MARYLAND OFFICE OF THE PUBLIC DEFENDER

POSITION ON PROPOSED LEGISLATION

BILL: **HB0029 -- STANDARDS FOR INVOLUNTARY ADMISSIONS AND PETITIONS FOR EMERGENCY EVALUATION – SUBSTANCE USE DISORDER**

POSITION: **Unfavorable**

DATE: **January 29, 2021**

The Maryland Office of the Public Defender respectfully requests that the Committee issue an unfavorable report on House Bill 29.

The Mental Health Division of the Maryland Office of the Public Defender represents individuals facing involuntary commitment to psychiatric facilities in over 35 private and State psychiatric hospital/facilities across the State of Maryland. We represent approximately 800 clients per month at involuntary civil commitment hearings. We understand that there is a serious substance abuse crisis in our State, but oppose this bill because it will not help individuals suffering from substance use disorders, and it will cause harm to individuals with mental illness who require treatment in an inpatient setting.

Altering Maryland's current standards for involuntary psychiatric commitment to allow the involuntary commitment of individuals with substance use disorders will pit individuals with substance use disorders against individuals with serious mental disorders as both groups of Marylanders compete for finite mental health treatment resources.

There are a limited number of involuntary inpatient psychiatric beds in Maryland. There is presently a shortage of inpatient psychiatric beds for individuals who meet the current criteria for involuntary commitment. Expanding the criteria to make potentially thousands more Marylanders eligible for involuntary commitment will only compound that problem. Current Maryland law provides a number of due process protections for individuals who have been seized pursuant to an emergency petition and transported to an emergency department for evaluation. These protections include the following requirements:

1. That a physician examine the emergency evaluee within 6 hours of admission to the emergency department to determine whether the evaluee meets the requirements for involuntary admission. *MD Code, Health-General Section 10-624;*
2. That the physician or psychologist who has certified an emergency evaluee for involuntary admission to an inpatient psychiatric facility notify the Department of

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Health within 12 hours of certification if the emergency department has not been able to place the certified individual in an inpatient facility. In such cases the Department of Health shall receive and evaluate the individual unless the Department of Health is unable to provide for the placement of the certified individual other than in a facility operated by the Department; and

3. An emergency evaluee may not be kept at an emergency facility for more than 30 hours. *MD Code, Health-General Section 10-624.*

These statutes are violated daily in emergency departments across the State as patients are forced to board in the emergency department for days, weeks and even months waiting for a bed in an inpatient psychiatric facility. This bill would make matters worse leading to over-crowded emergency rooms and longer waits for inpatient beds. The harmful consequences of emergency room boarding have been studied and documented in numerous research articles, including ***The Impact of Psychiatric Patient Boarding in Emergency Departments,*** **B. A. Nicks**[1] **and D. M. Manthey**[1] in which the researchers found that:

"Prolonged ED stays are associated with increased risk of symptom exacerbation or elopement for patients with mental health/substance abuse issues. External stimuli from the busy emergency department can increase patient anxiety and agitation, which is potentially harmful for both patients and staff. Elopement from the emergency department prior to definitive screening and treatment can lead to increased risk of self-harm and suicide. In addition, mental health patients in the emergency department contribute to other system issues such as increased ancillary resource utilization by safety attendants or security officers as a safety measure to protect staff and patients. Poor clinical outcomes, evidenced as delays in care and increases in morbidity and mortality, have been directly associated with ED overcrowding and lack of available emergency beds."

It should also be noted that the Department of Health does not take calls from emergency departments seeking assistance with finding inpatient psychiatric beds, nor does the Department receive and evaluate individuals that emergency departments cannot place.

Involuntary inpatient psychiatric units in Maryland hospitals do not provide drug treatment.

The definition of mental disorder for purposes of involuntary commitment specifically excludes a primary diagnosis of substance abuse. *COMAR 10.21.01.01.02(16)(c)* states that "Mental disorder" does not include mental retardation or a primary diagnosis of alcohol or drug abuse. Consequently, staff at involuntary inpatient units and facilities are not trained substance abuse treatment providers. Some units may offer an occasional AA meeting if there are a sufficient number of patients on a unit who use substances and are interested, but that is the extent of substance abuse treatment available on involuntary inpatient units. A couple of private psychiatric hospitals have co-occurring units that treat individuals with mental health and substance abuse issues but those units treat voluntary patients.

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In 2017, the average stay on an inpatient psychiatric unit in a general hospital in Maryland was 5 days. The average stay in a private psychiatric hospital was 11 days. (Department of Health Joint Chairman Report on Inpatient Psychiatric Bed Capacity, 2018)

The length of stay in both types of inpatient psychiatric facilities has remained constant since at least 2012. Medical insurance companies and Medicaid typically only approve 3-5 days of care upon the hospital's initial request. Inpatient units in general hospitals and private psychiatric hospitals are designed to provide acute care. Patients are stabilized on psychiatric medications and they are released**.** Standard drug treatment for individuals with severe substance abuse disorders typically involves long term stays at inpatient drug treatment rehabilitation facilities. Individuals involuntarily committed to inpatient psychiatric units due to a substance abuse disorders will not receive that type of substance abuse treatment. Substance abusers may not be able to abuse substance while on an inpatient psychiatric unit, but they will be discharged with an essentially untreated substance use disorder.

There are a number of severe collateral consequences resulting from an involuntary civil commitment.

The Maryland Court of Appeals in *D.L. v. Sheppard Pratt Health System, Inc.,et al, 465 Md. 339 (2019)* discussed the significant consequences that flow from an involuntary civil commitment. Those consequences include: (i) potential loss of driving privileges; (ii) prohibitions from engaging in certain occupations; (iii) implications towards child custody disputes; (iv) restrictions on immigration status; (v) implications toward any future involuntary admissions: (vii) certain statutory reporting requirements; and (viii) loss of the second amendment right to own or possess firearms at the State and federal levels. Facilities are required to submit to the Federal Bureau of Investigations National Instant Criminal Background Check System the name and identifying information of the individual admitted, the date of admission and the name of the facility. Individuals with substance use disorders who receive treatment in traditional rehabilitation facilities retain greater privacy over their treatment records, and do not suffer the collateral consequences stemming from an involuntary civil commitment.

For these reasons, the Office of the Public Defender recommends that HB 29 be given an unfavorable report.

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