specialists (CNSs) in psychiatric and mental health nursing and psychiatric nurse practitioners (NPs) have the authority to issue emergency petitions. Emergency petitions serve as a vehicle for practitioners to require an individual to be evaluated for mental fitness by a psychiatrist. This allows for expedited care to an individual who may be vulnerable. It is critical for these individuals to be seen and cared for, in a timely and efficient manner.

The Board is concerned with the written language in SB 398, particularly, the requirement of a CNS or NP to physically accompany an emergency evaluee to an emergency facility. This requirement may impose barriers to care for the emergency evaluee. The first concern would be for the safety of the practitioner, especially if the individual under observation is violent. Transporting the individual in an ambulance may not be the most appropriate method of transportation. It is sometimes necessary for the individual to be taken to an emergency facility in a peace officer's vehicle.

The second point of concern is if the practitioner is required to accompany an emergency evaluee, the practitioner may second guess their decision to authorize an emergency petition. The practitioner would have to be mindful that they would be pulled away from their duties at the institution they serve for an indefinite period of time. This may cause significant delays for an individual to receive care, which could lead to serious harm or even death.

For the reasons discussed above, the Board of Nursing respectfully submits this letter of opposition for SB 398.

I hope this information is useful. For more information, please contact Iman Farid, Health Policy Analyst, at (410) 585 – 1536 (iman.farid@maryland.gov) or Rhonda Scott, Deputy Director, at (410) 585 – 1953 (rhonda.scott2@maryland.gov).

Sincerely,

Gary N. Hicks
Board President

The opinion of the Board expressed in this document does not necessarily reflect that of the Department of Health or the Administration.

SB 398 _Mental Health Law - Petitions for Emergenc
Uploaded by: Breidenstine, Adrienne
Position: UNF

Behavioral Health System Baltimore

February 9, 2021

Senate Finance Committee
TESTIMONY IN OPPOSITION
SB 398 Mental Health Law - Petitions for Emergency Evaluation - Procedures

Behavioral Health System Baltimore (BHSB) is a nonprofit organization that serves as the local behavioral health authority (LBHA) for Baltimore City. BHSB works to increase access to a full range of quality behavioral health (mental health and substance use) services and advocates for innovative approaches to prevention, early intervention, treatment and recovery for individuals, families, and communities. Baltimore City represents nearly 35 percent of the public behavioral health system in Maryland, serving over 77,000 people with mental illness and substance use disorders (collectively referred to as "behavioral health") annually.

Behavioral Health System Baltimore opposes SB 398 Mental Health Law - Petitions for Emergency Evaluation - Procedures. SB 398 would allow a range of mental health practitioners to transport an individual under Emergency Petition (EP) to an emergency room.

BHSB recognizes the intent behind this bill is to reduce police interaction when responding to people with a mental health crisis, however, the approach of having a non-officer transport for individuals under EP is misguided and could result in further harm to the individual in crisis and the practitioners involved.

For some, involuntary admission into treatment is an approach to help people in crisis and engage them into care. However, EPs should be used judiciously, reserved only for individuals with serious mental illness and who are a true danger to themselves and/or others.

To reduce police interactions with people in mental health crisis, we must have a comprehensive behavioral health system that includes robust crisis services to ensure that people get the care they need at the exact time they need it. Behavioral health crisis response services are an essential component of an effective emergency response system. Without them, people end up unnecessarily calling the police and using emergency medical services and hospitals. When used, Baltimore's behavioral health crisis response system has helped countless Baltimoreans overcome potentially life-threatening crises.

We often take for granted our emergency response system – police, fire, and hospitals – to address these issues, but often they are not best suited for that specialized task. There must be broader, systemic investment in behavioral health crisis services and the other services people need. This is a shared obligation of the city and the state. Maryland's system has been under-valued and under-resourced for too long.

As such, BHSB urges the Senate Finance Committee to oppose SB 398 and focus efforts on strengthening and expanding crisis response services to ensure immediate access to these life-saving urgent care services for people with mental illness crisis.

Maryland Psychological Association - Unfavorable -

Uploaded by: Brocato, Barbara

Position: UNF

MARYLAND PSYCHOLOGICAL ASSOCIATION

10480 Little Patuxent Parkway, Ste 910, Columbia, MD 21044. Office 410-992-4258. Fax: 410-992-7732. www.marylandpsychology.org

January 29, 2021

Senator Delores G. Kelley, Chair
Senate Finance Committee
11 Bladen Street
Miller Senate Office Building, 3 East
Annapolis, MD 21401

RE: SB 398 – Mental Health Law – Petitions for Emergency Evaluation – Procedures

Position: **Unfavorable**

Dear Chair, Vice Chair, and Committee Members:

The Maryland Psychological Association represents over 1000 doctoral level psychologists throughout the state. **We write in opposition to SB 398, which would require a variety of health care professionals, including psychologists, to take an individual to the nearest emergency facility if the healthcare professional (psychologist) is presented with a petition signed by either a health care professional or a peace officer or has been endorsed by a court within 5 days prior to the presentation.**

While we support the legislation's intent of reducing the danger to people in crisis from negative interactions with peace officers as well as protecting peace officer's safety, we believe there are better ways to accomplish this goal. We would be glad to work with legislators on seeking solutions to this challenge.

Psychologists/healthcare professionals are not trained, nor do they possess the appropriate equipment and/or materials to safely transport a violent individual. We do not possess either the knowledge or training of how to protect one's self while transporting a dangerous individual. As a result, this bill has the potential to place both the patient and healthcare provider/psychologist in physical danger.

As written, this bill would put psychologists/health care practitioners in the position of having to determine the legitimacy of an emergency petition prepared by someone else, something that is not within our scope of practice. Additionally, an unintended consequence of this legislation could be the reduction of petitions for evaluation, based on the concerns expressed above.

For the reasons noted above the Maryland Psychological Association asks for an **UNFAVORABLE** report on Senate Bill 398. Thank you for considering our comments on SB 398. If we can be of any further assistance as the Senate Finance Committee considers this bill, please do not hesitate to contact the MPA Executive Director, Stefanie Reeves, MA, CAE at 410-992-4258 or exec@marylandpsychology.org.

Esther Finglass
Esther Finglass, Ph.D.
President

R. Patrick Savage, Jr.
R. Patrick Savage, Jr., Ph.D.
Chair, MPA Legislative Committee

cc: Richard Bloch, Esq., Counsel for Maryland Psychological Association
Barbara Brocato & Dan Shattuck, MPA Government Affairs

SB 398- Senate Bill 398 - Mental Health Law - Peti

Uploaded by: Dorrien, Erin

Position: UNF

Maryland
Hospital Association

February 9, 2021

To: The Honorable Delores G. Kelley, Chair, Senate Finance Committee

Re: Letter of Concern - Senate Bill 398 - Mental Health Law - Petitions for Emergency Evaluation - Procedures

Dear Chair Kelley:

On behalf of the Maryland Hospital Association's (MHA) 60 member hospitals and health systems, we appreciate the opportunity to comment on Senate Bill 398. The hospital field recognizes the intent of the legislation to limit interaction between those in behavioral health crisis and the police and values efforts to destigmatize behavioral health treatment and behavioral health crisis.

Yet, Maryland hospitals are concerned SB 398 may have unintended consequences that would harm patient care.

Current law outlines very discrete steps for executing a petition for emergency evaluation (EP). The steps require a petitioner to involve a peace officer (police officer) to transfer the patient to an emergency facility for evaluation. Clinicians at the receiving facility may also request the peace officer remain with the patient if the patient is exhibiting erratic or violent behavior. SB 398 eliminates the requirement that a peace officer be involved in the execution of an EP.

In a 2018 survey from the American College of Emergency Physicians, 47% of emergency department (ED) physicians reported being assaulted at work, and 71% said they witnessed an assault.[1] It is important to have a peace officer present who can secure a patient if necessary.

Many patients who require an EP are not violent, yet an individual in a behavioral health crisis could become confused or unpredictable—during transport or while at the emergency facility.

MHA member hospitals raised concerns about clinicians transporting EP patients to the hospital in the clinicians' private vehicles. Hospitals would need to create policies and procedures to transport EP patients for hospital-based providers, but independent practitioners would have to decide on their own whether they can make the transport. Given this change, liability issues may arise.

The hospital field supports expanded access to crisis services outside of the ED. MHA supported HB 332 in the 2020 legislative session. This required the Maryland Department of Health

[1] American College of Emergency Physicians. (September 2018). ACEP Emergency Department Violence Poll Research Results.

(MDH) to develop a model program for crisis stabilization centers, which care for individuals in behavioral health crisis and helps them remain in a more appropriate, therapeutic setting than a hospital ED. Due to the COVID-19 pandemic, MDH has not begun the stakeholder work to establish the model program.

Through the Regional Partnership Catalyst Grant Program, the Health Services Cost Review Commission began offering grants to improve access to crisis services Jan. 1. Applicants were required to show they support the implementation and expansion of behavioral health crisis management models, specifically the "Crisis Now: Transforming Services is Within Our Reach" action plan created by the National Action Alliance for Suicide Prevention.[2] Three awards, totaling $79.1 million over five years, were granted to transform crisis care in the regions.[3]

The state should promote programs to reduce the need for emergency petition evaluations, including expanding crisis support and behavioral health services throughout the care continuum. If an individual's behavioral health care needs are met, we can ensure fewer people experience behavioral health crisis.

We hope you take these considerations under advisement when deliberating on SB 398.

For more information, please contact:
Erin Dorrien, Director, Government Affairs & Policy
Edorrien@mhaonline.org

[2]Maryland Health Services Cost Review Commission. (November 2020). "Regional Partnership Catalyst Grant Program Final Funding Recommendation." "
[3] ibid

MD Judiciary - Testimony SB 398.pdf
Uploaded by: Elalamy, Sara
Position: UNF

MARYLAND JUDICIAL CONFERENCE
GOVERNMENT RELATIONS AND PUBLIC AFFAIRS

Hon. Mary Ellen Barbera
Chief Judge

187 Harry S. Truman Parkway
Annapolis, MD 21401

MEMORANDUM

TO:	Senate Finance Committee
FROM:	Legislative Committee Suzanne D. Pelz, Esq. 410-260-1523
RE:	Senate Bill 398 Mental Health Law – Petitions for Emergency Evaluation - Procedures
DATE:	February 2, 2021 (2/9)
POSITION:	Oppose, as drafted

The Maryland Judiciary opposes Senate Bill 398, as drafted.

The Judiciary understands and appreciates the policy aims of the bill but has some process concerns with its drafting. In particular, the Judiciary is concerned with the language that deletes the obligation to inform the evaluee of the meaning and the content of the petition. The filing of the petition is entirely discretionary for the enumerated professionals as set forth in the introduction to Health General Section 10 – 622. However, the process that is to follow once a petition is filed and granted must be consistent with due process. Thus, "shall" and not "may" is appropriate and the Judiciary opposes the proposed change.

Further, as to Health General Section 10-624, the proposed language creates ambiguity as to who is serving the petition and bringing the evaluee to the hospital once the petition is granted by the court. The existing law allows for the possibility that any of the enumerated professionals may voluntarily escort a client/ patient to an emergency room. The statute is designed to address its use when they are unwilling. The proposed language creates an ambiguity as to who would transport the unwilling evaluee once the court has granted the petition. Thus, each may defer to the other, resulting in no one having the duty. In such a case, the petition could expire without the evaluee being seen at the nearest emergency facility and despite the court having determined there was probable cause that the evaluee was suffering from a mental disorder and presented a danger.

cc. Hon. Jill Carter
Judicial Council
Legislative Committee
Kelley O'Connor

SB 398 Written Testimony MD ENA Feb_9_2021 Mental
Uploaded by: Tenney, Lisa
Position: UNF

EMERGENCY NURSES ASSOCIATION

Maryland State Council
Safe Practice Safe Care

To: Senate Finance Committee
3 East Wing
Miller Senate Office Building
11 Bladen Street
Annapolis, MD, 21401

Chairwoman, Senator Delores G. Kelley
Vice Chairman, Senator Brian Feldman
Senator Malcolm Augustine
Senator Pamela G. Beidle
Senator Joanne C. Benson
Senator Antonio L. Hayes
Senator Stephen S. Hershey, Jr.
Senator J. B. Jennings
Senator Katherine Klausmeier
Senator Benjamin Kramer
Senator Justin Ready

From: Maryland State Council of the Emergency Nurses Association

Date: February 4, 2021

Re: Written testimony: ***SB 398*** *Mental Health Law – Petitions for Emergency Evaluation – Procedures*

I am writing on behalf of the Maryland State Council of the Emergency Nurses Association. We are seeking an unfavorable review of ***SB 398*** *Mental Health Law – Petitions for Emergency Evaluation – Procedures.*

"Workplace violence against healthcare workers is a national crisis. The Occupational Safety and Health Administration (OSHA) found that although

workers in the healthcare sector accounted for only 20% of workplace injuries, they make up about 50% of all victims of workplace assault. Between 2002 and 2013, serious incidents of workplace violence were four times more common for workers in the healthcare sector than for all other workers in the United States. Some even die from their injuries. Many suffer physical and emotional trauma that drives them away from the critical work of emergency nursing." (Emergency Nurses Association, 2018).

SB 398 – *Mental Health Law – Petitions for Emergency Evaluations – Procedures* would allow behavioral health providers, including psychiatric nurse practitioners and clinical nurse specialists in psychiatric and mental health, to transport a patient to an emergency facility under an Emergency Petition. Maryland's emergency nurses serve on the front-line caring for Maryland's citizens who are having a mental health crisis and those who are experiencing a change in mental status. These patients are often brought in on Emergency Petitions that were sought by people who were worried about their welfare and feared that they were a danger to themselves or someone else. Unfortunately, these patients are often emotionally volatile with poor insight and impulse control. When a decision is made to seek treatment, especially if it is against the patient's wishes, the risk of violence is a reality. Knowing that this "decision and transfer" is such a high-risk time, having a healthcare practitioner transport an Emergency Petition patient alone to an ED may cause unnecessary workplace violence. We would like to see the use of Community Mental Health Crisis Intervention Response Teams explored as an alternative to sole Peace Officer responders.

All efforts must be taken to assure the safest hand-off-of-care from field practitioners, Peace Officers, and EMS to the receiving ED medical providers, staff, and hospital security personnel. It is important to assure that whoever brings the patient to the ED reviews and explains the circumstances that warranted the Emergency Petition to the receiving physician or practitioner. This information and history help with the diagnosis and treatment of the patient. Requiring the Peace Officers to stay until the ED staff and hospital security staff can safely assume care of the patient is a best practice. It plays a particularly important role in the prevention of workplace violence in the ED, especially since federal and other regulators have limited the role and powers of hospital security staff. Thank you.

Sincerely,

Lisa Tenney

Lisa Tenney, BSN, RN, CEN, CPHRM
Chair, Government Affairs Committee
Maryland State Council Emergency Nurses Association
lctenney@gmail.com

Lisa Tenney
9226 Bluebird Terrace
Gaithersburg, MD 20879
240-731-2736

SB398_Hopkins.Coble_LOI.pdf
Uploaded by: Coble, Annie
Position: INFO

JOHNS HOPKINS
UNIVERSITY & MEDICINE
Government and Community Affairs

SB 398
Letter of Information

TO: The Honorable Delores Kelley
Chair, Senate Finance Committee

FROM: Annie Coble
Assistant Director, State Affairs
Johns Hopkins University and Medicine

DATE: February 9, 2021

Johns Hopkins wants to provide information regarding **Senate Bill 398 Mental Health Law – Petitions for Emergency Evaluation - Procedures.** This bill would expand the providers allowed to transport emergency petition patients to beyond just peace officers. If this bill were to pass the providers that could transport patients would include physicians, psychologists, clinical social workers, licensed clinical professional counselors, clinical nurse specialists in psychiatric and mental health nursing, psychiatric nurse practitioners, licensed clinical marriage and family therapists, health officers or designees. Johns Hopkins understands that often peace officers are not the most appropriate response to someone in a psychiatric emergency.

The way behavioral health crises are managed needs to be carefully reevaluated and reconsidered across the country. That is why Maryland's Health Services Cost Review Commission last year awarded grants to hospitals across the state for the Regional Partnership Catalyst Grant for Behavioral Health Crisis Services. Johns Hopkins was awarded this grant, along with sixteen other hospitals, three local behavioral authorities and community organizations across Baltimore City, Baltimore County, Carroll County and Howard County as a part of the Greater Baltimore Regional Integrated Crisis System (GBRICS). GBRICS aims to address behavioral health crises through a robust crisis hotline and referral system and increased access to mobile crisis services, which helps to serve individuals in the community instead of through the criminal justice system or hospital emergency departments.

We are proud to be a member of GBRICS and believe it has the opportunity to truly make a difference to the behavioral health system in Maryland. Johns Hopkins wanted to make sure this Committee was aware of the work of GBRICS while considering **Senate Bill 398 Mental Health Law – Petitions for Emergency Evaluation – Procedures.**

2021 MNA SB 398 Senate Side.pdf
Uploaded by: Elliott, Robyn
Position: INFO

Committee:	**Finance**
Bill Number:	**Senate Bill 398**
Title:	**Mental Health Law – Petitions for Emergency Evaluation - Procedures**
Hearing Date:	**February 9, 2021**
Position:	**Letter of Concern**

The Maryland Nurses Association (MNA) submits this letter of concern for *Senate Bill 398 – Mental Health Law – Petitions for Emergency Evaluations – Procedures.* This bill would allow behavioral health providers, including psychiatric nurse practitioners and clinical nurse specialist in psychiatric and mental health, to bring an emergency evaluee to an emergency facility under an emergency petition.

MNA strongly supports the intent of this legislation, which is to decrease the involvement of law enforcement in responding to individuals in a behavioral health crisis. We support the bill's emphasis on the involvement of behavioral health professionals at the earliest possible moment in the emergency petition process.

MNA is concerned that nurses and their colleagues will face an increased risk of workplace violence as an unintended consequence of this bill. Under current statute, a hospital can request that the peace officer remain at the facility after providing transportation of the patient to the hospital. This option is critical as federal rules limit the type of security that hospitals can directly provide in a patient setting. If an evaluee poses a danger, the peace officer's presence may be critical to protecting hospital staff, patients, and visitors.

The bill allows for health care practitioners to directly transport an individual to a hospital for an emergency evaluation. In these cases, is there a way for the hospital to request a peace officer to be present if the patients poses a danger to themselves, hospital staff, other patients, or visitors? This is a gap not addressed by the bill. Nurses are concerned because of the high rate of workplace violence they face, particularly in emergency rooms.

Thank you for your consideration of our testimony. We would be happy to work with the bill sponsors, Committee members and other stakeholders in addressing these concerns so that the legislation can move forward. If we can provide any further information, please contact Robyn Elliott at relliott@policypartners.net or (443) 926-3443.