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WRITTEN TESTIMONY IN OPPOSITION OF
House Bill 1017: Frederick County – Mental Health Law – Assisted Outpatient Treatment Pilot Program
Health and Government Operations, House
March 9, 2022

Thank you Chair Pendergrass, Vice-Chair Peña-Melnyk, and committee members for your dedication to improving the quality and accessibility of healthcare services for all Marylanders. On Our Own of Maryland 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 provide free, voluntary behavioral health recovery support services to 5,000+ Marylanders.

On Our Own of Maryland strongly opposes HB1017, which would establish an "Assisted Outpatient Treatment (AOT)" preventive outpatient civil commitment pilot program in Frederick County. While not the intent of the bill or its sponsors, the model proposed ignores the reality of our current BH system gaps and barriers, would injure people with behavioral health challenges, and may impede the expansion of effective, evidence-based BH practices such as Assertive Community Treatment, Mobile Crisis Teams, and Peer Support that are already working well in our state.

We need services, not sentences: There is a dire need to increase access and decrease barriers to services for Marylanders living with BH challenges, as recognized in several other bills currently under consideration.[1] Introducing a judicial process not only does nothing to create appropriate and accessible services out of thin air, but adds serious consequences for non-compliance. AOT's unspoken expectations are that the individual, with or without a dedicated supporter, will follow complex rules and requirements even if they are effectively absent from the decision-making process; have time, transportation, and financial resources for multiple service appointments and hearings; and somehow successfully navigate into programs despite well-established BH service network inadequacies. Especially for individuals reliant on public services, added administrative burdens for overworked case managers are likely to result in poorly managed care and increased stigma against individuals enrolled in AOT.

We need to be heard, not handcuffed: Far from a 'lack of insight', individuals have legitimate and rational reasons for not wanting to participate in certain behavioral health services, often based on prior experiences: intense negative side effects from medications, disrespectful or unhelpful treatment by providers, or dehumanizing restraint, seclusion, or even assault during crisis or hospitalizations. Involuntary interventions create fear and distrust, and the significant stigma and trauma of forced treatment has serious long-term consequences for individuals' health and wellbeing:

- "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

[1] Such as 2022 House Bills 8, 48, 97, 129, 293, 407, 408, 421, 517, 529, 578, 625, 684, 912, 935, and others

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."

The absence of the individual's voice in their own treatment decisions under this proposed AOT program is counterproductive and unethical. Self-report of effects and experiences are crucial for safety and quality of care, and require a trusting relationship between the peer and their provider(s). Not only does this bill not include any assessment or accountability mechanism regarding the personal experiences or outcomes of those enrolled, it codifies multiple opportunities for disregarding the input of the individual, up to and including their literal absence. Ignoring Psychiatric Advance Directives is particularly troubling, as PADs are often used to communicate prior negative experiences with specific medications or provider institutions, as well as effective self-help strategies.

We need what helps, not what harms: At least 6 large systematic research literature reviews show very limited to no evidence that mandating outpatient treatment reduces hospital readmissions[2,3] or improves social functioning or psychiatric symptoms.[4,5,6] In fact, over a 12-month period, there was no difference in hospital readmission rates for those who were mandated into treatment when compared to those who received it voluntarily.[7]

It is the availability of appropriate, accessible services – not a loved one's concern, a psychiatrist's prediction, or a judge's order – that determines who receives care in the community, institutionalization, incarceration, or nothing.

What helps people enter recovery is being seen, heard, respected, trusted, and supported. Community-based, person-centered, trauma-informed services like Assertive Community Treatment (ACT), Mobile Crisis Teams, and Peer Support have been shown to improve outcomes in individuals living with severe mental health challenges. ACT teams in particular, which meet people where they are in the community, have been shown to help reduce hospital readmissions and length of stay,[8,9] and improve psychiatric symptoms.[10] The On Our Own affiliated network has demonstrated for decades that collaborative, choice-based peer support works for people with serious BH challenges. All of these services are available, albeit limited, in Frederick County; their enhancement and expansion would likely result in a far greater increase of the types of positive outcomes this AOT program seeks to achieve.

Forced treatment is inherently harmful, and should only be used as the very last resort in situations with significant safety concerns. Maryland has well-established criteria and protocols for involuntary interventions, but the AOT program described by this bill would proactively harm and unnecessarily infringe on the civil rights of people with BH challenges without just cause. **We strongly urge an unfavorable report on SB 807. Thank you for hearing us.**

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[2] Maughan, Daniel & Molodynski, Andrew & Rugkåsa, Jorun & Burns, Tom. (2013). A systematic review of the effect of community treatment orders on service use. Social psychiatry and psychiatric epidemiology. 49. 10.1007/s00127-013-0781-0.

[3] Kisely, S.R, Campbell, L.A, Scott, A (2007). Randomized and non-randomised evidence for the effect of compulsory community and involuntary outpatient treatment on mental health service use. Psychol Med 37(1), 3-14.

[4] Kisely SR, Hall K, Community Health Systems: An updated meta-analysis of randomized controlled evidence for the effectiveness of community treatment orders (March 2014). Canadian Psychiatric Association.

[5] Kisely S.R, Campbell L.A, Preston N.J. Compulsory community and involuntary outpatient treatment for people with severe mental disorders. Cochrane Database Syst. Rev. 3:CL004408. The review was updated in 2011. Cochrane Database Syst. Rev. 2.

[6] Ridgely, M. Susan, John Borum, and John Petrila, The Effectiveness of Involuntary Outpatient Treatment: Empirical Evidence and the Experience of Eight States. Santa Monica, CA: RAND Corporation, 2001. https://www.rand.org/pubs/monograph_reports/MR1340.html.

[7] Ibid

[8] Vijverberg R, Ferdinand R, Beekman A, van Meijel B. The effect of youth assertive community treatment: a systematic PRISMA review. BMC Psychiatry. 2017 Aug;17(1):284. DOI: 10.1186/s12888-017-1446-4. PMID: 28768492; PMCID: PMC5541424.

[9] Ponka D, Agbata E, Kendall C, Stergiopoulos V, Mendonca O, et al. (2020) The effectiveness of case management interventions for the homeless, vulnerably housed and persons with lived experience: A systematic review. PLOS ONE 15(4): e0230896.

[10] Ibid