2021 Maryland "Defining Danger" Bill
Rebuttals to Anticipated Opposing Arguments

1. "Defining the danger standard as proposed will lead to a dramatic and unsupportable strain in already overcrowded and understaffed emergency departments. It is unlikely that many of these individuals will meet the criteria for inpatient admission and will therefore spend hours in an emergency department waiting for service only be to returned to the community." (MedChi)

The bill would add the same definition of "danger to life or safety of the individual or of others" to the inpatient admission standard as it would to the emergency evaluation standard. With consistent training among the professions tasked with applying this definition at each point in the commitment process, there is no reason why the standard should be interpreted more broadly at one point in the process than another.

Nor is there cause for concern that allowing civil commitment of individuals who are not actively violent, suicidal or otherwise posing a risk of bodily injury will lead to a surge in civil commitments that the system could not accommodate. The proposed definition of "danger" is not intended and should not be expected to increase the number of individuals subject to hospitalization. Rather, the intent is to facilitate earlier hospitalization of the same individuals who, if left untreated, will eventually decompensate further and end up hospitalized under more dire circumstances which require longer hospital stays for stabilization. Earlier intervention should ultimately lead to less strain on hospitals by facilitating treatment when illness is less acute, requiring shorter hospitalizations and/or before the need for forensic competency restoration. In addition, the repeated ER visits of those who are unable to care for themselves and are experiencing psychiatric deterioration would be eliminated if earlier hospital treatment is provided.

2. "The State would be better served to expand and develop a more robust crisis response system that can appropriately respond to the needs of the individuals that are intended to be served by this legislation. There are several successful models of crisis response systems across the country -- adoption of a model tailored for Maryland would be a more effective approach than expansion of the use of emergency petitions." (MedChi)

This argument presents a false choice between two policies that are not in conflict and should be pursued simultaneously. There is no question that a more robust crisis response system would enable more Marylanders to access timely mental health care. There is also little reason to believe that this reform alone would enable access for the individuals intended to be served by this legislation, i.e., those who are [quoting the bill] "currently unable to make a rational and informed decision as to whether to submit to treatment." However well-resourced, a crisis response system that depends on the individual's desire for assistance will often be stymied by the inability of many in crisis to recognize their own desperate need.

Ideally, a progressive civil commitment standard and a robust crisis response system work in tandem. A model for this is Tucson, Arizona, where an enlightened commitment law offers one of multiple pathways into care, empowering mobile crisis outreach workers with a critical tool when their best efforts to solicit voluntary treatment fail.

3. The bill is unnecessary because Maryland case law has established that "danger to the life or safety of the individual" in existing law already encompasses grave disability criteria. (MHAM)

In In Re JCN, 460 Md. 371 (2018), the Maryland Court of Appeals held that clear and convincing evidence of the petitioner's "delusion that she could function without medication and follow-up treatment," considered in light of

her life-threatening thyroid condition and severe mental illness, was sufficient to support a finding that she presented a danger to her own life or safety. The decision affirms that a "danger to the life or safety of the individual" arises when mental illness prevents the individual from meeting a basic survival need.

Welcome as it may be, the JCN ruling does not obviate the need for this bill. To the extent that the bill seeks to codify JCN, it is necessary because the frontline implementers of the civil commitment law (law enforcement and evaluating physicians) are much more likely to be aware of statutory language than of court precedent. And unlike the JCN ruling, the bill language is explicit in listing other essential survival needs, in addition to health, that can trigger civil commitment if the individual is unable to meet them: food, clothing, shelter and safety.

The bill also goes beyond the grave disability circumstance addressed in JCN by further recognizing risk of substantial psychiatric deterioration as a danger justifying commitment under certain conditions.

4. Involuntarily committing an individual who poses no current risk of bodily harm to self or others is unconstitutional under the Supreme Court ruling in O'Connor v Donaldson, 42 U.S. 563 (1975). (Disability Rights Maryland)

In O'Connor, the Supreme Court famously held that "a State cannot constitutionally confine without more a non-dangerous individual who is capable of surviving safely in freedom."

Kenneth Donaldson, the psychiatric hospital patient seeking release in O'Connor, had been confined for 15 years in a Florida state hospital with no meaningful attempt to offer him treatment for his purported mental illness. This absence of treatment was critical to the court's analysis of the case. In context, it is abundantly clear that when the court referenced "confinement without more," it meant confinement without treatment. Any doubt about this is settled by a footnote in which Justice Stewart, writing for the unanimous court, points out that "there is no reason now to decide … whether the State may compulsorily confine a non-dangerous, mentally ill individual for the purpose of treatment."

Since civil commitment in Maryland is by definition confinement for the purpose of treatment, O'Connor has no bearing on the constitutionality of this bill. In any event, the bill does not seek confinement of the "non-dangerous," but rather aims to reasonably recognize the inability to meet basic survival needs or protect oneself from significant psychiatric deterioration as forms of danger-to-self. Such commitment criteria are highly common among the states and have never been successfully challenged on constitutional grounds.

5. "More precise guidelines for the dangerousness standard could be better achieved through regulation, and improved provider training to help health care for professionals would apply this standard more consistently." (DHMH under O'Malley Admin.)

A danger standard must be interpreted across a range of participants in the commitment process, including peace officers, mental health practitioners, judges, and families. Law is a much more effective vehicle than health regulation to disseminate knowledge of what "danger" means to these disparate audiences. (Peace officers, for example, carry handbooks which provide reference only to statutes, not regulations.) Laws also receive greater deference from courts, and are more difficult to tinker with or dilute upon the whims of changing administrations. For these reasons, it is essential to enshrine the definition of "danger" in statute, in keeping with the practice of all 46 states that currently provide such guidance.