Disability Rights Maryland

Empowerment. Integration. Equality.

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SENATE FINANCE COMMITTEE

Senate Bill 453: Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment Programs

February 20, 2024

Position: Oppose

Disability Rights Maryland (DRM) is the protection and advocacy organization for the state of Maryland; the mission of the organization, part of a national network of similar agencies, is to advocate for the legal rights of people with disabilities throughout the state. In the context of mental health disabilities, we advocate for access to person-centered, culturally responsive, trauma-informed care in the most integrated setting available. We appreciate the opportunity to provide testimony on SB 453, which would create an assisted outpatient treatment program (AOT) and authorize nurse practitioners to certify individuals for involuntary admission. DRM opposes SB 453 because it deprives people with mental health disabilities of bodily autonomy, eliminates due process protections, and ignores the states' obligations under the Americans with Disabilities Act to provide services in the most integrated setting available, which includes providing any necessary accommodations to support people with disabilities in making and communicating health care decisions.

I. DRM opposes creation and implementation of Assisted Outpatient Treatment

Proponents of AOT often rely on stereotypes that people with mental health disabilities are dangerous and require treatment to reduce public health risks of untreated mental illness. However, evidence consistently demonstrates that people with mental health disabilities are less likely to be dangerous when compared to the general population.[1] Thus, justifying the need for AOT as a means for reducing violent crime is not based in evidence. People with mental illness may experience increased rates of homelessness; this is not necessarily a result of mental illness, but rather, a result of long-term under-resourcing of voluntary services and supports for people with mental health disabilities.[2] According to the World Health Organization, which recently issued guidance opposing the expansion of involuntary civil commitment, the solution to these issues is not expanding involuntary mental health intervention, but rather enhancing access to a diverse array of flexible and sustainable voluntary resources that have demonstrated efficacy.[3] This approach is also consistent with the National Institute of Minority Health Disparities' recent recognition of people with disabilities as a health disparity population. In accordance with this approach, some voluntary evidence-based approaches that could more effectively address the needs of people with mental health

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[1] Eric B. Elbogen, et al., *Beyond Mental Illness: Targeting Stronger and More Direct Pathways to Violence*, 4 CLINICAL PSYCHOLOGICAL SCIENCE (2016), https://doi.org/10.1177/2167702615619363

[2] World Health Organization, *Mental health, human rights and legislation: guidance and practice*, 106-108 (Oct. 2023)

[3] *Id*. at 1-2.

disabilities include Intensive and Sustained Engagement Teams, Open Dialogue, self-directed mental health services, peer respite, psychiatric advanced directives, and supported decision making.

a. AOT is not an evidence-based method for improving mental health outcomes for people with serious and persistent mental illness.

Despite the claims made by proponents of AOT and the statistics cited in the governor's proposed budget,[4] AOT is not an evidence-based method for delivering care that improves outcomes for people with serious and persistent mental illness.[5] Three randomized controlled trials have been conducted to assess the efficacy of involuntary outpatient treatment relative to the efficacy of those same services when they are offered on a voluntary basis. All three of these randomized controlled trials found that the addition of a court order did not reduce rates of hospitalization, enhance treatment compliance, reduce crime, or save money.[6] More recent meta-analyses further substantiate these results.[7] Instead, the evidence suggests that the improvements touted by proponents of AOT are associated with enhanced access to community services and supports, not the court-ordered nature of mental health treatment.[8]

b. AOT carries significant risks of harm that must be accounted for in assessing whether mandating involuntary outpatient treatment is ethical or legal.

First, research consistently demonstrates that significant racial and class disparities exist in the implementation of AOT programs, as AOT programs disproportionately target Black and Brown

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[4] *Compare* Department of Budget and Management, *Maryland Budget Highlights FY 2025*, 6 (Jan. 7, 2024) ("Funding $3 million to establish Assisted Outpatient Treatment (AOT) programs in counties because studies indicate that in other areas AOT has decreased incarceration by 87 percent and inpatient hospitalizations by 70 percent, leading to 83 percent fewer arrests and a 74 percent decrease in homelessness") *with* Tom Burns *et al.*, *Coercion in Mental Health: A Trial of the Effectiveness of Community Treatment Orders and an Investigation of Informal Coercion in Community Mental Health Care,* NIHR Journals Library (Dec. 2016) (involuntary outpatient treatment orders did not reduce hospitalization and there was no evidence of cost-effectiveness).

[5] Ctr. for Pub. Representation, et al., Involuntary Outpatient Commitment: A legal and policy analysis (June 2023), *available at* https://drive.google.com/file/d/1np9tyej9Jwx6Tkixnd_D4Dg6ZIHHt3w_/view.

[6] Henry J. Steadman, Ph.D. et al., *Assessing the New York City Involuntary Outpatient Commitment Pilot Program*, 52 PSYCHIATRIC SVCS. 330 (2001) (finding court mandated ACT did not lower rates of hospitalization or crime, nor improve treatment compliance); Marvin S. Swartz, M.D., et al., *A Randomized Controlled Trial of Outpatient Commitment in North Carolina*, 52 PSYCHIATRIC SVCS. 325 (2001) (finding a 6-month AOT order demonstrated no improvement in any outcome studied); Tom Burns, et al., *Community treatment orders for patients with psychosis (OCTET): a randomised controlled trial*, 381 LANCET 1627 (May 11, 2013) (finding no reduction in hospitalization was associated with outpatient commitment).

[7] Jorun Rugkasa, *Effectiveness of Community Treatment Orders: The International Evidence*, 61 Canadian Journal of Psychiatry 1 (2016) (meta-analysis of clinical literature around the globe found that involuntary outpatient treatment schemes do not achieve their stated goals of keeping people in treatment and out of hospitals); Tom Burns *et al.*, *Coercion in Mental Health: A Trial of the Effectiveness of Community Treatment Orders and an Investigation of Informal Coercion in Community Mental Health Care,* NIHR Journals Library (Dec. 2016) (involuntary outpatient treatment orders did not reduce hospitalization and there was no evidence of cost-effectiveness).

[8] M. Susan Ridgely et al., *The Effectiveness of Involuntary Outpatient Treatment: Empirical Evidence and the Experience of Eight States*, RAND INSTIT.FOR CIVIL JUSTICE *at* 99 (2001).

people, as well as individuals who are impacted by poverty.[9] The reasons for these disparities is multi-factorial, but much of the disparity arises from the failure to guarantee access to person-centered, culturally responsive, and trauma-informed services that address the unique socio-cultural needs of Black and Brown people as well as those experiencing poverty.[10] Thus, enacting a law authorizing AOT may only exaggerate these racial disparities by penalizing Black and Brown people for the system's failure to meet their needs, rather than investing in the resources necessary to guarantee Black and Brown Marylanders are provided equal access to appropriate health care in the most integrated setting available.

Implementing court ordered treatment such as AOT also increases the risk that people with mental health disabilities will experience unwanted law enforcement interaction, given SB 453's provision authorizing a peace officer to detain and transport an individual for an AOT evaluation and provides that non-compliance with an AOT order can justify an emergency evaluation. Law enforcement responses to people experiencing acute exacerbations of mental illness already account for at least 25% of police killings, and Black people with disabilities account for a disproportionate number of those deaths.[11]

Moreover, the use of involuntary mental health treatment has been known to lead to trauma due to the threat associated with using the court process to compel compliance with mental health treatment. Trauma from involuntary mental health treatment may decrease one's likelihood of engaging in future mental health treatment, cause PTSD, and may even increase an individual's risk for suicide.[12] Thus, the risk of harm associated with AOT is significant, and given the evidence demonstrating that court- ordered treatment is no more effective than voluntary services, the risks associated with AOT likely far outweigh any potential benefits, raising a question as to whether the state has a rational basis for creating an AOT program.[13]

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[9] *See* Marvin S. Swartz, et al., *New York State Assisted Outpatient Treatment program evaluation*, Duke University School of Medicine at vii (2009) (suggesting that the overrepresentation of Black people in New York's Outpatient Civil Commitment program is attributable to their "higher likelihood of being poor, higher likelihood of being uninsured, and higher likelihood of being treated by the public mental health system"). There is also an overrepresentation in Maryland's Public Behavioral Health System, which may suggest the same disparate effect is likely to occur. See SAMHSA, 2022 Uniform Reporting Summary Output Tables Executive Summary (2022), https://www.samhsa.gov/data/sites/default/files/reports/rpt42757/Maryland.pdf

[10] *See* Sirry M. Alang, PhD, *Mental health care among blacks in America: Confronting racism and constructing solutions*, 54 HEALTH SVCS. RSCH. 346-55 (April 2019).

[11] *See* Susan Mizner, ACLU, *Police "Command and Control" Culture Is Often Lethal—Especially for People with Disabilities*, ACLU (May 10, 2018).

[12] Nev Jones, et al., *Investigating the impact of involuntary psychiatric hospitalization on youth and young adult trust and help-seeking in pathways to care*, SOC. PSYCHIATRY EPIDEMIOLOGY (2021) (involuntary treatment deterred future help seeking); Antonio Iudici, MD, PhD, et al., *Implications of Involuntary Psychiatric Admission: Health, Social, and Clinical Effects on Patients,* 210 J. NERVOUS AND MENTAL DISEASE (April 2022) (involuntary or coerced treatment led to worse outcomes relative to those seeking voluntary treatment).

[13] See Courtney A. Bergan, *The Right to Choose and Refuse Mental Health Care: A Human Rights Based Approach to Ending Compulsory Psychiatric Intervention*, 27 J. HEALTH CARE L. & POL'Y 94-95 (2024).

c. AOT may hinder future efforts to create and implement innovative, evidence-based strategies to voluntarily engage people with mental health disabilities in voluntary treatment.

Maryland is an innovator in behavioral health as the state has led the pack in developing peer-led, choice-based services. However, implementing AOT state-wide risks interfering with the development of innovative, equitable, evidence-based behavioral health initiatives that address individuals' needs.[14] While many proponents of AOT suggest that AOT is merely another tool in the toolbox for increasing the spectrum of behavioral health care, this ignores the reality that increasing the use of coercive treatment methods decreases access to voluntary treatment.[15] Thus, if Maryland implements AOT now, prior to piloting less restrictive, voluntary interventions, the state will be less likely to be successful at creating and implementing innovative voluntary interventions in the future.

d. The AOT program as defined in SB 453 may violate the Americans with Disabilities Act.

Mental illness is a disability; people with mental health disabilities are afforded the same protections against discrimination and unjust segregation under the Americans with Disabilities Act as individuals with other types of disabilities. AOT stereotypes people with mental health disabilities as incapable of making and communicating healthcare decisions and abdicates the state's obligations to accommodate people with mental health disabilities. Moreover, it fails to guarantee access to care in the most integrated setting available, as well as ensure that individuals with mental health disabilities receive reasonable accommodations to guarantee equal opportunities to access and benefit from public programs, activities, and services.

First, the provisions of SB 453 stereotype individuals with mental health disabilities by suggesting that refusal of treatment is always due to the individuals' inability to recognize their mental illness, therefore justifying the state's ability to force people into treatment through the use of a court order. In reality, people may refuse mental health treatment for a host of reasons including, but not limited to, prior negative experiences in treatment such as lack of informed consent; adverse side effects that may outweigh benefits an individual receives; lack of access to treatments that are needed and wanted; lack of access to basic needs such as housing or food; persistent trauma in treatment settings due to abuse or deprivation of autonomy; and beliefs that individuals with severe mental illness are incapable of knowing their own experiences. Generally, the pathologization of treatment refusal is also limited to medications, rather than other resources and supports. Yet, in reality, only a minority of patients experiencing

[14] *See* Morgan Shields & Rinad S. Beidas, *The Need to Prioritize Patient-Centered Care in Inpatient Psychiatry as a Matter of Social Justice*, 3 JAMA HEALTH F. 1 (2022) (threat of involuntary care and informational disparities creates subdued market demand for quality which makes patients more vulnerable to abuse and reduces treatment choices); Morgan C. Shields & Ari Ne'eman, *Expanding Civil Commitment Laws Is Bad Mental Health Policy*, HEALTH AFFAIRS (Apr. 6, 2018).
[15] *See id*.

psychosis benefit from taking psychiatric medications long term. [16] Even amongst those patients who obtain significant benefits, those benefits may still come with significant risks of side effects.[17] It is important to remember that concerns about medication side effects, such as tardive dyskinesia, do not amount to an inability to recognize an individual's need for treatment, as it is understandable that individuals with mental health disabilities may refuse treatment when the risks are experienced as outweighing potential benefits. Therefore, it is essential that patients have the opportunity to explain the unique risks and benefits they experience with psychiatric medications, and that they not be forced into treatment for the purpose of taking medications over their express refusal.

Second, under Title II of the Americans with Disabilities Act, public entities must provide services to people with disabilities in the most integrated setting available. The United States Department of Justice (DOJ) defines integrated settings as those that, "afford individuals choice in their daily life activities" and "offer access to community activities and opportunities at times, frequencies and with persons of an individual's choosing."[18] AOT's deprivation of choice about whether an individual engages in services and the types of services an individual must participate in, potentially contravenes the state's Olmstead obligations, especially if these same individuals may lack access to the same levels of voluntary services in the public behavioral health system. Under the provisions of SB 453, the eligibility for an AOT order would be broader than the eligibility for voluntary services in the public behavioral health system.[19] Eligibility for Mobile Treatment Services (which encompasses Assertive Community Treatment) in the public

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[16] Research suggests only one-third of people experiencing psychosis require and benefit from psychiatric medications, and only one-fifth of patients may need ongoing medication treatment. *See* Jaakko Seikkula, et al., *Five-year experience of first-episode nonaffective psychosis in open-dialogue approach: Treatment principles, follow-up outcomes, and two case studies*, 16 PSYCHOTHERAPY RSCH. 214 (March 2006) (when psychotherapy was used as a primary intervention and anti-psychotics only administered as an adjunct for those unresponsive to primary intervention, only 33% of the cohort required anti-psychotic medication, and only 20% required regular anti-psychotic medication); *see also* Brett J. Deacon, *The biomedical model of mental disorder: A critical analysis of its validity, utility, and effects on psychotherapy research*, 33 CLINICAL PSYCH. REV. 846-61 (Apr. 8, 2013).

[17] Beng-Choon Ho et al., *Long-Term Antipsychotic Treatment and Brain Volumes: A Longitudinal Study of First-Episode Schizophrenia*, 68 ARCHIVES GEN. PSYCHIATRY 128 (2011) (documenting long term antipsychotic use associated with longitudinal dose-dependent decreases in global brain volume that is not explained by symptom severity or drug use); Martin Harrow et al., *A 20-Year Multi-Follow Up Longitudinal Study Assessing Whether Antipsychotic Medications Contribute to Work Functioning in Schizophrenia*, 256 PSYCHIATRY RSCH. 267, 269–71 (2017) (finding that long term antipsychotic treatment is associated with worse vocational outcomes when compared with those not prescribed antipsychotic medications); Stefan Weinmann et al., *Influence of Antipsychotics on Mortality in Schizophrenia: Systematic Review*, 113 SCHIZOPHRENIA RSCH. 1, 3–7(2009) (finding that antipsychotic medication is associated with a higher risk of mortality); Katherine Jonas et al., *Two Hypotheses on the High Incidence of Dementia in Psychotic Disorders*, 78 JAMA PSYCHIATRY 1305, 1305 (2021) (reporting that antipsychotic medications are associated with an increased risk of dementia); Nikolai Albert et al., *Cognitive Functioning Following Discontinuation of Antipsychotic Medication. A Naturalistic Sub-Group Analysis from the OPUS II Trial*, 49 PSYCH. MED. 1138, 1143 (2019) (finding that people diagnosed with psychosis demonstrate improved cognitive functioning after discontinuing antipsychotic medications).

[18] C.R. Div., U.S. Dep't of Just., *Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C*. (Feb. 28, 2020).

[19] *See* Optum, *State of Maryland Medical Necessity Criteria,* 21-22 (July 1, 2020).

behavioral health system requires an individual have a DSM 5 diagnosis in the priority population and that the individual experience a pattern of frequent hospitalizations, arrests, or emergency room visits due to their mental illness, which is generally interpreted as twice within the past year, while the provisions of SB 453 make one eligible for involuntary treatment when they have visited an emergency room, been hospitalized, or arrested twice within the past 3 years or when an individual has been a danger to self or others once in the past 3 years.[20] Therefore, the provisions of SB 453 fail to guarantee access to services in the most integrated setting available, making the bill vulnerable to a legal challenge under the Americans with Disabilities Act.

Lastly, both the Americans with Disabilities Act and Section 504 of the Rehabilitation Act afford people with mental health disabilities the right to the reasonable accommodations necessary to guarantee their equal access to public programs and federally funded health care programs, including modifications to program policies or provision of auxiliary aids or services that an individual with a disability may need to make and communicate health care decisions. Some examples of potential accommodations that may assist many with severe mental illness to make and communicate health care decisions could include auxiliary services to assist with communication of needs; decision-making supports such as psychiatric advanced directives and supported decision-making; access to increased treatment choices; access to specialized providers; enhanced social supports; extending appointment times; enhanced peer support; programs that use intensive and sustained engagement; and expanded home and community-based services. A court order mandating participation in treatment over an individual's express refusal is not an accommodation of the individual's disability; rather, it undermines the principle outlined in United States Department of Justice regulations that the requests of individuals with disabilities are entitled to primary consideration in selecting auxiliary aids or services that are most appropriate for their needs.[21] Deprivation of disabled people's rights to bodily autonomy is the type of discrimination that the Americans with Disabilities Act was enacted to protect against.[22]

e. The AOT program proposed in SB 453 would jeopardize the bodily autonomy of people with mental health disabilities, a right guaranteed under the 14th Amendment of the U.S. Constitution and Article 24 of the Maryland Declaration of rights.

Generally, States' police powers only permit legislatures to create narrow exceptions to the overall right to refuse treatment when a patient's refusal of medical intervention may endanger the general health and welfare of others and the need for medical intervention is narrowly

[20] *Id*.
[21] 28 C.F.R. § 35.160 (b)(2) ("In determining what types of auxiliary aids and services are necessary, a public entity shall give primary consideration to the requests of individuals with disabilities. In order to be effective, auxiliary aids and services must be provided in accessible formats, in a timely manner, and in such a way as to protect the privacy and independence of the individual with a disability.").
[22] *See* 42 U.S.C. § 12101 (ADA legislative history).

tailored to further a compelling state interest.[23] Moreover, public health legislation compelling treatment over an individual's refusal also cannot rely solely on benefits conferred to a third party.

While proponents of SB 453 insist that AOT has been found Constitutional when challenged in other states, these challenges have occurred in state courts, and thus they cannot be presumed to be consistent with the unique provisions of the Maryland constitution.[24] This is especially true given the significant variation in AOT laws across states. Also, of note is the reality that all controlling U.S. Supreme Court precedent on involuntary civil commitment was decided prior to the passage of the Americans with Disabilities Act. Thus, it is not known how the passage of the ADA in conjunction with Constitutional challenges, might impact legal challenges in the context of involuntary civil commitment.

The right to refuse unwanted medical intervention was first discussed by the United States Supreme Court in *Jacobson v. Massachusetts*.[25] Importantly, *Jacobson* addressed the issue of court-ordered medical care; imposed the consequence for noncompliance was a monetary fine rather than forced medical care. The U.S. Supreme Court determined that the state may impose "reasonable regulations" compelling an individual to submit to medical treatment, when doing so is necessary for the safety of the community.[26] However, the Court also cautioned against the abuse of the state's police powers to coerce medical intervention, when doing so may impose an undue risk to an individual or is not necessary for the safety of the community. In fact, the *Jacobson* Court went as far to specify that courts are compelled to interfere with "arbitrary, unreasonable" and "oppressive" public health regulations that contravene the Constitution, including those that are otherwise valid, but are cruel and inhumane when applied in the context of an individual's particular condition.

While *Jacobson* was decided over a century ago, courts have relied on this framework to identify the existence of a fundamental right to refuse unwanted medical intervention. *Cruzan by Cruzan v. Dir. Missouri Dep't of Health*,, which established the right to refuse medical intervention even cites prior cases involving involuntary mental health care, stating "[t]he State's imposition of medical treatment on an unwilling competent adult necessarily involves some form of restraint and intrusion" and thus, "such forced treatment may burden that

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[23] *See, e.g.*, *Washington v. Glucksberg*, 521 U.S. 702, 720-21 (1997) (identifying a fundamental right to refuse life sustaining care); *O'Connor v. Donaldson*, 422 U.S. 563, 575–76 (1975) ("a State cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends.").

[24] One notable difference between challenges in other states and Maryland, is that Maryland courts have found the state's parens patriae authority is limited to individuals who are deemed to be incompetent to make medical decisions, so reliance on the state's parens patriae authority to uphold AOT is unlikely to be successful. *See, e.g.*, Williams v. Wilzack, 319 Md. 485, 573 A.2d 809, 812 (1990) (striking down a state statute ordering involuntary psychiatric medication over individuals' express refusal).

[25] *Jacobson v. Massachusetts,* 197 U.S. 11 (1905).

[26] *Id.* at 24–25 (holding that states may enact laws mandating medical treatment when they are reasonably expected to protect public safety).

individual's liberty interests as much as any state coercion."[27] In refining the right to refuse unwanted medical intervention, the U.S. Supreme Court also found a fundamental right to refuse unwanted life sustaining care in *Washington v. Glucksberg*, reasoning that the "State's interest here goes beyond protecting the vulnerable from coercion; it extends to protecting disabled and terminally ill people from prejudice, negative and inaccurate stereotypes, and 'societal indifference.'"[28] Moreover, Maryland courts have specifically found that lack of insight and the inability to recognize one's need for life-sustaining treatment does not justify involuntary medical intervention that is provided over one's express refusal.[29]

Additionally, justifying involuntary mental health treatment to reduce the need for institutionalization is likely not a legitimate rationale to override an individual's right to refuse care based on Maryland's current case law[30] and such rationale misconstrues the ADA's integration mandate, which specifically forecloses on a state's right to impose unwanted mental health care to preserve access to the community.[31] Using such rationale to justify public health legislation ignores the historic misuse of involuntary intervention such as in *Buck v. Bell*, which justified involuntary sterilization to "enable those who otherwise must be kept confined to be returned to the world, and thus open the asylum to others." [32] *Buck v. Bell* cast a shameful shadow over our country's history and should serve as a cautionary tale when enacting legislation that overrides the fundamental rights of those with mental health disabilities.

f. **The AOT program proposed in SB 453 may deprive people with mental health disabilities of equal protection under the law, a right guaranteed under the 14th Amendment of the U.S. Constitution and Article 24 of the Maryland Declaration of Rights.**

Maryland prides itself on being a behavioral health innovator and a sanctuary state that guarantees bodily autonomy for marginalized communities, as the state has instituted protections to guarantee rights to gender-affirming care and abortion rights. Yet, by implementing AOT, Maryland would not be demonstrating the same respect for bodily autonomy rights for people with mental health disabilities. While proponents of AOT suggest forced treatment is justified based on the idea that people with severe mental illness do not recognize their illness or need for treatment, the Maryland courts have not found the inability to recognize one's need for treatment justifies subjecting people with life-threatening physical

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[27] *Cruzan by Cruzan v. Dir., Missouri Dep't of Health*, 497 U.S. 261, 288 (1990) (O'Connor, J. concurring) (citing *Washington v. Harper,* 494 U.S. 210, 221 (1990); *Parham v. J.R.*, 442 U.S. 584, 600 (1979)).

[28] *Washington v. Glucksberg*, 521 U.S. 702, 720-21 (1997) (citing *Cruzan*, 497 U.S., at 278–279).

[29] *Stouffer v. Reid*, 993 A.2d 104, 111 (Md. 2010).

[30] S*ee, e.g., Allmond v. Md. State Dep't of Health & Mental Hygiene*, 442 Md. 592, 618 (2016) (finding promoting access to care in the least restrictive setting available was not a valid justification for authorizing involuntary medication).

[31] *Olmstead v. L.C.*, 527 U.S. 581, 607 (1999) ("under Title II of the ADA, States are required to provide community-based treatment for persons with mental disabilities when the State's treatment professionals determine that such placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated")

[32] *Buck v. Bell*, 274 U.S. 200, 208 (1927).

conditions to involuntary treatment.[33] Therefore, implementing AOT based on the inability to recognize one's need for treatment may violate the state's obligations to guarantee equal protection of the laws.[34]

Therefore, DRM believes that AOT is ineffective public health policy that risks depriving people with mental health disabilities of legal and constitutional rights.

II. DRM opposes the provisions of SB 453 that reduce protections for involuntary civil commitment by authorizing nurse practitioners to certify people for involuntary admission.

DRM also opposes the addition of nurse practitioners to the health care professionals who can certify people for involuntary admission to psychiatric hospitals, as nurse practitioners have less training in screening for somatic conditions that may cause an acute change in mental status, and they have less training in the evaluation and treatment of mental illness. DRM has witnessed that as community programs have increased reliance on nurse practitioners, individuals in these programs are more likely to be improperly subjected to emergency petitions due to a lack of training and experience on the part of the program staff; we fear that a similar scenario could result if nurse practitioners are authorized to certify people for involuntary admission. DRM is concerned that allowing nurse practitioners to certify individuals with mental illness for involuntary admission to psychiatric hospitals may increase the risk that those individuals with mental illness will be erroneously deprived of their right to liberty.

In summary, DRM strongly opposes SB 453 due to the risk that it may deprive individuals with mental health disabilities of bodily autonomy rights and jeopardize efforts to create an innovative, person-centered, culturally responsive, and trauma-informed behavioral health system in Maryland. Please contact Courtney Bergan, Disability Rights Maryland's Equal Justice Works Fellow for more information at CourtneyB@DisabilityRightsMd.org or 443-692-2477.

Attachment:

1. World Health Organization, *Mental health, human rights and legislation: Guidance and practice,* Executive Summary (Oct. 9, 2023), full report available at https://www.who.int/publications/i/item/9789240080737.

[33] *E.g.*, *Stouffer v. Reid*, 993 A.2d 104, 111 (Md. 2010) (finding a patient has a right to refuse somatic care for treatable medical condition, even if refusing treatment was fatal and the patient lacks insight into their condition because states interest in preserving life is not sufficient to override a patient's right to refuse care).
[34] *See* Courtney A. Bergan, *The Right to Choose and Refuse Mental Health Care: A Human Rights Based Approach to Ending Compulsory Psychiatric Intervention*, 27 J. HEALTH CARE L. & POL'Y 94-95 (2024).

ATTACHMENT 1

Mental health, human rights and legislation

Guidance and practice

World Health Organization

UNITED NATIONS HUMAN RIGHTS OFFICE OF THE HIGH COMMISSIONER

Executive summary

Introduction

Mental health is a growing public health priority and human rights imperative. As a result, increasing numbers of countries are adopting or reforming mental health-related legislation. Existing legislation often fails to address the social and economic factors that affect mental health, and can thereby perpetuate discrimination and human rights violations, such as denial of legal capacity, coercive practices, institutionalization, and poor-quality care, including in mental health care settings.

In response, the World Health Organization (WHO) and the Office of the United Nations High Commissioner for Human Rights (OHCHR), among other international stakeholders, are actively advocating for a human rights approach to mental health. The international human rights framework, particularly the Convention on the Rights of Persons with Disabilities (CRPD), calls for a significant shift from biomedical approaches towards a support paradigm that promotes personhood, autonomy, and community inclusion.

This joint WHO–OHCHR publication, *Mental health, human rights and legislation: guidance and practice* (hereinafter, "the Guidance"), aims to assist countries in adopting, amending, or implementing legislation related to mental health. Its objective is to ensure that mental health policies, systems, services, and programmes provide high-quality care and support for all, in line with international human rights standards, including the CRPD. The Guidance encourages the integration of mental health into general legislation rather than the adoption of mental health-specific laws.

The Guidance is intended for legislators, policy-makers, and professionals involved in mental health legislation and care. It may also be helpful to those working in related fields, such as United Nations entities, government officials, persons with mental health conditions and psychosocial disabilities, professional organizations, family members, civil society organizations, organizations of persons with disabilities, humanitarian workers, community-based organizations, faith-based organizations, researchers, academics and media representatives.

The Guidance has three chapters and a checklist covering the process and content of ensuring rights-based legislation:

- **Chapter 1** discusses the challenges associated with current mental health legislation and highlights the need for reforms that align with the international human rights framework.
- **Chapter 2** describes the main principles and issues that legislation on mental health should incorporate, with examples of rights-based provisions.
- **Chapter 3** explains how to develop, implement, and evaluate mental health-related legislation following a rights-based process.
- **Checklist** for countries to evaluate whether their legislation adopts a rights-based approach.

Chapter 1. Rethinking legislation on mental health

Mental health and well-being are strongly associated with social, economic, and physical environments, as well as poverty, violence, and discrimination. However, most mental health systems focus on diagnosis, medication, and symptom reduction, neglecting the social determinants that affect people's mental health. Too many people experience discrimination and human rights violations when seeking mental health care and support: some are denied care because of their race, gender, sexual orientation, age, disability, or social status. Others are exposed to poor-quality services and inhuman living conditions, without safe water and basic sanitation or are subjected to treatment that is dehumanizing and degrading. Involuntary hospitalization and treatment, seclusion or solitary confinement, and the use of restraints are also prevalent in most mental health systems. Women, girls, and people with diverse sexual orientation, gender identity, gender expression and sex characteristics (SOGIESC) can further face harmful practices, such as forced sterilization, coerced abortion, and conversion therapies. The widespread human rights violations and harm caused by mental health systems has led to a legacy of trauma that impacts many individuals and communities and spans generations.

During the past 150 years, legislation on mental health has legitimized and, in some cases, facilitated these human rights violations: early laws consolidated paternalism and the concept that people with mental health conditions and psychosocial disabilities are "dangerous". Existing mental health laws have significant implications for human rights, being often outdated, narrow in their understanding of human rights, and reliant on a reductionist biomedical model. The stand-alone legislation of most countries includes provisions to limit rights, such as through involuntary commitment and forced treatment, restraint, and seclusion. Furthermore, mental health laws often reinforce power structures and contribute to the oppression of marginalized populations. While the adoption of the Convention on the Rights of Persons with Disabilities (CRPD) has renewed interest in revisiting legislation on mental health from a human rights perspective, most countries have not challenged longstanding biomedical approaches and compulsory treatment powers.

The international human rights framework requires that countries adopt a rights-based approach to legislation on mental health. Mental health is a fundamental human rights concern and essential to realize the right to health. The CRPD reinforces the protection of international standards of human rights in mental health care and recognizes that the rights of persons with mental health conditions and psychosocial disabilities are equal to those of any person. The CRPD creates an enabling legal environment from which to develop rights-based mental health systems that prioritize a person's empowerment and active participation in their own recovery.

Legislation on mental health must therefore take a new direction away from the narrow traditional "biomedical paradigm" that has contributed to coercive and confined environments in mental health services *(16)*. To achieve this and fully embrace human rights, the Guidance proposes new approaches, such as setting a clear mandate for mental health systems to adopt rights-based approaches; enabling person-centred and community-based services; raising awareness and challenging stigma; eradicating discrimination and coercion; promoting community inclusion and participation; and developing accountability measures. Any new direction requires the engagement and participation of those with lived experience, including experience of intergenerational trauma, in shaping the law to reflect and respond to their perspectives in the pursuit of recovery, reparation and healing. This collaborative approach is essential to create a mental health system that respects human rights, prioritizes care and support over control, and supports individuals in achieving their full potential.

Chapter 2. Legislative provisions for person-centred, recovery-oriented and rights-based mental health systems

Chapter 2 proposes a set of legislative provisions that countries can adopt to support a human rights-based approach to mental health. It covers areas in which legislation can protect, promote, and support international human rights treaties as they pertain to mental health. It also offers examples of texts and provisions that different countries have adopted, with detailed guidance for drafting rights-based provisions. The areas covered are:

Equality and non-discrimination: key national legislative provisions for upholding the principles of equality and non-discrimination in the mental health system and ensuring the equal enjoyment of rights for all people in the provision of mental health services. Examples include the prohibition of all forms of discrimination, including in health insurance and in the provision of reasonable accommodation; challenging stigma and discrimination in communities; and the equal recognition of rights within mental health services, including in relation to access to information, confidentiality, privacy, and facilities.

Personhood and legal capacity: important legislative provisions for the recognition of and respect for the legal capacity of people using mental health services and providing them with appropriate support if required. Examples include the prohibition of substitute decision-making; making available supported decision-making; safeguarding a person's will and preferences; and respecting children's evolving capacities.

Informed consent and eliminating coercive practices: essential legislative provisions for eliminating coercion in mental health services and upholding the right to free and informed consent. Examples include promoting and protecting the right to free and informed consent; supporting advance planning; the provision of crisis support; the prohibition of involuntary hospitalization and treatment; and eliminating seclusion and restraint.

Access to quality mental health services: important provisions for addressing these issues with a view to eliminating barriers to accessing good-quality mental health services and support. Examples include ensuring parity between physical and mental health; the availability, accessibility, acceptability and quality of mental health services; financing; and gender, cultural and age considerations in mental health care.

Implementing mental health services in the community: key provisions for transforming and implementing person-centred and rights-based community mental health and support services. Examples include integrating mental health in general health care settings; developing person-centred and rights-based community mental health services; integrating peer-led and peer-run services; and supporting deinstitutionalization.

Full and effective participation in public decisions: important legislative provisions for recognizing and supporting the rights of people with lived experience to participate and be actively involved in all public decision-making processes concerning mental health systems.

Accountability: legislative provisions to ensure and enforce accountability within mental health services. Examples include strengthening information systems; establishing independent monitoring bodies; and initiating effective mechanisms for remedies and redress.

Cross-sectoral reforms: principal legislative provisions dealing with the interface between mental health and other sectors, including the judiciary. Examples include promoting community inclusion and multisectoral coordination and action; supporting organizations of persons with lived experience and families; and their access to justice.

Chapter 3. Developing, implementing and evaluating rights-based legislation on mental health

This chapter emphasizes the importance of adopting a human rights-based approach when reviewing or adopting legislation related to mental health. It outlines the basic steps to be taken in the process, including:

- involving and consulting persons with lived experience and their representative organizations;
- understanding the international human rights law framework;
- conducting a comprehensive review of legislation on mental health;
- assessing the barriers to rights-based mental health care; and
- drafting and debating a proposal for mental health related legislation.

The Guidance also identifies entry points for advocacy and mobilization and discusses the process of implementing the law. This includes the role of bodies responsible for implementation; the development of regulations and other guidance; the importance of public education and awareness; and the training of key stakeholders.

In conclusion, the Guidance highlights the importance of evaluating the law and suggests a number of policy options for carrying it out.

Checklist for assessing rights-based legislation on mental health

The checklist forms an important part of the Guidance by providing a practical way for countries to determine whether mental health-related legislation or a draft bill are compliant with international human rights obligations. It aims to identify the principal issues that need to be addressed to ensure that the legislation is rights-based.

The main content of the Guidance should be referred to when using the checklist, as the questions are not exhaustive.