House Bill 1160: Mental Health Law- Reform of Laws and Delivery of Service
Health and Government Operations Committee
March 9, 2022
Position: Unfavorable

Dear Chairwomen Kelly and Pendergrass and Members of the Senate Finance and House Government and Operations Committees:

The undersigned organizations **strongly oppose House Bill 1017 and Senate Bill 807, as amended, and HB 1160,** which together would significantly expand when and how Marylanders with mental illness can be subjected to involuntary inpatient and outpatient psychiatric treatment. By removing the decision to engage in treatment from the individual receiving services, even absent imminent health and safety concerns, these bills raise serious constitutional issues, will increase existing racial and ethnic disparities in the receipt of involuntary treatment, and will surely exacerbate the long wait times for receipt of mental health services, prioritizing those who do not want treatment over those who do. Combined, these bills will also overrun hospital psychiatric inpatient units with people on Emergency Petitions.

Research shows that the vast majority of individuals with mental illness are better served by access to appropriate behavioral health services in the community. Forced treatment is only appropriate in the rare circumstance when there is a serious and immediate safety threat. Not only is forced treatment a serious rights violation, it is often counterproductive. Fear of being deprived of autonomy discourages people from seeking care. Coercion undermines therapeutic relationships and long-term treatment. The reliance on forced treatment may also confirm false stereotypes about people with mental illnesses being inherently dangerous. Moreover, the experience of forced treatment is traumatic and humiliating, often exacerbating a person's mental health condition. For individuals with developmental and behavioral health disabilities, inpatient psychiatric treatment is rarely the most appropriate clinical intervention, and is often not medically necessary – rather, access to appropriate community services is essential. It is important to note that there is already a wait for psychiatric inpatient beds in Maryland hospitals, due to the lack of sufficient community mental health and behavioral support services for persons with mental health and developmental disabilities. Making it easier to involuntarily commit individuals with mental illness will put added pressure on an already overburdened system.

Data on involuntary commitment collected by the Maryland Office of the Public Defender indicates that Black Marylanders are more likely to be retained at hearing as compared to white peers. This disparity mirrors national disparities related to mental health diagnosis and inpatient commitment. Black individuals on average are up to four times more likely than whites to receive a schizophrenia diagnosis – even after controlling for all other demographic variables, and more than twice as likely to be involuntarily committed to state psychiatric hospitals. Any revision to Maryland's involuntary commitment process must take these disparities into consideration, and changes must be made with an eye toward reducing inequities in how the process is applied.

HB 1017/SB 807 would create an outpatient commitment program in Frederick County that would authorize a court to order an individual with a mental health disability to involuntary outpatient treatment of potentially unlimited duration, upon a finding that an individual is likely to deteriorate to the point where they pose a danger to the life or safety of themselves or others and is unlikely to adequately adhere to treatment on a voluntary basis. Data on outpatient commitment show it confers

no additional benefit above access to effective community services. The threat of forced treatment, with medication that has harmful side effects, often deters individuals from voluntarily seeking treatment. Further, outpatient commitment undermines the therapeutic alliance between the provider and consumer of mental health services.

Similarly, HB 1160, would expand involuntary commitment in frightening ways. The bill would define as "dangerous" those individuals at risk of psychiatric deterioration and broaden commitment to include individuals who are "reasonably expected, if not hospitalized" to present a danger to self or others. However, just because an individual's mental health symptoms may be worsening does not necessarily make them a danger, nor does it mean involuntary hospitalization is the clinically appropriate level of care. And predictions of future dangerousness are notoriously unreliable, with studies consistently finding clinical assessments of future dangerousness to be "accurate in no more than one out of three predictions"[1] and only "slightly more reliable than chance."[2]

The goal of emergency involuntary commitment should be to protect the safety of the individual in crisis, as well as the safety of others. As a clinical tool, it should only be used only as a last resort. We support the use of other treatment services, include ACT team services and peer supports as critical to addressing mental health crises and promoting recovery. In our experience, individuals will be less likely to engage in treatment and will turn away from mental health services if they are coerced into participating into programs or treatment that they do not choose for themselves.

Effective and responsive mental health systems preserve free choice to make medical decisions, listen carefully to consumers, and offer the type of services and support that consumers prefer. Such systems do not simply respond to crises but develop plans in partnership with the individuals they serve to avert crises. Shared responsibility promotes "buy-in" and results in better treatment outcomes. In the long run, the best way to secure "treatment compliance" is to respect consumer choice.

Instead of passing legislation that would expand coercive treatment in Maryland, we urge you to prioritize developing and funding additional community mental health and behavioral support services, establishing treatment alternatives that are trauma-informed, culturally appropriate, and which utilize peers and evidence-based treatment modalities to meet individuals where they are. While these bills appear to target individuals with mental health disabilities, in practice they would also negatively impact on individuals with developmental disabilities, those with traumatic brain injuries, and others with physical and behavioral health disabilities.

Thank you for your careful consideration of these bills. For all of the reasons set forth, we ask the Senate Finance and House Health and Government Operations Committees to give these bills an unfavorable report.

Signed,

Accessible Resources for Independence, 1406B Crain Hwy S #206, Glen Burnie, MD 21061

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[1] Monahan, J., Structured Risk Assessment of Violence, *Textbook of Violence Assessment and Management* 17, 20-21 (Simon and Tardiff eds., 2008).

[2] *See, e.g., In re the Detention of D.W., et. al. v. the Department of Social and Health Services*, No. 90110-4 (Supreme Court of Washington, August 7, 2014)

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Behavioral Health System Baltimore, Tower II, 100 S Charles St 8th floor, Baltimore, MD 21201

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Disability Rights Maryland, 1500 Union Ave., Ste. 2000, Baltimore, MD 21211

The Freedom Center, 202 Perry Pkwy #5, Gaithersburg, MD 20877

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Independence Now, 12301 Old Columbia Pike # 101, Silver Spring, MD 20904

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