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Senate Finance Committee

SB 453- Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment Programs

Position: Oppose

Dear Madame Chair and Members of the Committee:

I am writing as a concerned Marylander and an individual who has been labeled with "serious and persistent mental illness" to express my strong opposition to SB 453's authorization and implementation of Assisted Outpatient Treatment, while also making changes to procedures for inpatient civil commitment which could authorize nurse practitioners to certify an individual for involuntary admission. I was first forcibly hospitalized when I was 15 years old, and that led to nearly two decades of forced and coerced treatment with over 30 hospitalizations, along with several stays in long-term residential treatment facilities. I was deemed "treatment resistant," "non-compliant," and even "hopeless" by the professionals who were supposed to be helping me. Being coerced into treatment more times than I can count only contributed to significant trauma, and increased my sense of shame and hopelessness, leading to multiple suicide attempts that left me in the ICU and increased resistance to engaging in treatment voluntarily. While now you may look at me and think that is hard to believe, that is only because I was finally afforded dignity, respect, and choice in mental health treatment.

Some, including the proponents of this bill, insist that forced treatment is necessary to save lives, and some may even suggest I am only alive because of forced psychiatric intervention. Many who used coercion and force to compel my compliance with treatment indicated that they were concerned for my safety, and they were just trying to save my life, and I believe those concerns were mostly genuine, but perhaps the response misguided. However, there were also times when those concerns were not genuine, and compulsory intervention was misused in situations where I was experiencing significant interpersonal violence. I can tell you that my life was not "saved" by involuntary intervention, and the false dichotomy of forced treatment or no treatment is only a distraction from the real need, which is focusing on how we can effectively support and accommodate people with mental health disabilities so they can have access to informed choices.

For me, I was granted access to appropriate mental health supports just five years ago after I testified before the Maryland General Assembly. Only then, did I receive access to voluntary, high-quality, clinically appropriate, trauma-informed, and culturally responsive services and supports that accommodated my various disabilities and other needs. Being afforded autonomy, choice, and material resources allowed me to return to school in 2020 and this past November I was sworn in to the Maryland Bar. After realizing that my experience with coerced and forced treatment was not an outlier, but rather forced treatment resulting in trauma is incredibly common, I've decided to dedicate my work to enhancing access to person-centered, culturally responsive, trauma-informed, and choice-based support that honors individuals experiences. Last

month, I even published a law review article that is based off my combined personal and professional experiences.[1]

So, while you may look at me now and believe that I am different than those who you envision qualifying for AOT, I can assure you, even now I would still qualify for AOT under the criteria set forth in SB 453. I am only the exception in how people perceive people with severe and persistent mental illness because I was offered the unique opportunity to access services that conformed to my needs rather than being forced to conform to a system that was causing me harm. I am not the exception in being able to live a full and meaningful life when afforded access to clinically appropriate, culturally responsive, choice-based supports.

For me, there were three life-changing moments which enabled me to voluntarily engage in mental health services, all of which involved respecting my autonomy and choices, not coercion.

The first moment came when a public defender stood up and fought for my stated interests, after a hospital tried to claim I was incapable of consenting to treatment. My clinicians claimed I "didn't recognize my need for treatment" after I refused treatment due to severe medication side effects. Being told I couldn't recognize my need for treatment was incredibly dehumanizing and nearly cost me my life because doctors were dismissing my concerns that I couldn't breathe after starting a new medication. In reality, this concern turned out to be a life-threatening reaction to an antipsychotic medication that impeded my ability to breathe and swallow. Despite experiencing involuntary treatment countless times, this public defender was the first to recognize the harm being caused by clinicians dismissing my concerns about treatment. Having someone truly fight for me and my stated interests showed me for the first time in two decades that I was a human being who was worth fighting for. Coerced and forced treatment had been so dehumanizing, that until that moment, I believed I was merely a "parasite," unworthy of dignity, respect, or having my basic needs met.

The second moment came when I was afforded access to a case manager provided to me through another state's Department of Mental Health, who wasn't bound to the limits typically placed on community programs in the public mental health system. She focused on supporting me with getting my basic needs met, in terms of accessing stable housing, food, safety from interpersonal violence I was experiencing, and helping me locate clinically appropriate treatment. While I was reluctant to engage with her because this was part of a program associated with placement in a state hospital, I engaged with her because I realized she was not interested in coercing me into treatment that met her agenda. She was interested in helping me meet my stated needs and remain in the community, even if that might look different than how others might envision.

The final and arguably most important moment came when I gained access to clinically appropriate mental health treatment that honored me as a person and accommodated my disabilities. When this mental health professional said to me, "people need to stop trying to control you and instead support you and encourage you," it helped me realize that perhaps this time really could be different. But it was not a quick fix, as it took years of rebuilding trust that

[1] 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 49 (2024), available at https://digitalcommons.law.umaryland.edu/jhclp/vol27/iss1/6/.

had been broken through prior forced and coerced treatment. It required patience, flexibility, and trial and error. There were still hospitalizations in between, yet slowly but surely over the past five years, I went from spending more days in the hospital than in the community, to spending more time in the community with hospital stays gradually becoming shorter and less frequent as my team collaboratively figured out how to effectively support me in the community. That support required 6 hours of individual professional support per week, monthly medication management with a psychiatrist that is versed in my medical and psychiatric needs, and peer support, all of which is covered by my insurance or grant funded.

Importantly, my clinicians are curious when I refuse treatment, rather than coercive, and that allows me to be open when I think I no longer need a medication or treatment, without fear of being met with force or coercion. Through curiosity we explore and learn together. Sometimes I might still stop taking a medication, but in doing so I usually realize with the support of my now trusted clinicians, that a medication was helping me, so I restart it on my own volition, and occasionally I realize that a medication is no longer helping me so I discontinue it with my team's support. However, opening that dialogue took people listening to my experience, believing that it was true for me, and respecting my choices. It required patience and respect, rather than using fear to coerce my compliance to achieve the outcomes that they desired.

Today I still require and have access to that same level of sustained support that I now engage in willingly and voluntarily because I was offered the time, space, and mutual respect necessary to build trusting and collaborative relationships. While my hospitalizations are less frequent, I would still qualify for an AOT order under the eligibility criteria identified in SB 453 if my family or clinicians who are less familiar with my history, decided to seek that out. I know that I am still vulnerable to involuntary intervention based on the requirements identified in the law and stereotypes about my diagnoses, so I still get panic attacks whenever I hear an ambulance or a police car drive by, thinking that they might be coming to haul me off to a psychiatric hospital where I could be restrained and forcibly medicated for disagreeing with clinicians who don't offer the patience, curiosity, and respect afforded by my current team.

Coercion is neither necessary nor effective in helping people access effective mental health supports or establishing the trust that is most vital to effective mental health treatment. Because we can help and support people without traumatizing them or depriving individuals of bodily autonomy. We can offer help without the risks of harm of forced psychiatric intervention and by doing so, expand access to dignified and compassionate mental health services. If we develop supports that holistically meet individuals needs and develop systems that are designed to adapt to people rather than forcing people to adapt to a system that may not serve them, then coercion and force become unnecessary.

I strongly urge this committee to issue an unfavorable report on SB 453, which risks harming those who are most marginalized by our communities. Maryland is a state that has been an innovator in developing high-quality, peer-led, mental health supports, so let's put these resources towards more effective, voluntary solutions such as peer respite, self-directed mental health services, and intensive and sustained engagement teams that are known to sustainably help people with significant mental health disabilities live meaningful lives, without the need for

coercion or force. Let's maintain Maryland's place of excellence along with Massachusetts and Connecticut by saying "No" to AOT.

If you have any questions, please don't hesitate to contact me via email at cbergan@umaryland.edu.

Sincerely,

Courtney Bergan, J.D.