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WRITTEN TESTIMONY IN OPPOSITION TO SB 480 Mental Health Law – Assisted Outpatient Treatment Programs

Thank you Chair Griffith, Vice Chair Klausmeier, and committee members for your commitment to improving the quality and accessibility of healthcare services for Marylanders. On Our Own of Maryland (OOOMD) is a nonprofit behavioral health 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 throughout Maryland offer free, voluntary recovery support services to nearly 6,500 community members, many of whom live with 'Serious Mental Illness' and socioeconomic barriers.

OOOMD strongly opposes SB 480, which would authorize counties to establish involuntary outpatient commitment programs ("assisted outpatient treatment" or AOT) with parameters significantly outside the current scope of permitted use of forced treatment, and which expose Marylanders experiencing behavioral health challenges to multiple risks for harmful impact.

While we appreciate the sponsors' goal of increasing engagement between people experiencing behavioral health conditions and recovery support services, the program model proposed suffers from a number of serious flaws:

1. The broad eligibility criteria and process associated with AOT programs invites unnecessary, inappropriate, excessive, or malicious potential application.
2. Involuntary treatment is inherently harmful, and involuntary outpatient commitment programs do not produce better outcomes than voluntary programs.
3. AOT programs fail to acknowledge known evidence about the recovery process, address obvious and current structural barriers to seeking and receiving effective behavioral health services, or leverage voluntary best practices (e.g. Assertive Community Treatment, Peer-Delivered Recovery Support Programs, etc.) to achieve the same or better results without infringement on civil rights.

We also respectfully challenge the characterization of people living with 'Serious Mental Illness' as described in the Preamble of the bill:

Engagement is Based in Experience, Not Insight: Many people living with 'Serious Mental Illness' have experienced inaccessible, inconsistent, ineffective, or coercive treatment from our fragmented healthcare system, and it is on the basis of these bad experiences that they hesitate or choose not to further engage. As described in the *SMI Adviser*, a joint resource produced by SAMHSA and the American Psychiatric Association:

"For many people living with SMI, their first contact with the system is during a crisis. This is a time of extreme vulnerability… Some individuals have experienced restraint, seclusion, and/or forced medication. This can result in refusal to re-engage in a system that they do not trust or that causes fear. Some feel that clinicians only remember them as they were during crisis and do not perceive them as they currently are… The failure of clinicians to establish an alliance with the individual is a frequent cause of disengagement or refusal of all treatment."[1]

When it comes to questions of insight, the most pervasive and persistent issue is service systems' lack of acknowledgement and redress to the deep and lasting impact of paternalistic and coercive treatment on individuals' reasonable concerns about violations of bodily integrity, priority for self-protection, awareness of disparate and discriminatory treatment of persons from marginalized identity groups, and subsequent lack of trust in service providers.

Engagement Requires Support for All Life Dimensions: The bill language focuses narrowly on the role of psychiatry and medication, but there are multiple other factors that can support or disrupt both an individual's wellness as well as their ability to participate or 'maintain compliance' in services. Some of these factors include: co-occurring medical conditions, stress in employment, familial, or social relationships, limitations on insurance coverage, lack of financial resources, housing instability, transportation access, and/or the loss of social support and reduced perception of self-worth stemming from experiences of coercive treatment.[2]

Program Design Threatens Patient Rights

The bill proposes an AOT program with excessively broad criteria, and which prioritizes predictions by a single clinician over actual comprehensive assessment of that unique individual's status.

This proposed program would ultimately allow for an individual to be made the subject of a court case wherein they must defend against being involuntarily committed to a required mental health treatment plan (including medication) designed without their consent or involvement, by clinicians with whom they may have no or minimal interaction, and which could rest in large part on the basis of an psychiatric evaluation gained by forceful means initiated via the initial hearing.

Eligibility Criteria: We have serious concerns about the following aspects and implications of the proposed program's eligibility criteria:

- At no point is AOT eligibility limited only to cases where a person is verified as unwilling to voluntarily engage in services. Persons who demonstrate agreement to voluntary treatment should not be subject to involuntary means.

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[1]Henry, Patrick. What are some of the key reasons individuals do not follow up on treatment following their initial engagement for crisis care? SMI Adviser Knowledge Base. November 18, 2021.
[2]Xu, Z., Lay, B., Oexle, N., et al. (2018). Involuntary psychiatric hospitalisation, stigma stress and recovery: A 2-Year study. Epidemiology and Psychiatric Sciences, 28(04), 458–465. https://doi.org/10.1017/s2045796018000021

- The ‘lookback’ period of four (4) years for incidents of hospitalization or harm (threatened or actual) is surprisingly long, and effectively turns voluntary disclosure of distress or voluntary use of emergency behavioral services into evidence for forced treatment.
- The petition may be based on the opinion of a single psychiatrist not required to personally examine the individual, and who is afforded an outsized assumption of reliability with regard to predicting the individual’s current and future medical status and their ability and access to voluntarily use services and support at present or in the future. There is no requirement for clinical assessment of capacity for medical decision-making or for a “thorough psychiatric and physical examination,” which is advised by the American Psychiatric Association’s position statement on involuntary civil commitment “because many patients… also suffer from other medical illnesses and substance use disorders that may be causally related to their symptoms and may impede recovery.”[3]
- There no requirement for a comprehensive evaluation of all current or possibly available support services that may meet the individual’s needs, or for sufficient consideration of the full scope of an individual’s reasons for disengagement or barriers to accessing services, such as economic or logistical barriers, social and cultural considerations, or any history of unsatisfactory, poor, or traumatic previous experiences with healthcare or social service systems. Without this information, an accurate assessment of whether AOT is truly the “least restrictive alternative” and would effectively “maintain the health and safety” of the individual cannot be made.

Petition Process: Embedded in the petition process are multiple opportunities to disregard the individual’s rights, expressed needs, preferences, or choices, including:

- Neither the individual, nor their guardian, nor their health care agent are required to be involved in any treatment plan decisions (including medication) required under the AOT program. Given that most individuals may not have a ready representative or advocate, and that only “a reasonable opportunity to participate” must be offered, this item combined with the short timeline between petition and hearing provides cover for effective silencing of the individual in healthcare decisions about their mind and body.
- Only one specific clinician (psychiatrist) is required to participate in the evaluation and lead the treatment plan design. Sole evaluators are undeniably vulnerable to bias, whether explicit or unintentional, and Maryland’s current involuntary admission certificate requires agreement between two evaluators. While the AOT process as outlined in the bill may in practice involve more than one clinician (ex: providing testimony for petition, treatment plan design, emergency evaluation), the terms as drafted appear to technically allow this to occur on a sequential basis without real-time collaboration or conference.

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[3] American Psychiatric Association (2020). Position Statement on Involuntary Outpatient Commitment and Related Programs of Assisted Outpatient Treatment. APA. https://www.psychiatry.org/getattachment/d50db97b-59aa-4dd4-a0ec-d09b4e19112e/Position-Involuntary-Outpatient-Commitment.pdf

- A Mental Health Advance Directive may be disregarded at the sole discretion of the aforementioned psychiatrist, if assumed to be "contrary to [the individual's] best interest." It is unethical to determine 'best interest' without meaningful consultation with the individual whose interests are at stake, as could be permitted by this program.[4]

Court Ordered Treatment: The hearing to mandate participation in an AOT program must be completed within three (3) business days of the petition, leaving an extremely short time in which the individual must secure legal representation and assemble their defense. Additionally, we are highly concerned about the following aspects of AOT program implementation:

- The hearing may be conducted in the absence of the individual, despite having a significant and lasting impact on their liberty and collateral consequences (e.g. employment opportunities) of an involuntary commitment status determination.
- If the individual refused evaluation at the time of the petition filing, the hearing judge may order the individual to be taken into custody for an emergency psychiatric evaluation without meeting the criteria for Maryland's Emergency Petition process.
- The order for AOT may be established for a period of up to one (1) year, but there is no provision or requirement that court order be immediately terminated as soon as the person no longer meets criteria for involuntary treatment.
- "Material Changes" to the healthcare treatment plan may be made without the prior approval of the court in the case where "circumstances may immediately require" as determined by a singular treating psychiatrist.[5]

People living with 'Serious Mental Illness' already face high levels of stigma that result in a perceived lack of credibility.[6] Maryland and the medical profession have established practices to determine capacity and competency for decision-making in healthcare settings and in legal matters. A program which may result in a long-lasting legal order for medical treatment that may be renewed indefinitely should take every precaution to protect against overriding the civil rights of a person who can be found capable and competent to make decisions about their healthcare, even if their decisions contradict the opinions of some single medical professional.

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[4] 10-6A-03(C)(2) allows for the absence of direct evaluation of the individual prior to petition filing. 10-6A-05(B)(1) allows for disregard of the Mental Health Advance Directive. 10-6A-06(D) allows for a hearing to take place in the absence of the individual against whom the petition has been filed.

[5] 10-6A-07(C) allows for the court to amend the Treatment Plan and require the individual's compliance. 10-6A-07(F) allows for a treating psychiatrist to make material changes without prior approval from the court.

[6] Crichton, P., Carel, H., & Kidd, I. J. (2017). Epistemic injustice in psychiatry. BJPsych Bulletin, 41(2), 65–70. https://doi.org/10.1192/pb.bp.115.050682

Forced Treatment Does More Harm Than Good

Involuntary commitment is rejected by leading health policy organizations including Mental Health America, Bazelon Center for Mental Health Law, and the World Health Organization.[7,8,9] Research has shown that prior forced treatment can negatively impact individuals' future experience with behavioral health care, including voluntarily sought services.[10] To illustrate the intensity and negative impact of forced treatment experiences, we offer these personal examples from our statewide peer network:

- "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."
- "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."
- "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. I have a pre-existing thyroid condition and my psychiatrist had never prescribed it to me because of this. [During one hospitalization] staff informed me that my options were to take Lithium or to do electroshock treatment. I was exhausted…and agreed to take [it]. After release, my psychiatrist immediately took me off it because of how it would affect my thyroid."

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[7] Mental Health America. Position Statement 22: Involuntary Mental Health Treatment. https://www.mhanational.org/issues/position-statement-22-involuntary-mental-health-treatment

[8] Bazelon Center for Mental Health Law. Forced Treatment. https://www.bazelon.org/our-work/mental-health-systems/forced-treatment/

[9] World Health Organization (2021). Guidance on community mental health services: promoting person-centered and rights-based approaches. WHO Report. https://www.who.int/publications/i/item/9789240025707

[10] Strauss, J. L., Zervakis, J. B., Stechuchak, et al (2012). Adverse impact of coercive treatments on psychiatric inpatients' satisfaction with care. Community Mental Health Journal, 49(4), 457–465. https://doi.org/10.1007/s10597-012-9539-5

Lack of Evidence for AOT Outcomes: At least 6 large systematic research literature reviews show very limited to no evidence that mandating outpatient treatment reduces hospital readmissions or improves social functioning or psychiatric symptoms.[11,12,13,14,15] 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.[16] A 2018 systematic review of 41 studies concluded that compulsory community treatment "does not have a clear positive effect on readmission and use of inpatient beds."[17]

Lack of Data on Civil Commitment Practices and Outcomes: Across the country, there is a startling lack of available and transparent data or consistent evaluation regarding how involuntary civil commitment (inpatient and outpatient) is used, and what positive or negative outcomes result. Even those working within behavioral health services may carry incorrect assumptions about eligibility criteria; in a 2001 national survey of psychiatrists, approximately 30% of respondents "gave incorrect answers about… grounds for civil commitment in their state." [18]

Closer to home, the Maryland Behavioral Health Administration's 2021 *Involuntary Stakeholders' Workgroup Report* acknowledged that "there is unclear language in the statutes and regulations, which has led to wide interpretation of the law on involuntary civil commitment" in our state, and recommended both "comprehensive training around the dangerousness standard" and collection of "additional data elements about civil commitment."[19] To our knowledge, neither effort has commenced as of yet.

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[11] Maughan, D., Molodynski, A., Rugkåsa, J., & Burns, T. (2013). A systematic review of the effect of community treatment orders on service use. Social Psychiatry and Psychiatric Epidemiology, 49(4), 651–663. https://doi.org/10.1007/s00127-013-0781-0

[12] 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. *Psychological Medicine* 37(1). https://doi.org/10.1017/s0033291706008592

[13] Kisely S.R & Hall K (2014). Community Health Systems: An updated meta-analysis of randomized controlled evidence for the effectiveness of community treatment order. *Canadian Psychiatric Association.*

[14] Kisely, S. R., Campbell, L. A., & Preston, N. J. (2011). Compulsory community and involuntary outpatient treatment for people with severe mental disorders. *Cochrane Database of Systematic Reviews*. https://doi.org/10.1002/14651858.cd004408.pub3

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

[16] Ibid

[17] Barnett, P., Matthews, H., Lloyd-Evans, B., et al (2018). Compulsory community treatment to reduce readmission to hospital and increase engagement with community care in people with mental illness: A systematic review and meta-analysis. *The Lancet Psychiatry*, *5*(12), 1013–1022. https://doi.org/10.1016/s2215-0366(18)30382-1

[18] Brooks RA (2007). Psychiatrists' opinions about involuntary civil commitment: results of a national survey. *J Am Acad Psychiatry Law*; 35:219–228 as *cited in* https://ps.psychiatryonline.org/doi/10.1176/appi.ps.202000212

[19] Behavioral Health Administration (2021). Involuntary Stakeholder's Workgroup Report.

Better Options Are Available

In practice, AOT programs can fail to acknowledge known evidence about how best to support the recovery process, address obvious and current structural barriers to seeking and receiving effective behavioral health services, or leverage voluntary best practices to achieve the same or better results.

Understanding Recovery: SAMHSA recognizes the four major dimensions that support recovery are health, home, purpose, and community.[20] Recovery is possible for persons who were previously institutionalized and who live with Serious Mental Illness. A 2018 national, geographically stratified, and random cross-sectional survey on recovery and remission from Serious Mental Illness includes the following findings:[21]

- A series of studies show 20% to 70% of people with a carefully determined schizophrenia diagnosis who leave institutional settings experience significant periods of symptom abatement, limited hospitalizations, and enhanced functioning over time.
- Approximately one third of individuals who experienced a serious mental illness in their lifetime reported current "recovery-remission" (i.e. no impairments in the previous 12 months). "This finding is contrary to traditional beliefs about a consistently deteriorating negative outlook… Being in remission does not imply that impairments may not return, but the remission rate is consistent with findings suggesting that these conditions are typically episodic... High levels of quality of life and community participation (e.g., work, school, parenting, leisure and recreation) occur even when impairments are present. Therefore, although one-third of individuals were found to be in recovery-remission over a 12-month period, this likely does not reflect recovery to the degree that these individuals, as well as those still reporting impairments, are leading satisfying and fulfilling lives."

Assertive Community Treatment (ACT): The ACT model is recognized by SAMHSA as an Evidence-Based Practice and has been the subject of more than 25 Randomized Controlled Trials, with research showing it to be effective in reducing hospitalization while being no more expensive than traditional care and more satisfaction to consumers and their families.[22] However, the State of Maryland has only 25 ACT teams in operation,[23] which is insufficient to meet the current demand for voluntary enrollment in these services. Expansion of ACT teams so that any person experiencing 'Serious Mental Illness' in Maryland could receive this high-intensity, cost-effective

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[20] Substance Abuse and Mental Health Services Administration (last updated 2023, Feb 16). Recovery and Recovery Support. *SAMHSA*. https://www.samhsa.gov/find-help/recovery

[21] Salzer, M. S., Brusilovskiy, E., & Townley, G. (2018). National estimates of recovery-remission from serious mental illness. *Psychiatric Services*, *69*(5), 523–528. https://doi.org/10.1176/appi.ps.201700401

[22] Substance Abuse and Mental Health Services Administration (2008). Assertive Community Treatment: The Evidence. *Center for Mental Health Services, SAMHSA, US DHHS*,Pub. No. SMA-08-4344.

[23] As reported by the Evidence-Based Practice Center of the University of Maryland School of Medicine, Department of Psychiatry. https://ebpcenter.umaryland.edu/Training-Topics/Assertive-Community-Treatment/

service would likely result in the sort of positive outcomes desired by proponents of the AOT model, but with a higher degree of confidence and no infringement on civil rights.

Peer Support and Recovery Support Practices: A 2014 study published in the journal *World Psychiatry* identifies 10 empirically-validated interventions that support recovery: peer support workers, advance directives, wellness recovery action planning, illness management and recovery, REFOCUS, strengths model, recovery colleges or recovery education programs, individual placement and support, supported housing, and mental health trialogues.[24] A number of these practices are already available in Maryland, including through On Our Own of Maryland's statewide network of peer-operated Wellness & Recovery Centers. Unfortunately, these tremendously affordable and highly desirable peer-delivered self-management programs and low-barrier, open access community support options are significantly under-resourced.

Conclusion

There is a dire need to increase access and decrease barriers to services for Marylanders living with behavioral health challenges, as recognized in several other bills introduced this session.[25]

SB 480 not only does nothing to create appropriate and accessible services, but it adds serious consequences for individuals determined "non-compliant" in the eyes of a treatment provider. AOT's unspoken expectations are that the individual will follow complex rules and requirements even if they are effectively absent from the decision-making process; will sustain the emotional and legal resources necessary to resist paternalistic or ill-fitting treatment plans or advocate for needed updates; and will somehow successfully maintain consistent care in a variety of services despite well-established network inadequacy and workforce shortages. It is the availability of appropriate, accessible services – not a loved one's concern, a psychiatrist's prediction, or a judge's order – that actually determine who receives care in the community, and who is institutionalized, incarcerated, or offered nothing.

Forced treatment is inherently harmful, and should only be used as the very last resort in situations with significant safety concerns. People experiencing emotional distress need services, not sentences. The best use of state resources is to enhance and expand voluntary, community-based services that are already working well instead of wagering a wealth of unknown consequences through creation of the proposed AOT program.

We strongly urge an unfavorable report on SB 480. Thank you for listening.

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[24] Slade M, Amering M, & Farkas M, et al (2014). Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems. *World Psychiatry*: 13(1):12-20. doi: 10.1002/wps.20084.

[25] Bills from 2023 Legislative Session: SB 362/HB 1249 (Certified Community Behavioral Health Clinics - Established); SB 582/HB 1148 (Behavioral Health Care - Treatment and Access); SB 283/HB 418 (Mental Health - Workforce Development – Fund Established)