MCPA-MSA_ SB 453-Mental Health-Emergency Evaluatio
Uploaded by: Andrea Mansfield
Position: FAV

Maryland Chiefs of Police Association
Maryland Sheriffs' Association

MEMORANDUM

TO: The Honorable Pamela Beidle, Chair and
Members of the Finance Committee

FROM: Darren Popkin, Executive Director, MCPA-MSA Joint Legislative Committee
Andrea Mansfield, Representative, MCPA-MSA Joint Legislative Committee
Natasha Mehu, Representative, MCPA-MSA Joint Legislative Committee

DATE: February 20, 2024

RE: **SB 453 – Mental Health – Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment Programs**

POSITION: SUPPORT

The Maryland Chiefs of Police Association (MCPA) and the Maryland Sheriffs' Association (MSA) **SUPPORT SB 453**. This bill, among other changes, authorizes a peace officer to transport an individual subject to an emergency evaluation to a nearby emergency facility instead of nearest; and authorizes a psychiatric nurse practitioner to conduct the examine in addition to a physician.

SB 453 focuses on reforming the behavioral health system to ensure individuals who need services can get them. In addition to authorizing the establishment of Assisted Outpatient Treatment facilities, the bill makes improvements to the emergency transport of individuals needing services and seeks to reduce wait times for individuals to be examined. Often times, the nearest emergency facility is already overcrowded with patients. This means the individual in need of an emergency evaluation must wait an extended time, or the peace officer must be given authority to take the individual elsewhere. These situations already pose an increased risk of volatility, increasing the jeopardy of harm to both the officer and the subject in need of treatment. Once at a facility, if a physician is not available, the individual must wait again for services and if requested, the peace officer is required to stay with the individual until the evaluation takes place.

The changes proposed by SB 453 will streamline the process allowing individuals in need to be seen more quickly and create efficiencies for the peace officer. For these reasons, MCPA and MSA **SUPPORT SB 453** and request a **FAVORABLE** Committee report.

532 Baltimore Boulevard, Suite 308
Westminster, Maryland 21157
667-314-3216 / 667-314-3236

AHarrison FAV Bill SB453.pdf
Uploaded by: Ashlee Reyes
Position: FAV

Favorable Bill SB453
Alexis K. Harrison
Prince George's County

I am a Maryland citizen and State Government Employee. I am concerned about improving treatment for those with a serious mental illness (SMI) -- one of our most vulnerable populations. Maryland needs to establish a strong, evidenced-based assisted outpatient treatment (AOT) program that reduces homelessness, hospitalizations, arrests, incarceration, trauma, and suicide for those with a SMI. An AOT program would be a viable option to address these public health crises.

While it is sadly too late for some with a SMI, passing an AOT bill will save the lives of others with a SMI. Please see the February 5, Baltimore Sun Op-Ed about the tragic loss of life at: https://www.baltimoresun.com/2024/02/05/maryland-assisted-outpatient-treatment/.

It is time for Maryland to join the 47 other states that have laws to authorize an AOT program. Let's help to ensure that no Marylander will be left behind. AOT saves lives!

Please give a favorable report to SB453. Make the right choice for Marylanders suffering with SMI and pass this bill!

BDaly Favorable SB453.pdf
Uploaded by: Ashlee Reyes
Position: FAV

Favorable SB453
Brenda Daly
Prince George's County

I am a longtime friend of a caregiver and the honorary grandmother of her 35-year old son, Ben, who was diagnosed with a severe mental illness (SMI) as a young adult. I knew him most of his life and was proud of him. In December 2023, he tragically passed away. He was found unconscious on the street in Baltimore City as a John Doe because he had no identification. Please read the devastating February 5, Baltimore Sun Op-Ed: https://www.baltimoresun.com/2024/02/05/maryland-assisted-outpatient-treatment/ that addresses how my grandson struggled with staying connected to voluntary outpatient treatment.

Voluntary services alone do not work for everyone with a SMI. I know first-hand that over the years, Ben started at least 11 voluntary outpatient services. At times, some of the treatments were successful and he was in recovery – living on his own, working part-time, interacting with family, friends and engaged in his community. Other times, due to his lack of awareness about his SMI, treatments were not successful. He would stop taking his medication, became psychotic, determined to be a danger to himself, and hospitalized.

Since 2020, he was hospitalized 18 times in six Maryland counties and Baltimore City—where he last lived —. He died after a 30-day voluntary hospital admission. Only one of his 18 admissions were involuntary and 17 were voluntary. My grandson wanted help. He wanted to recover -- but he was unable to stay connected to treatment. This very often caused him to lose his housing, become homeless, and be disconnected from treatment. The cycle would start over but now it is sadly too late for his life to be saved. But the lives of others with a SMI can be saved because assisted outpatient treatment (AOT) programs save lives.

Ben's mother was his biggest advocate to help him get the treatment that he needed. And, she volunteers with several mental health organizations to serve other families and offer improvements to Maryland's public behavioral health system.

How much longer do Maryland families have to suffer watching their loved ones decompensate? How much longer do Maryland caregivers have to watch their loved one's cycle between the ER, hospitals, arrests, jails, and homelessness? How many more individuals with a SMI must die before it is enough? If Maryland had AOT, my grandson would have had a better chance of being successful with treatment compliance in the community. It is time for Maryland to join the 47 other states that have laws to authorize AOT programs.

Please give a favorable report to SB453.

C. Jones Favorable SB453.pdf
Uploaded by: Ashlee Reyes
Position: FAV

Testimony
Supporting Assisted Outpatient Treatment (AOT) Bills in Maryland

16 February 2024

Favorable SB453

Clarence Jones Jr. and Jaculin H. Jones
13016 Weiss Drive
Bowie, Maryland 20715
Prince George's County

We are Maryland citizens concerned about improving treatment for those with a serious mental illness (SMI) -- one of our most vulnerable populations. Maryland needs to establish a strong, evidenced-based assisted outpatient treatment (AOT) program that reduces homelessness, hospitalizations, arrests, incarceration, trauma, and suicide for those with a SMI. AOT saves lives!

We have a family member who has a mental illness. It has been a true journey of the unexpected.

While it is sadly too late for some with a SMI, passing an AOT bill will save the lives of others with a SMI. Please see the February 5, Baltimore Sun Op-Ed about the tragic loss of life at: https://www.baltimoresun.com/2024/02/05/maryland-assisted-outpatient-treatment/.

It is time for Maryland to join the 47 other states that have laws to authorize an AOT program. Let's help to ensure that no Marylander will be left behind.

Please, please, give a favorable report to SB453.

Signed
-s-
Clarence and Jaculin Jones

CMarshall Favorable SB453.pdf
Uploaded by: Ashlee Reyes
Position: FAV

Favorable Bill SB453
Cheryl Renea Marshall
8109 Allentown Road
Ft. Washington, MD 20744

I am a Maryland citizen concerned about improving treatment for those with a serious mental illness (SMI) -- one of our most vulnerable populations. Maryland needs to establish a strong, evidenced-based assisted outpatient treatment (AOT) program that reduces homelessness, hospitalizations, arrests, incarceration, trauma, and suicide for those with a SMI. AOT saves lives!

While it is sadly too late for some with a SMI (especially my oldest son who died 9 years ago from a SMI) passing an AOT bill will save the lives of others with a SMI. Please see the February 5, Baltimore Sun Op-Ed about the loss of life at: https://www.baltimoresun.com/2024/02/05/maryland-assisted-outpatient-treatment/.

It is time for Maryland to join the 47 other states that have laws to authorize an AOT program. Let's help to ensure that no Marylander will be left behind.

Please give a favorable report to SB453.

DPinkett Favorable SB453.pdf
Uploaded by: Ashlee Reyes
Position: FAV

Favorable SB453
Debra Pinkett
Prince George's County

I am a Maryland citizen concerned about improving treatment for those with a serious mental illness (SMI) -- one of our most vulnerable populations. Maryland needs to establish a strong, evidenced-based assisted outpatient treatment (AOT) program that reduces homelessness, hospitalizations, arrests, incarceration, trauma, and suicide for those with a SMI. AOT saves lives!

While it is sadly too late for some with a SMI, passing an AOT bill will save the lives of others with a SMI. Please see the February 5, Baltimore Sun Op-Ed about the tragic loss of life at: https://www.baltimoresun.com/2024/02/05/maryland-assisted-outpatient-treatment/.

It is time for Maryland to join the 47 other states that have laws to authorize an AOT program. Please give a favorable report to SB453 to help ensure that no Marylander will be left behind.

FAV SB 453 Steve Raabe.pdf
Uploaded by: Ashlee Reyes
Position: FAV

Testimony of Steve Raabe
622 Wood Lot Trail Road, Annapolis (Anne Arundel County), MD 21401

Position: Support

I am submitting this testimony in my capacity as President of OpinionWorks LLC, a non-partisan, independent research organization based in Annapolis, to share recent polling on voter attitudes about Assisted Outpatient Treatment (AOT).

These findings are based on our statewide poll of 518 registered voters, commissioned by the Treatment Advocacy Center and conducted online and by telephone by my firm from December 8 to 12, 2023. The poll has a potential sampling error of ±4.3% at the 95% confidence level.

This poll identifies overwhelming support for AOT – with four out of five Maryland voters in favor. This support crosses party lines, and is characterized by a high level of urgency, driven by deep concerns about mental health problems and mental illness in Maryland's communities, and in voters' own families. Voters say AOT offers support to help address these problems in multiple ways.

The law was described to poll respondents as follows:

"State leaders in Maryland are considering a new law to improve mental health called "assisted outpatient treatment." For people with serious mental illness, such as schizophrenia or severe bipolar disorder, the law would let a civil court order supervised mental health treatment and services in their community, in cases where the individual has a history of not following treatment after repeated hospitalizations for mental illness, got mental health services while in jail, or is a danger to themselves or others. No forced outpatient medication or court ordered penalties, such as jail or fines, are allowed."

Voter support for AOT is overwhelming. More than four out of five voters across Maryland (81%) are in favor of AOT. Only about one in ten (11%) are opposed, with 8% unsure.

- Support for AOT crosses all party lines, with 85% of Democrats, 68% of Republicans, and 84% of unaffiliated voters in favor.
- It is supported by 81% of African-American, 92% of Hispanic, 83% of Asian, and 81% of White voters.
- Support is also extremely strong in all regions of Maryland, never falling below 70% in any region of the State.

Several factors help explain the extremely high level of support for AOT. First among these is how serious a problem people feel mental illness is in Maryland's communities today. Seven out of ten voters (70%) believe mental illness is "a serious problem," or "a crisis that needs immediate attention."

This level of concern translates into widespread impatience for action by the State, with a resounding 86% of voters across Maryland saying, "Untreated serious mental Illness is a significant problem in Maryland and should be a top priority for our state."

This issue touches people personally. Mental health issues and mental illness have impacted an enormous number of Marylanders, with 70% saying that they, or someone in their life, has experienced mental health issues or mental illness.

Voters also strongly indicated that they have concerns that people suffering from serious mental illness could be a danger to themselves or others, leading 88% to agree with the statement, "People suffering

from serious mental illness should be required to receive treatment if they are likely to be a danger to themselves or others."

The poll tested a variety of reasons why people might support AOT. Three ideas emerged as the most compelling for voters. Taken together, these arguments identify three important dimensions of voters' support for AOT:

- **Leading the list is this: Voters believe AOT would be effective**, because it "promotes continuity of care, breaking the revolving door of repeat hospitalizations, incarceration, homelessness, and even tragic interactions with law enforcement."
- **The second most compelling reason for voters is the idea that AOT respects people's personal rights.** The idea was expressed like this: "Assisted outpatient treatment helps people with serious mental illness get outpatient treatment in their community, while respecting their personal rights. It does not force people into hospitalization or to take medication."
- **Also scoring very strongly is the support that AOT can provide for families,** stated like this: "Many people who suffer from serious mental illness are unable to recognize that they have a disorder and need assistance. Without assisted outpatient treatment, family members cannot intervene to get necessary mental health treatment for their loved ones."

Voters strongly endorse Assisted Outpatient Treatment because their level of concern about mental health problems in their communities and in their own families is so high, and because they believe this law would help in multiple ways. In fact, this poll conveys a sense of urgency about this issue. Marylanders want the State to act.

A more detailed memorandum outlining the results of the poll is available from the Treatment Advocacy Center.

Thank you for the opportunity to provide this overview of public attitudes about this issue.

Fav SB453 Adrienne Epps.pdf
Uploaded by: Ashlee Reyes
Position: FAV

Favorable SB453
Adrienne Denise Epps
Prince George's County

I am a Maryland citizen concerned about improving treatment for those with a serious mental illness (SMI) - one of our most vulnerable populations. Maryland needs to establish a strong, evidenced-based assisted outpatient treatment (AOT) program that reduces homelessness, hospitalizations, arrests, incarceration, trauma and suicide for those with a SMI. AOT save lives! While it is sadly too late for some with a SMI, please see the February 5, Baltimore Sun Op-Ed about the loss of life at: https://www.baltimoresun.com/2024/02/05/maryland-assisted-outpatient-treatment/, passing an AOT bill will save the lives of others with a SMI.

It is time for Maryland to join the 47 other states that have laws to authorize an AOT program.

Please give a favorable report to SB453.

Fav SB453 Grace Williams.pdf
Uploaded by: Ashlee Reyes
Position: FAV

Favorable Bill: SB453
Grace Williams
Prince George's County

I am a caregiver of an adult loved one diagnosed with a serious mental illness (SMI). I am concerned about improving treatment in Maryland for one of our most vulnerable populations. Maryland needs to establish a strong, evidenced-based assisted outpatient treatment (AOT) program that reduces homelessness, hospitalizations, arrests, incarceration, trauma, and suicide for those with a SMI. AOT programs save lives.

While it is sadly too late for some with a SMI, passing an AOT bill will save the lives of others with a SMI. Please see the February 5, Baltimore Sun Op-Ed about the loss of life at: https://www.baltimoresun.com/2024/02/05/maryland-assisted-outpatient-treatment/.

It is time for Maryland to join the 47 other states that have laws to authorize an AOT program. Let's help to ensure that no Marylander will be left behind.

Please give a favorable report to SB453.

FAV SB453 Kim Parker.pdf
Uploaded by: Ashlee Reyes
Position: FAV

Favorable SB453
Kimberly K. Parker
Prince George's County

I am a mother of a 25-year-old young adult son who is diagnosed with a severe mental illness (SMI). Over the past several years, my son has had several inpatient psychiatric admissions. I had to obtain an Emergency Petition to get him the medical help that he needed.

Upon discharge from the hospital, very often, there is no coordination or connection to outpatient treatment services. Caregivers are expected to fill the gap and link their loved ones to voluntary treatment. This is very challenging and stressful on families.

Last year, within weeks of being discharged from a Prince George's County (PGC) hospital, my son was re-admitted to the same hospital! I had to advocate for something different to happen upon discharge to prevent him from being homeless. My son was admitted to a voluntary residential crisis service (RCS) in Charles County. Today, my son is doing so much better because the RCS was life altering. I want his recovery to continue!

Knowing things could change with having a SMI, an AOT program would provide a treatment option to connect our loved ones to outpatient services. This would lift the burden currently placed on families and caregivers.

While it is sadly too late for some with an SMI, passing an AOT bill will save the lives of others with a SMI. Please see the Op-Ed in the February 5 edition of the Baltimore Sun about the tragic loss of life at: https://www.baltimoresun.com/2024/02/05/maryland-assisted–outpatient

Studies show that AOT programs reduce hospitalizations, violent behavior, and victimization. On top of that, incidents of arrest and incarceration decrease as well. Further, an AOT program could decrease the illegal use of substances and homeless nights, helping counties to save money in ways unimaginable.

It is time for Maryland to join the 47 other states that have laws to authorize an AOT program. Let's help to ensure that no Marylander will be left behind. Please add your voice to the thousands of us crying for an AOT program in Maryland. Together, we can save lives.

Thank you for reading my testimony. Please give a favorable report to SB453.
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FAV SB453 S.Johnson.pdf
Uploaded by: Ashlee Reyes
Position: FAV

Favorable Bill SB453
Sheila Johnson
Prince George's County

I am a long-time friend of the caregiver whose son recently lost his life. Please see the February 5, Baltimore Sun Op-Ed about the loss of another life at: https://www.baltimoresun.com/2024/02/05/maryland-assisted-outpatient-treatment/.

I am aware of the struggles that she and her son experienced trying to get him treatment. As a friend and a citizen, I am concerned about improving treatment for those with a serious mental illness (SMI) -- one of our most vulnerable populations. Maryland needs to establish a strong, evidenced-based assisted outpatient treatment (AOT) program that reduces homelessness, hospitalizations, arrests, incarceration, trauma, and suicide for those with a SMI. AOT saves lives!

While it is sadly too late for some with a SMI, passing an AOT bill will save the lives of others with a SMI. It is time for Maryland to join the 47 other states that have laws to authorize an AOT program. Let's help to ensure that no Marylander will be left behind.

Please give a favorable report to SB453.

Favorable Bill SB 453 Loretta Brown.pdf
Uploaded by: Ashlee Reyes
Position: FAV

Favorable Bill SB 453

Loretta Brown

Maryland Resident

I am a Maryland citizen concerned about improving treatment for those with a serious mental illness (SMI) -- one of our most vulnerable populations. Maryland needs to establish a strong, evidenced-based assisted outpatient treatment (AOT) program that reduces homelessness, hospitalizations, arrests, incarceration, trauma, and suicide for those with a SMI. AOT saves lives!

While it is sadly too late for some with a SMI, passing an AOT bill will save the lives of others with a SMI. Please see the February 5, Baltimore Sun Op-Ed about the loss of life at: https://www.baltimoresun.com/2024/02/05/maryland-assisted-outpatient-treatment/

It is time for Maryland to join the 47 other states that have laws to authorize an AOT program. Let's help to ensure that no Marylander will be left behind.

Please give a favorable report to SB 453.

Thank you,

Loretta Brown

Favorable SB 453 Bradley Tarr.pdf
Uploaded by: Ashlee Reyes
Position: FAV

Favorable: SB 453

Bradley Tarr- AOT graduate

Lexington, Ohio

Good afternoon, my name is Bradley Tarr, I am 30 years old, and I reside in Lexington, Ohio. Thank you for taking time to read my testimony today, in support of SB 453.

I would like to tell you a bit about my experience with mental illness so you can better understand why I support this bill. When I was 11, I was diagnosed with mental illness. From age 11-26, I was in and out of hospitals well over 20 times.

When I was in fourth grade, I went through a major suicidal depressive season. I was eventually sent to Akron Children's Hospital for 2 weeks and was placed on medication. My diagnosis was "Chronic Depression."

While I was in High School, I was virtually a boomerang. I was in and out of the hospital so many times I lost count. Sometimes my symptoms could be triggered by a sports season, by a big test, or by a girlfriend breaking up with me. I experienced suicidal depression, insomnia, brain hypertension, paranoia, and severe manic symptoms. During this time, my psychiatrist was several times over, and each doctor would radically change which meds I was on. One particular medicine gave me such a side effect of rage that I ended up randomly punching several holes in my mom's walls and cabinets.

In my sophomore year, there was even a social media hate group created entitled, "I Survived the Wrath of Brad Tarr." It was a page dedicated to humiliating me, attempting to ruin my reputation, to fan the flames of rumors about my supposed behavior and intentions, and to caricaturing my Christian faith. Fortunately, my principal had it taken down quickly. My diagnoses during that period was "Bipolar Disorder" and "Unspecified Mood Disorder."

Four years later, while I was at college, my symptoms flared up again. I had gone 3 days without sleep, was having angry outbursts over small matters, and was behaving in a paranoid manner. I was pacing around campus, talking to myself. I spent 14 days in a New England hospital, and was then sent home.

Within 4 weeks of being home, my symptoms began scaring my mother. She would lock her bedroom door at night for fear that my delusions or hallucinations would flare up and I would hurt her. I was illogical, I was unreasonable, and my grasp on reality was tenuous at best. She was unable to continue sharing an Apartment with me. I had to get out. It was Winter, and I was homeless. I was estranged from family because none of them knew how to cope with me, not even my siblings. I ended up in a homeless shelter.

I was there for about a month, in small quarters, that were crowded and cramped, with about 12 other people who were far sicker than even I was. After several days of being verbally threatened and bullied by others-- at one point a Schizophrenic man loudly threatened to slit my throat open-- I reared back and punched a hole in the wall of the shelter. This landed in trouble with the Law, and I was placed on 14 months of intensive Mental Health Court Probation. I was happy when I graduated from that program. It was the most trying ordeal of my life.

Two years later, I was super-symptomatic; it was the worst symptomatic season of my entire life. From February-May of 2019, I was hospitalized 5 times. I was depressed, then manic, then depressed again. I had severe bouts of insomnia, paranoia, delusions, and severe headaches. I had visual, auditory, and olfactory hallucinations. My delusions would vary. At one point I thought I was the Director of the NSA. Another time, I was the Secretary of Defense. I saw all things around me as a coded message from the Government. For 2 weeks I was a 007 Agent. I thought I was encountering MI-6 Agents almost everywhere I went. They were even dispersed and scattered throughout the crows during Mass at Church.

In May of 2019, I was placed in the Richland County Assisted Outpatient Treatment Program. AOT is a collaboration between civil courts and the mental health system and is intended for those who are caught in the revolving door of hospitalization, homelessness, and incarceration. It was through this program that I finally received the help, support, and encouragement that I so desperately needed. I will forever be grateful Probate Judge Mayer and the mental health team at Catalyst Life Services for helping me to turn my life around.

I tell you all this, because I think it is important for you to understand that I know what it is like to have your life spiral out of control due to mental illness and not have the ability to stop it from crashing to the floor. I lost everything; my family, my home, and my personal liberty. Fortunately, through AOT, I have all those things back, but it was a long and difficult journey to get where I am today. It could have been a much shorter journey, had AOT reached me sooner.

SB453 makes it possible for others to get the life-saving Treatment they need. As was given to me. It will restore their competency, and their independence.

I urge you to pass this Bill.

It will save lives.

Respectfully,

Bradley N. Tarr

Favorable SB 453 Judge Burke.pdf
Uploaded by: Ashlee Reyes
Position: FAV

SB 453
Judge Stephanie Pearce Burke
Position: Support

Chair Melony Griffith and the members of the Senate Finance Committee:

I write in support of SB 453 because Maryland judges should have options for court-ordered treatment which are less restrictive than hospitalization or incarceration. I was not always a believer in assisted outpatient treatment (AOT), but through my experience, I have come to see AOT as an invaluable tool which creates a meaningful partnership between the court, the community mental health care provider and SMI adults living in our communities who have historically fallen through the cracks.

The Kentucky General Assembly passed AOT in 2017 over the strong objection of the Kentucky District Judges Association and the Kentucky Department of Public Advocacy. I testified against the bill on behalf of Kentucky's 115 District Court judges. As a state District Court Judge in Louisville, Jefferson County, Kentucky, I initially shared the same objections that you are no doubt hearing in Maryland, the same objections that state legislators always hear regarding AOT-objections rooted in a fundamental misunderstanding of AOT's intent and compassionate approach to saving lives through court-ordered outpatient care.

Surprisingly, court-ordered assisted outpatient treatment is effective because it is not wielded with a heavy-hand, but with a patient-centered focus, and it provides an alternative that is less restrictive than involuntary hospitalization or incarceration. The "least restrictive alternative" language in SB 453 means that, for people who are in need of clinical treatment, AOT can keep them living in the community instead of a psychiatric inpatient facility. The express lack of contempt power also means that courts will have to work with the respondent and their treatment team to ensure adherence to the treatment plan.

As President of the Kentucky District Judges Association, I can say that our judges now strongly support the implementation of AOT across Kentucky. AOT is working in Kentucky and will work in Maryland if the legislature will give the counties that want to implement it a chance. Furthermore, Kentucky is taking advantage of federal grant funding to start AOT programs and Maryland can too if the General Assembly passes enabling legislation. I ask you to vote favorably in committee for SB 453. AOT can save the lives of Marylanders who have not had sufficient community-based services with court support.

Judge Stephanie Pearce Burke

President, Kentucky District Judges Association

JEFFERSON DIS1RICT COURT
LOUIS D. BRANDEIS HALL OF JUSTICE
600 West Jefferson Street
Louisville, Kentucky 40202
Direct: (502)641-0895

Favorable SB 453 Judge Stormer.pdf
Uploaded by: Ashlee Reyes
Position: FAV

JUDGE ELINORE MARSH STORMER

Summit County Court of Common Pleas

Probate Division
209 S. High Street
Akron, Ohio 44308
330.643.2323
www.summitohioprobate.com

February 6, 2024

Chair Melony Griffith and the members of the Senate Finance Committee:

While every state has different laws, the need for effective treatment for those with a serious mental illness crosses all borders. I am the Probate Court Judge in Summit County, Ohio. In 2016, we started a "New Day Court" to provide assisted outpatient treatment (AOT) to help hundreds of individuals with severe mental illness break the cycle of hospitalizations, homelessness, and criminal justice involvement.

Using "therapeutic jurisprudence", we practice AOT so that it is sympathetic to the individual needs of each client. I remember each one of the AOT cases that have come before me, and we have had remarkable success in Summit County in achieving one of AOT's goals- reducing the need for psychiatric hospitalizations.

In my Court, during 2016-2017, 152 clients participated in my New Day Court and only 14 were re-hospitalized while in the program. The civil court order combined with tailored treatment, was the key to keeping the vast majority of clients out of hospitals, allowing them to receive community-based services instead. They have the opportunity to live their best lives.

I write in support of SB 453 so that the Maryland judiciary can have the same option of AOT as a piece in the toolkit for judges to work with the mental healthcare system and individuals with mental illness to provide more compassionate and effective treatment.

I have trained judges and mental health clinicians from across the country in how best to use their state's AOT enabling legislation to reach desirable outcomes for people with severe mental illness who may lack insight into their illness and symptoms. I have followed their success stories, which, regardless of jurisdiction, produce the desired effect of helping participants engage in meaningful recovery.

In many states with AOT statutes, opponents of the legislation warn that its passing will open flood gates of individuals entering the court system. In fact, most of the clients are already here in our system. A carefully tailored bill like SB 453, combined with judges who are willing to understand and properly utilize AOT, treats only a small number of people who can thrive with a civil court treatment order.

I urge you to pass SB 453 out of committee so that Maryland judges can work with stakeholders to help the people and their communities meet the service needs of those with severe mental illness. Maryland can join the other 47 states using this process.

Please feel free to contact me if you desire additional information.

Elinore Marsh Stormer

Judge Elinore Marsh Stormer

Favorable SB 453 Lindsay Moran.pdf
Uploaded by: Ashlee Reyes
Position: FAV

Favorable: SB 453

Lindsay Moran

Director of Communications, Treatment Advocacy Center

Resident of Annapolis, Maryland

In 1999, my cousin Andrew Goldstein – a man living with schizophrenia in the throes of a psychotic break - pushed Kendra Webdale, a promising and beautiful young woman, in front of a subway train and to her death in New York City. I did not know Andrew well growing up – having seen him only at a couple of weddings and Bar Mitzvahs over the years – but all that I did know of him was that he was a bright seemingly normal kid. Andrew and I are the same age. As a kid, I recall family members talking about his genius capacity for mathematics.

It was after Kendra's murder that I learned that Andrew had showed signs of severe mental illness in his late teenage years; had been diagnosed with schizophrenia; showed improvement with hospitalization and medication; but that he had been discharged from a medical facility and was living on the streets in the days before he killed Kendra.

What was more horrifying to discover was that Andrew – semi-cognizant that he was a danger to himself and others – had actually been banging on the doors of hospitals in the city, begging to be taken in. For whatever reason, he was not admitted.

My cousin was the quintessential case of someone who fell through the cracks of the mental health system. The results were incomprehensibly tragic. An innocent life was taken; and Andrew – even though doctors agreed that he was mentally ill and even though he had been diagnosed with schizophrenia some 10 years prior – pled guilty *without* an insanity defense on the advice of his lawyer. Andrew spent most of his adult life incarcerated, where his illness continued to go untreated and where he suffered the expected trauma and abuse of someone with severe mental illness (SMI) in prison.

One good thing did come out of this tragedy. Due in part to the extraordinary efforts of the Webdale family, **Kendra's Law** became effective in November of the same year of her murder. This New York State Law grants judges the authority to issue orders requiring people who meet certain criteria, including recent acts of harm to self or others – such as my cousin surely did - to regularly undergo psychiatric treatment via AOT.

Now, most states have AOT. When I recently joined the Treatment Advocacy Center as Director of Communications, I was stunned to realize my home state of Maryland does not. AOT could have saved the life of Kendra Webdale. It could have helped keep my cousin Andrew off the streets and prevented him from committing a senseless act of murder.

AOT does save countless lives where it is an option. Here in Maryland, our neighbors experiencing homelessness due to untreated SMI, families of those living with SMI, and everyone who cycles through the revolving door of homelessness, jail, and hospitalization deserve to have this humane preventative option. Let us please not wait until another shocking and horrific tragedy happens before we adopt AOT.

Thank you,

Lindsay Moran

Director of Communications, Treatment Advocacy Center

Resident of Annapolis, Maryland

Favorable: SB 453

Favorable SB453 S. Scott.pdf
Uploaded by: Ashlee Reyes
Position: FAV

Favorable SB453
Serese Scott
Prince George's County

I am a family member of a loved one who was diagnosed with a severe mental illness (SMI). I want to ensure that all outpatient treatment options are available to individuals with a SMI and their families. I am asking you to support SB452 to establish an assisted outpatient treatment (AOT) program in Maryland. Studies show that AOT programs reduce hospitalizations, victimization, incidents of arrest and incarceration, and homelessness.

And, AOT saves lives. While it is sadly too late for some with an SMI, passing an AOT bill will save the lives of others with a SMI. Please see the Op-Ed in the February 5 edition of the Baltimore Sun about the tragic loss of life at: https://www.baltimoresun.com/2024/02/05/maryland-assisted–outpatient.

It is time for Maryland to join the 47 other states that have laws to authorize an AOT program. Let's help to ensure that no Marylander has to die or be left behind. Please give a favorable report to SB453.
.

Janice Edwards SB 453.pdf
Uploaded by: Ashlee Reyes
Position: FAV

February 11, 2024
Position: Favorable
Bill HB576 - *Mental Health – Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment Programs*
Janice Edwards
District 19, Montgomery County, Maryland

"Every life matters." True?

I am writing in support of the provision of assisted outpatient treatment (AOT) resources for those who need help in living with a serious mental illness because every life does matter.

Though some folks are able to go through life in a seemingly independent way, there are others who thrive with greater support and reinforcements. I have helped to support individuals living with serious mental illness. What I have come to know is that treatment works. Services received (a supportive community, therapy, sharing in groups with peers, medication, alternative therapies, etc.) can vary widely, but what we know is that once an individual is able to experience improvements in their mental health, they have hope and are often more willing to embrace mental health care in the community.

I support HB576 to establish a strong, evidenced-based assisted outpatient treatment (AOT) program to ensure the best possible health outcomes for those living with a serious mental illness and the communities that are connected to these individuals. It's clear that in order to improve and save lives, we as a caring community need to be able to act when dangerous behavior often involving repeat hospitalizations, the criminal justice system, etc. leads to self-harm, and even death.

With declines in health for many in our post-COVID19 pandemic world, we must act now. Yes, the prospect of ever having to require someone to comply with a court ordered medical treatment plan in the community is serious, and fortunately it's a very rare situation. If 47 other states have enacted laws to authorize AOT programs, surely Marylanders can promote the development of a strong and balanced program to help those living with serious mental illness to live their best lives.

Thank you for your thoughtful consideration of this request for a favorable report to HB576.

KParker Favorable SB453.pdf
Uploaded by: Ashlee Reyes
Position: FAV

Favorable SB453
Kimberly K. Parker
Prince George's County

I am a mother of a 25-year-old young adult son who is diagnosed with a severe mental illness (SMI). Over the past several years, my son has had several inpatient psychiatric admissions. I had to obtain an Emergency Petition to get him the medical help that he needed.

Upon discharge from the hospital, very often, there is no coordination or connection to outpatient treatment services. Caregivers are expected to fill the gap and link their loved ones to voluntary treatment. This is very challenging and stressful on families.

Last year, within weeks of being discharged from a Prince George's County (PGC) hospital, my son was re-admitted to the same hospital! I had to advocate for something different to happen upon discharge to prevent him from being homeless. My son was admitted to a voluntary residential crisis service (RCS) in Charles County. Today, my son is doing so much better because the RCS was life altering. I want his recovery to continue!

Knowing things could change with having a SMI, an AOT program would provide a treatment option to connect our loved ones to outpatient services. This would lift the burden currently placed on families and caregivers.

While it is sadly too late for some with an SMI, passing an AOT bill will save the lives of others with a SMI. Please see the Op-Ed in the February 5 edition of the Baltimore Sun about the tragic loss of life at: https://www.baltimoresun.com/2024/02/05/maryland-assisted–outpatient

Studies show that AOT programs reduce hospitalizations, violent behavior, and victimization. On top of that, incidents of arrest and incarceration decrease as well. Further, an AOT program could decrease the illegal use of substances and homeless nights, helping counties to save money in ways unimaginable.

It is time for Maryland to join the 47 other states that have laws to authorize an AOT program. Let's help to ensure that no Marylander will be left behind. Please add your voice to the thousands of us crying for an AOT program in Maryland. Together, we can save lives.

Thank you for reading my testimony. Please give a favorable report to SB453.
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Seanniece Bamiro FAV SB 453.pdf
Uploaded by: Ashlee Reyes
Position: FAV

Testimony in Support of SB 453 Assisted Outpatient Treatment (AOT) Bills in Maryland
Position: Favorable

Seanniece Bamiro
Prince George's County
District 25

February 12, 2024

Dear Chair Beidle, Vice Chair Klausmeier and members of the Senate Finance Committee:

My name is Seanniece Bamiro and I am a District 25 resident and an advocate for mental health. Maryland should improve treatment for people with serious mental illnesses (SMIs) and one way of doing that is by establishing evidenced-based assisted outpatient treatment (AOT) programs. AOT programs treat the whole person and uncover the root issues associated with patterns of behavior and have been said to reduce trauma, homelessness, suicide, and involvement with police. If established, Maryland would join 47 other states that have authorized AOT programs.

I stand in solidarity with my fellow mental health advocate Ms. Debra Bennet whose son died by suicide related to mental health issues. In her Baltimore Sun op-ed (https://www.baltimoresun.com/2024/02/05/maryland-assisted-outpatient-treatment/), she states that while it was too late for her son to benefit from assisted outpatient treatment programs, establishing and funding these in the state of Maryland can be a life-saving intervention for other Marylanders going through the same hardships.

I urge you to save the lives of Marylanders experiencing mental health issues and give a favorable report to SB 453.

Thank you,

Seanniece Bamiro
Seanniece.Bamiro@gmail.com

Stacy Derrick Favorable SB453.pdf
Uploaded by: Ashlee Reyes
Position: FAV

Favorable **SB 453**

Stacy Derrick

12412 Quail Woods Drive

Germantown, MD 20874

I am writing to ask for your support **SB 453**.

I am a professional in the mental health field. I am the co-founder of Help in the Home. Help in the Home specializes in working with individuals who have a severe and persistent mental illness.

AOT is the practice of placing an individual with severe mental illness under court order to adhere to outpatient treatment to maintain the individual's health and safety. It is a tool appropriate for a small subset of high risk, very ill individuals who lack the capacity to recognize their illness, causing them to refuse and avoid voluntary treatment options. Maryland is one of only three states that does not have a statewide statute authorizing involuntary treatment in the community or AOT(reference). I am going to share about one of our clients who needs AOT.

Our client, we will call him Jon, is an elderly African American male who is diagnosed with Schizophrenia and has a long history of repeated hospitalizations and releases. For years, Jon has been in and out of hospitals and jail. He has been emergency petitioned well over 20 times with one arrest, and has been kicked out of 3 different apartments for property damage and disturbance of others due to his behavior. Each time he was discharged to a rehab or a crisis center for anywhere from 3 days to 2 weeks. In 2017 with no other choice he ended up at the mens shelter in Rockville. In a span of 2 months he was emergency petitioned from the shelter 4 times. Out of the 4 times I was only able to convince a social worker to keep him for an extra couple days one time. She released him to a different shelter where he walked out and disappeared on the first day. It is only by chance that Jon has not harmed anyone yet. Jon continues on this vicious cycle with no government interference. Jon deserves to have AOT.

AOT can be life-savings. This evidence-based treatment has been proven to reduce hospitalizations, arrests, homelessness and incarceration. Many people who suffer from serious mental illness are unable to recognize that they have a disorder (anosognosia) and need assistance. AOT gives mental health professionals and families another tool to help treat people suffering from serious mental illness in a community-based setting. Without assisted outpatient treatment, family members

cannot intervene to get necessary mental health treatment for their loved ones. Studies show that AOT can dramatically improve treatment outcomes and substantially reduce the likelihood of repeat hospitalization and criminal justice involvement for its target population.

Please support **Hsb 453** favorably. Thank you for your time.

Stacy Derrick,

Co-founder

Help in the Home

SB453_Barb_FAV.pdf
Uploaded by: Carolyn Knight
Position: FAV

Mental Health – Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment Programs

Testimony for SB 453
Finance Committee
Date: February 20, 2024
From: Barb - Montgomery & Prince George's Counties

POSITION: FAVORABLE

I have a family member who has severe mental illness. As a result, he was homeless, living in a car and subsequently wandering aimlessly around the Bowie, sleeping in parks, etc. for months.

The man in question was a lawyer (who of course had lost his law job), yet couldn't understand that it wasn't normal for a lawyer to have no home, and sleep on park benches. It is painful to contemplate how penniless he was, as well as unmoored from reality.

A police called one day to say that he had given my number to the policeman. Our family was asked to come get him because he was wandering in the middle of traffic, barefoot and filthy. The policeman had said, "He's going to get himself killed out here."

This young man did not understand that he was ill or needed medication. He was detached from reality, let alone any concept of right and wrong. This posed a danger both to himself and others.

It's obvious someone in this condition doesn't have the mental capacity to make sound judgments that affect his or her own well-being. A friend of mine put it succinctly: "The laws protect an individual's right to remain crazy…."

The pain of this situation to the family is impossible to overstate. The mental well-being of all family members was affected.

Irrational behavior by someone who is sick may harm innocent members of the public. It is incumbent upon us to find humane ways to help—which can include laws that make it possible to insist that people take medication for severe, disabling psychotic illnesses.

I prefer to remain anonymous due to the personal nature of this testimony. But I do attest to the fact that the above letter is based on real--and devastating—personal experience.

Thank you for your attention to solving this very serious problem.

Barb

SB453_Beck_FAV.pdf
Uploaded by: Carolyn Knight
Position: FAV

Mental Health – Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment Programs

Testimony for SB 453
Finance Committee
Date: February 20, 2024
From: Gina Beck, District 15, Montgomery County

POSITION: FAVORABLE

My son is a 32-year-old man who experienced a downward spiral in his life over the past 7 years due the lack of AOT. He was first hospitalized in February 2016, for attempting self-harm. After four days he was released to his apartment with a prescription for antipsychotic medication which we filled upon his release. I tried to get him to come and stay at home in Maryland while he recovered, but he was a 24-year-old student at the University of the District of Columbia, and he wanted to return to school and continue his studies.

He took his meds and went back to school. He was ok for a few months but then stopped taking meds and was using marijuana. Six months later in September 2016, he told me the voices in his head were too much and I convinced him to go with me to the hospital. At this point he was hallucinating and delusional, stating he thought someone was trying to kill us. We went to Montgomery General Hospital in Olney, MD, because I had been told they had a very good Psychiatric Unit. Well, we never got to find out. I begged the ER personnel to take us out of the waiting room to a place where my son would be secured. Ninety minutes later they triaged him, took his vitals, acknowledged he was clearly psychotic, and sent him back to the waiting room. Again, I begged and told them he was going to run. They did not listen, and he ran. It took me hours to find him, get him back into my car, and back home. Three days later I convinced him again to go to the hospital. This time we went to Shady Grove Hospital in Rockville, MD. I explained the situation just as I had at Montgomery General, only Shady Grove responded and moved him behind locked doors within 20 minutes of our arrival.

My son was released from Shady Grove after five days in the Psych unit and was referred to the Out-patient day program. He went for two days but did not go on the 3rd and 4th day. When I physically dragged him there on day five, they would not let him attend. My husband and I made multiple attempts to keep him in outpatient treatment, but because he is an independent adult who has no insight into his illness, he refused to continue. Without AOT there was not treatment for him.

On October 16, 2016, in a completely psychotic episode, my son shattered and destroyed 19 oversized windows in our 200-year-old farmhouse, where he grew up and lived for 18 years. Sadly, I had no choice other than to call the police because I was afraid for his safety and for mine. The police chased him until he finally surrendered and put him in handcuffs. At my pleading, they took him to the hospital, not to jail. A Montgomery County District Attorney

advised me the only way for him to be ordered to get help for his mental illness was for me to press charges against him which would come with the risk of him going to jail. As the mother of a young black man that was not an option. Having only the police to turn to during his breakdown was terrifying enough.

In March 2022, my son was again hospitalized after not taking his medication for 18 months. He experienced a severe break with reality becoming physical with one of his caregivers. He was involuntarily committed to a hospital in Randallstown, 50 miles away from where we live in Montgomery County. They tried to release him in 3 days even though he had not been seen by a judge who had the power to continue his involuntary commitment. They were going to release him to a homeless shelter 50 miles away from home where he knew absolutely no one. I had to beg and threaten the hospital and my insurance company to keep him there even though he had attacked someone. In the end he was in the hospital for 30 days. I had to arrange for a very expensive treatment center to prove that he was stable enough for a different group home to take him. This facility cost me over $50,000 for 3 weeks. This is added to the $7000 a month I pay for him to live in group home. Neither the treatment center or the group homes he has lived in since 2017 are covered by insurance.

He is our only child and our family is devastated and broken.

AOT has proven, in several states, to have significantly reduced many of the negative and devastating outcomes of Mental Illness including suicide, homelessness, arrests, incarceration, hospitalizations, drug use and victimization. We can't change the past, but if we enact AOT in Maryland, maybe our loved ones suffering from mental illness and families like mine, will not have to repeatedly endure the heartbreaking, emotionally devastating, dangerous, and costly experiences I described above.

Thank you,

Gina Beck
Poolesville, MD 20837
301-518-2841

SB453_C.Knight_FAV.pdf
Uploaded by: Carolyn Knight
Position: FAV

Testimony for SB453
To: Finance Committee
From: Carolyn Knight, MSN, RN; District 14, Montgomery County

POSITION: SUPPORT

I have been an advocate for treatment and services for those with serious mental illness for 30 years and AOT specifically since 1999. I am very familiar with the arguments against the program and the strategies used to make existing programs so weak as to benefit very few potential clients. I have testified before a number of you in previous sessions.

One argument is that expanded, well-funded voluntary community services are an alternative to Assisted Outpatient Treatment. The inconvenient truth is that some with severe mental illness have anosognosia, the inability to recognize one's own illness and need for treatment. Many family members have experienced the stiff finger aggressively pressed into our chests, with the firm assertion that, "I'm not sick! YOU'RE the crazy one." My brother was one of these. It was not innate stubbornness, but one of the most diabolical symptoms of the brain disorder and very frequent in bipolar disorder and schizophrenia. Some can be persuaded, and enough trust established to participate in treatment, but others would not accept treatment if it came with a cash prize and was provided at a 5-star resort. The brain disorder will–not–allow–it. The alternative reality that comes with delusions and paranoia are powerful and seductive. The sad irony is that we have treatments that work. To achieve wellness, one must have a period of clarity to grasp the need for extended treatment to avoid relapse or at least the realization that life is better when adherent with treatment. AOT provides one path to serve those that cannot consistently engage voluntary in available services, no matter how stellar they are.

And while we wait for the voluntary services alone to repeatedly try to "engage" our loved ones, the consequences of non-treatment pile up: continued brain deterioration, repeat hospitalizations, homelessness, victimization, suicide, criminalization, violence, and premature death. Testifiers here today have lost their loved ones because AOT was not ordered. How many more lives must be sacrificed in the hope that voluntary services will work without requiring the court oversight and encouragement provided by AOT?

An additional claim is that voluntary services are more effective than AOT in reducing hospitalization. The opposition cites some research that includes pilot programs from over 2 decades ago that were not at all comparable to present day AOT programs. Other research they cite includes Community Ordered Treatment (COT) or Community Treatment Orders (CTO) from other countries, but ignore positive findings in those reports. One paper stated, "Studies using the New York dataset found that CTOs were associated with reduced [hospital] admission rates and inpatient days." Another cited article from 2001 concluded that "Involuntary outpatient commitment, when combined with intensive mental health services, can be effective in reducing the risk of negative outcomes. But whether a court order in and of itself has any effect is an unanswered question."

That question was answered in 2010 research on New York's AOT program which showed that AOT is more effective than voluntary services alone in reducing hospitalization. "The increased services available under AOT clearly improve recipient outcomes, however, the AOT court order, itself, and its monitoring do appear to offer additional benefits in improving outcomes." This research also showed significant reductions for individuals in hospitalizations (77%), arrests (83%), incarceration (87%), homelessness (74%), harmful behaviors (44%), and victimization (50%).[4] Additional data recently collected by SAMHSA from jurisdictions awarded grants to establish an AOT program also showed robust positive outcomes for individuals: 78% reduction in Emergency Department visits, 85% reduction on hospitalizations, 44% reduction in incarceration, 48% reduction in homeless nights, and 91% of participants agreed with the statement "I liked the services I received here."

However, the truth that is often overlooked is that for those who lack insight into their need for treatment and cannot adhere to voluntary treatment, the real alternatives are no treatment or AOT.

In summary, we get much right in Maryland as we care for the neediest among us. I am proud of our progressive record and the funding that has been budgeted for services. But we have a serious blind spot when it comes to the sickest of the sick. I have lived with and cared for one of these. He is about to turn 65 and as a result of involuntary outpatient treatment in another state he was spared the ravages of decades of untreated psychosis.

Please vote for SB453 to support this vital tool for patients like my brother.

Thank you

1. Report of the Continuity of Care Advisory Panel, Maryland Department of Health and Mental Hygiene, January 21, 2014. https://msa.maryland.gov/megafile/msa/speccol/sc5300/sc5339/000113/018000/018940/unrestricted/20140020e.pdf
2. Report of the Outpatient Services Programs Stakeholder Workgroup Maryland Department of Health and Mental Hygiene December 10, 2014 Senate Bill 882, Chapter 352 and House Bill 1267, Chapter 353 of the Acts of 2014. https://health.maryland.gov/bha/Documents/Involuntary%20Commitment%20Stakeholders.Final%20report%208.11.21.docx.pdf
3. Substance Abuse Mental Health Services Administration (SAMHSA), Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice. https://www.samhsa.gov/sites/default/files/civil-commitment-continuum-of-care_041919_508.pdf
4. Marvin Swartz, et al. "Assessing outcomes for consumers in New York's assisted outpatient treatment program." *Psychiatric Services* 61, no. 10 (2010): 976–981.

SB453_Campbell_FAV.pdf
Uploaded by: Carolyn Knight
Position: FAV

Testimony for SB 453
Finance Committee
Date: February 20, 2024
From: Shawn Campbell, MSW, District 17, Montgomery County

POSITION: FAVORABLE

My name is Shawn Campbell, MSW, and an employee of Help in the Home, LLC located in Rockville, Maryland. Help in the Home assists clients with severe and persistent mental illness. Our clients live in a safe and secure environment. There are countless Marylanders who do not have the opportunity to live their best lives due to an undiagnosed mental illness, many of whom are resistant to treatment and unaware of the severity of their illness.

SB 453 would help people in many ways to get treatment for those undiagnosed mental illnesses. When someone is struggling with mental illness, they will lack the capacity to recognize their actions and won't have the ability to process reality like you or me. What is unfortunately problematic for someone resistant to treatment is that they tend to self-medicate, thereby becoming addicted to drugs and alcohol to relieve their symptoms and exacerbate their problems.

There is a young man I will call “Sam”, who has walked away from every treatment center his parents have found for him. He refuses to meet with a psychiatrist or therapist or participate in any form of treatment. He is living with his girlfriend, losing weight, and increasingly becoming socially isolated. We are doing our best to monitor his condition for the development of physical/psychiatric conditions that meet the criteria for an emergency petition. Unfortunately, this is a painfully slow process in which we can only merely hope we'll be able to identify BEFORE a fatal tragedy occurs. Our only hope of getting treatment for Sam is through an emergency petition. However, without the passing of this SB 453, the emergency petition will allow for little real progress. It is likely that once he is stable enough to be discharged (i.e., no longer an immediate danger to himself or others), he will repeat the same cycle of refusing to go to appointments and decompensating until hospitalization is once again needed. With AOT, Sam would be much more likely to follow up with aftercare treatment, thereby increasing his prognosis for stabilization and recovery.

The State of Maryland stands at the precipice, and the time is now to pass SB 453 which would help those who cannot help themselves. With the passing of SB 453, we could see a drop in healthcare costs associated with people experiencing a mental health crisis who are admitted to the emergency rooms and help to keep them out of the jails, decrease acts of violence in our communities, and give them hope for their future.

Thank you.

SB453_CarmenA_FAV.pdf
Uploaded by: Carolyn Knight
Position: FAV

Mental Health – Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment Programs

Testimony for SB 453
Finance Committee
Date: February 20, 2024
From: Carmen A., Montgomery County

POSITION: FAVORABLE

I have a very close family member who suffers from serious mental illness. She has a long history of hospitalizations - **about 25 hospitalizations to no avail.**

She would be discharged after a very short time, at the most one week, with no follow-up services which lead to dropping her medication.

My family member has been **homeless** for about 3 years, after being discharged from several hospital stays. It became a pattern: hospital, shelter, hospital, shelter. When in shelters, there was no proper follow-up amid unsanitary conditions, and she was even **victimized by care takers and other shelter users**. **All outpatient treatments have proven a failure**.

Meanwhile, she **lost insight to her illness and need of treatment.** She was thrown out of the shelter she was in due to behavior resulting from lack of treatment and in a total state of psychosis she was accused of committing a felony. After **two years between jail and forensic hospitalization**, confronted with a slow and complicated judicial system, the felony charge was dropped for lack of evidence. But a second-degree assault charge remained, placing her on probation for 3 years. All this waiting turned into a devastating situation of uncertainty and injustice. Back in a shelter, she needs to wait again for housing that will hopefully include access to an Assisted Outpatient Treatment program.

I believe there must be a more humane, effective, and less costly way of taking care of our population with mental illness. One step in a good direction would be to establish an **Assisted Outpatient Treatment** program in Maryland. As developed by SAMHSA and the Treatment Advocacy Center, AOT has shown proven results in reducing homelessness and incarceration.

I request that the Committee give a favorable report to SB453.

Thank you for working towards the improvement of a broken, inhuman, and costly system.

SB453_Connors_FAV.pdf
Uploaded by: Carolyn Knight
Position: FAV

Mental Health – Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment Programs

Testimony for SB 453
Finance Committee
Date: February 20, 2024
From: Joanne Connors, District 19, Montgomery County

POSITION: FAVORABLE

I live with a serious mental illness. 20 years ago, I lived through numerous hospitalizations due to my lack of insight into my illness. I initially voluntarily went on the meds. But for some reason I stopped taking my medicine believing I no longer needed it.

Assisted Outpatient Treatment would have been so helpful for me. It would have given me the support and structure for staying on my meds and keeping me out of the hospital so many times.

AOT might have saved me from being homeless and spending all my savings to survive without a job. It might have saved my son from being abandoned by his mother.

AOT could only have had positive effects on my life and I wish it had been available 20 years ago when I struggled.

Please give **SB453** a favorable report. **I would very much like it to be available if I ever need it in the future.**

Sincerely,

Joanne Connors

SB453_CSnyder_FAV.pdf
Uploaded by: Carolyn Knight
Position: FAV

Mental Health – Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment Programs

Testimony for SB 453
Finance Committee
Date: February 20, 2024
From: Cherie Snyder, District 1A, Frostburg

POSITION: FAVORABLE

I am writing in support of SB453 because of my son, Bryan, who will be 40 in just one month.

Bryan has suffered horrifically from severe mental illness (SMI) complicated by Asperger's Syndrome (high functioning autism). Despite the most compassionate offerings of care from Sheppard Pratt hospital specialists as well as the local Western Maryland professionals at UPMC WMD, the ACHD, Archway Station, and DSS, my son lives alone with no friends other than imaginary ones, minimal contact with the outside world, and no meaning and purpose in a house filled with trash and filth. Only in a few emergency occasions where he became combative and the police were called were we able to hospitalize him because he is not considered to be a danger to himself or others. And then, after a few days when he is stabilized, he is discharged to his house with services in place and medication–and hope that this time he can remain stable. But there is only hope–and that is not enough because according to Maryland Law, the hands of all the compassionate and skilled healers in our community are tied. They cannot help Bryan if he does not want help. He has the "right" to live the way he wants. And within weeks of discharge, he refuses help. And all the professionals who want to help can do nothing - until the next emergency.

The problem is that the brain disease Bryan suffers from precludes the capacity to make and carry out the careful plans developed in the hospital once he is off medication and refuses support. This is not freedom; this is a jail and a hell from which Bryan has no way to escape.

Because he has a large family who loves and continues to support him and because I am a social worker whose background is mental health with many connections in the community–plus modest resources to support him and advocate for him–he has been protected. But I know without a doubt, if he did not have a family and resources, he would be dead, homeless, or in jail. He is fortunate in that sense, but that is not the case for so many seriously mentally ill.

However, just because he is alive and living in a small house I bought (due to repeated evictions from rental and residential services), it does not mean he is truly able to live as a human being should live - with dignity, meaning and purpose, and respect. He knows that his hygiene is horrible and that his rambling talk when he is in public is frightening

to others, so he stays home, living like a rat day in and day out with only a TV for company and imaginary friends and with food delivered from Gianni's pizza or Amazon or if we bring him meals.

Assisted Outpatient Treatment is the only service I know that can save the lives of people like Bryan - and give them the true freedom they deserve. Mental illness is not a right, it is a jail. And AOT offers a compassionate and collaborative key to freedom.

Please support SB453.

SB453_CWeinberg_FAV.pdf
Uploaded by: Carolyn Knight
Position: FAV

Testimony for SB 453
Finance Committee
Date: February 20, 2024
From: Claire Weinberg, District 18, Montgomery County

POSITION: FAVORABLE

My son had Schizophrenia, and he took his own life. Assisted Outpatient Treatment might have saved his life.

I don't believe my son ever had any awareness of the causes of his suffering. Even though he was paranoid, delusional, and hearing voices, he **NEVER RECOGNIZED THAT HE HAD AN ILLNESS so he REFUSED TREATMENT.**

Michael was diagnosed with schizophrenia as a teenager, after his first year in a University of Maryland Honors Program. Although he sometimes behaved bizarrely, he managed to get a degree in horticulture. He was too fearful to seek a professional job but did some heavy tree work for a friend, and odd jobs.

His only violent behavior – he was too gentle a soul to ever seriously hurt anyone – was to give an occasional guy a punch when he thought - THROUGH THE VOICES IN HIS HEAD - that the guy was propositioning him!

When picked up by the police for this on one occasion. He was given his freedom on the condition he would see the doctor at the county clinic and take medication. He went a short while but when the doctor left, he stopped going and stopped the medication. **There was no follow-up by the treatment provider.**

Michael had a history of non-compliance with treatment as well as an arrest, and the inability to care for himself. If the judge had issued an order for Assisted Outpatient Treatment, the provider would have been responsible for following up to encourage him to abide by the court-ordered treatment plan. If my son had stayed in treatment for a year under AOT, he would have had a chance to stabilize and possibly live a satisfying life. If he had deteriorated again, the treatment provider could have more easily petitioned him for evaluation for hospitalization. If he didn't meet the criteria for hospitalization, the provider would be watching to facilitate hospitalization as soon as possible.

Instead, without any treatment, Michael deteriorated to the point where he was suffering so much from fear, paranoia, hallucinations, and depression that **he shot and killed himself.**

Assisted Outpatient Treatment might have saved my son. Since he refused voluntary treatment, because of the severity of his illness, there was NO outpatient treatment option for him. How can Maryland continue to offer NO viable outpatient treatment option for the most ill and vulnerable? You cannot bring back my precious son, but you have the power to prevent the suicide of others by offering them the lifeline of AOT.

Please support SB 453.

SB453_G.F._FAV.pdf
Uploaded by: Carolyn Knight
Position: FAV

Mental Health - Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment Programs

Testimony for SB 453
Finance Committee
Date: February 20, 2024
From: G.F., District 15, Montgomery County

POSITION: FAVORABLE

I have 45-year-old daughter who has struggled with multiple neurological and psychiatric problems throughout her life.

She was unfortunately exposed to a slow carbon monoxide leak in our home over a 30-month period prior to first grade. This impact on her developing brain resulted in impaired judgement and memory.

Her teen years were marked by personal and social turmoil. She had an Individual Educational Plan (IEP), was seen by therapists, and placed on Ritalin. But her poor judgement and impulsivity led to misuse of the medication, poor friend choices, alcohol use, sniffing, cutting, and suicide attempts. She graduated from high school but only after being bounced around between many programs.

My daughter received many varied diagnoses over the years, including ADHD, Bi-Polar Disorder, Multiple Personality Disorder, Schizophrenia, and PTSD. She either did not take the prescribed medication, failed to participate in treatment, or combined the medications with other drugs and alcohol. She was unable to continue her education or remain employed and sometimes was homeless.

At one point I declared bankruptcy due to the costs of caring for her. When she qualified for disability payments, I was granted financial authority over her income in order to pay for her treatment and other needs.

The passage of time and increased maturity has helped mitigate the worst of her symptoms. She is now working and living with a boyfriend. She does take medication. Our relationship is strained and I worry a lot about her future. I wonder if a more intensive program like AOT might have helped save her from several decades of suffering.

Please vote in favor of SB 453 to possibly help the sickest of those with mental illness.

Thank you.

SB453_Yolanda_FAV.pdf
Uploaded by: Carolyn Knight
Position: FAV

Testimony for SB 453
Finance Committee
Date: February 20, 2024
From: Yolanda, Prince George's County

POSITION: FAVORABLE

Our son had a normal childhood despite having hearing loss and expressive speech delay. He was always an extremely social and kind individual, willing to help anyone in need. He was intellectual, loved to learn new things, took honors classes, participated in clubs (Engineering, STEM), did community service, and was on the honor roll.

From the ages of 11 to 18 years old, he played football for several organizations – Glenarden Boys Football, Flag Football, Charles H. Flowers (JV and Varsity teams). During that time he sustained several ***concussions*** that were not properly diagnosed and treated. I noticed subtle changes in his behavior and personality but thought it was just growing pains.

During his senior year in high school, he lost interest in attending classes and withdrew from his family and friends. Despite struggling, he did graduate. Afterward he attended college for 1½ years but dropped out because he was unable to concentrate. He then really shut down, shunning the few friends he had left.

After leaving school he tried to work by delivering groceries for Instacart. He lost that job after two car accidents. His illness worsened as he dealt with the job loss and injuries from those accidents. In May 2021 he had an even more serious accident in Delaware and ended up in the trauma ICU with a traumatic brain injury.

Six days after his release from the Delaware hospital we took out an Emergency Petition and he was re-hospitalized in Maryland for a psychiatric evaluation. That is when he was diagnosed with Bi-Polar Disorder and prescribed medication. He did have some awareness that he needed help and signed Maryland's Advanced Directive for Mental Health Treatment. Despite that he has been generally noncompliant with treatment. He cannot stay in our home because he is a danger to us and his siblings. After discharge he refused to go to a shelter and has been homeless and transient since May 2021. In June of 2022 a Virginia police officer executed an Emergency Petition and my son was held 2 days for psychiatric evaluation. He told me he walked to Warrenton, Virginia and then back to Maryland after release.

Last June he was involved in a fight with one of my neighbors. He was arrested and charged with assault. He was held in the Prince George's County Jail pre-trial, was found guilty, and is now serving a 3-year sentence.

We have been unsuccessful in getting our son the help he so desperately needs. Assisted Outpatient Treatment, a program supported by SAMHSA, has proved to reduce homelessness and incarceration in other states. **Maybe it can still help him after he gets out of jail.**

Please give a favorable report to SB453.

MC Federation of Families Testimony in Support of

Uploaded by: Celia Serkin

Position: FAV

Montgomery County Federation of Families for Children's Mental Health, Inc.
Colesville Professional Center
13321 New Hampshire Avenue, Terrace B
Silver Spring, MD 20904
301-879-5200 (phone) ✦ 301-879-0012 (fax)
info@mcfof.org
www.mcfof.org (website)

SB 453 Mental Health - Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment Programs
Senate Finance Committee
February 20, 2024
POSITION: SUPPORT

I am Celia Serkin, Executive Director of the Montgomery County Federation of Families for Children's Mental Health, Inc. (MC Federation of Families), a family peer support organization serving diverse families in Montgomery County who have children, youth, and/or young adults with mental health, substance use, or co-occurring challenges. Our Certified Family Peer Specialists are parents who have raised or are currently raising children with mental health, substance use, and/or co-occurring challenges. I am a Montgomery County resident and have two children, now adults, who have struggled since their childhood with mental health challenges. My son has debilitating depression. My daughter has co-occurring challenges.

MC Federation of Families is pleased to support **SB 453 Mental Health - Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment Programs.**

SB 453 requires a peace officer, when the peace officer receives a petition for emergency evaluation for an individual, to transport the emergency evaluee to a nearby emergency facility, rather than the nearest emergency facility; authorizes a psychiatric nurse practitioner to evaluate an emergency evaluee for purposes of involuntary admission; authorizes the Maryland Department of Health to require the admission of an emergency evaluee to an appropriate facility, rather than requiring the Department to provide for the admission within a certain time period; requires each county to establish an assisted outpatient treatment program; requires the Office of the Public Defender to provide representation in assisted outpatient treatment proceedings; and generally relates to the procedures for emergency evaluation and involuntary admission and assisted outpatient treatment (AOT) programs.

MC Federation of Families supports SB 453 because it improves treatment compliance and quality of life for adults with serious mental illness (SMI) and ultimately save lives. AOT significantly reduces hospitalizations, arrests, incarceration, homelessness, violence, and victimization in states where it is practiced. AOT will help adults with SMI, such as schizophrenia or bipolar disorder, with a history of hospitalizations, incarcerations or threats or acts of harm to self or others resulting from a lack of compliance with treatment for their SMI. These individuals often have diminished awareness of the need for treatment, caused by the illness itself. They are unlikely to adhere to treatment without an

AOT plan, and need treatment to prevent deterioration that would create a substantial risk of serious harm to the individual or to others.

As a family peer support organization, we have witnessed the devastating consequences of those suffering from SMI who are untreated, including death. We have seen those with SMI continuously going through revolving doors of repeat hospitalization, incarceration, and homelessness because they are unable due to their illness to recognize that they need treatment.

MC Federation of Families urges this committee to pass SB 453.

HB576 TESTIMONY.pdf
Uploaded by: Christina Flowers
Position: FAV

HB576 Testimony

From: Christina Flowers, Owner of Real Care Providers 501 (c)(3) , 2524 N. Charles Street, Baltimore MD 21218

POSITION: FAVORABLE

It saddens me to have to come to another hearing regarding HB576 again this year. I feel like our cries for help are not being heard. I dedicate so much time to those homeless on our streets whose lives are deteroriating and it all started with a lack of mental health care These are human people who breathe and bleed just like you and I and often cannot advocate for themselves. What happens when their judgment is so hindered that they don't get the appropraite care their mental health needs? Well come out to one day in Baltimore City with me for an hour and I can show you ow hundreds of mothers, grandmothers, military vets, disabled people are outside and helpless with one common denominator which is - they need mental health care. This trauma plagues our streets of Baltimore City causing more mental illness and where or when does it end?

Specifically they need the assistance of an AOT program to be implemented here in Maryland. The facts have shown its success in 47 other states and yet this state has the ability to make it happen for the vulnerable here and yet we still are waiting.

I attended these meetings last year in this same month. In just one year, THREE mothers who have advocated for this bill have had to bury their children. Not one, I said three mothers who stood before this board a year ago asking for help had to bury their children. Please let that sink in.

While you may not know what its like to be mentally ill or have a loved one who is mentally ill, the sad reality is its real for many people and people who are relying on you to make this change in Maryland. Please don't fail us any more and cause any more families unwarranted grief.

HB576 should be passed by each of you with FAVOR because it will change lives and at any expense it is truly worth it. I appreciate everyones time and look forward to seeing you all in person on Weds.

Thank You,

Minister Christina Flowers
cflow32@gmail.com

SB453_PellNeal_FAV .pdf
Uploaded by: Christina Neal
Position: FAV

Christina Pell Neal

11513 Morning Ride Drive
Potomac, MD 20854
Montgomery County
520.878.6255
Christina.pell.neal@gmail.com

February 19 2024

SB453 Testimony

SUPPORT

My 20 year-old-son Herbert Randall has had 10 inpatient Psychiatric hospitalizations and is now vulnerable and voiceless in a maximum-security prison because Maryland does not offer assisted outpatient treatment.

Bertie was sixteen when he was first hospitalized and although I spent over a million dollars to try to provide him care, Maryland did not support these efforts by providing Assisted Outpatient Treatment.

In March of 2022 I wrote a testimony hopeful for the bill for Assisted Outpatient Treatment to be passed, in order to mandate assisted Outpatient Treatment and try to save my sons life. Had it passed then, my son might have a had a chance, and not committed a crime only 4 months later that would change all of our lives forever. A few months after this bill was not passed, He had just been released from his last inpatient hospitalization at the University of Maryland. When I picked him up that bleak January day he told me that he was not planning on filling his prescription or following up with his psychiatrist. He had just turned 18 years old, I realized that I was powerless to help him, without the laws in Maryland changing.

In 2020 doctors diagnosed him with early onset Schizophrenia. Had he been ordered to be compliant with a treatment plan after hospitalization, Bertie would not be incarcerated for 9 years at the age of 18. He spent most of his high school years in Psychiatric hospitals or residential treatment centers to no avail due to the lack of mandated outpatient treatment.

Bertie had never been in trouble with the law or had as much as a speeding ticket, but due to his unmedicated illness and issues with untreated substance abuse, he is now lost in our criminal justice system. Instead of being treated for his illness and supported to live a productive life, he like millions of others with mental illness, is housed in maximum security prison, without access to proper medical and emotional support of his diagnosis. Heartbroken mothers like me are powerless to do anything.

My Grandfather US Senator Claiborne Pell (Rhode Island) said, “you don’t need to be the loudest voice in the room, but a voice for those with no voice at all”. Please be a voice for my son Bertie and the millions of others. I implore you to vote for assisted outpatient treatment and save countless children from my child’s fate.

Sincerely yours,

Christina Pell Neal

AOT Written Testimony Senate 2024.pdf
Uploaded by: Cynthia Lewis
Position: FAV

February 19, 2024

SB453 Testimony

Cynthia Major Lewis, MD
Assistant Professor
Director Adult Emergency Psychiatric Services
The Johns Hopkins University
1800 Orleans Street
Baltimore, MD 21287

Position: Support

To The Members of the Maryland Senate:

My name is Dr. Cynthia Major Lewis, and I am a Board-Certified Psychiatrist who is currently the Director of Adult Psychiatric Emergency Services at the Johns Hopkins Hospital in Baltimore, MD. **The views in this letter are my own and are not representing Johns Hopkins.** I am writing this letter in support of SB453, Mental Health-Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment Programs.

Assisted Outpatient Treatment (AOT) is court ordered mental health treatment for individuals with severe mental illness who have a history of noncompliance with treatment. This lack of compliance often leads to repeat emergency department visits, inpatient hospitalizations, arrest, incarceration, homelessness, victimization, suicide and violence.

A substantial body of research has established the effectiveness of Assisted Outpatient Treatment programs in improving treatment outcomes in patients with severe mental illness. Some studies have shown an 87% reduction in incarceration, 70% reduction in inpatient hospitalizations, 83% fewer arrests and an 87% decrease in homelessness. Assisted Outpatient Treatment Programs have been shown to increase treatment compliance and ease the strain placed on family members and caregivers.

Although research is limited, cost-effectiveness research studies and anecdotal evidence have reported government cost savings, shifting dollars being spent on countless emergency room visits and inpatient hospitalizations to lower cost outpatient treatment. There has been evidence of further cost savings because of the decreased interaction with police and the criminal justice system.

I completed my psychiatric residency program at Johns Hopkins in 2001. I was able to treat a diverse patient population, patients who come from all walks of life and have had the fortune of treating patients in various community settings. My passion lies in treating patients with severe mental illness, those who are often disenfranchised and most vulnerable.

After my residency training, I served three years in a rural health physician shortage area on the Eastern Shore of Maryland. I worked in underserved community mental health clinics, providing mental health treatment to patients who were accepting of care. After my service obligation, I returned to Johns Hopkins and worked primarily in our Community Mental Health Clinic on our East Baltimore campus. I also started a very small private practice.

I worked as an Attending psychiatrist in the Johns Hopkins Community Psychiatry clinic for sixteen years. I was able to form an alliance and develop a healthy patient/physician relationship with the majority of my patients. I treated a significant amount of patients who had Severe Mental Illness (SMI). These patients often carried diagnosis of Schizophrenia, Schizoaffective Disorder, Bipolar Affective Disorder and Severe forms of Depression. Our clinic had case managers, social workers, therapists, nurses, psychiatrists and many wrap around services that allowed us to keep most of our patients healthy, safe and out of the hospital. Patients who struggled in this setting

were often referred to a higher level of care like an ACT team or Capitation Program. Patients in these programs received more intensive treatment with the goal of keeping them well, supported and out of the hospital. We lost a small percentage of patients to noncompliance. Patients with psychotic and severe mental illness often have anosognosia. Some refer to this as a lack of insight or lack of ability to appreciate that one has an illness that needs treatment. This lack of insight is a significant contributor to refusal to comply with treatment.

It was not until I was asked to Direct the Adult Psychiatric Emergency Services at Johns Hopkins, that I began to get a sense that something was broken in Maryland's mental health system. My position allows me to spend 100% of my clinical time in the Emergency Department. Our emergency department is located in inner city Baltimore. We see many patients who have comorbid substance abuse and chronic medical problems along with severe mental illness.

While being embedded in the emergency department, I began to notice that I would often see the same patients, several times a month and often several times a week. These patients were coming into the Emergency Department on their own, often in need of food/shelter/rest or they were brought on an Emergency Petition; which requires them to be handcuffed by the police and brought to the Emergency Department; against their will for evaluation; if an interested person believes they have a mental illness that is causing them to be a danger to themselves or others. Once evaluated, a determination is made regarding appropriate disposition. Patients who require inpatient admission can sign a voluntary form and come into the hospital voluntarily or what is often the case, they can be placed on involuntary certificates if it is determined that they present a danger to themselves or others.

With the help of a safe therapeutic environment, therapy and medication management, patients with severe mental illness often get better when hospitalized and become safe for discharge back to the community.

I became increasingly alarmed when I would see these same patients back in the emergency department within days, weeks or months of their previous presentation or hospitalization. A frequent pattern is that soon after discharge, patients in this population stop their medication and fail to follow up with outpatient care. Their symptoms of psychosis, mania or depression return. They become unable to care for themselves or a danger to themselves and others. They find themselves with exhausted and burned -out family members who are no longer able to care for them. This leads to insecure housing and homelessness. They re-present to the Emergency Department either on their own or via Emergency Petition, only to repeat the cycle above.

As I continued to watch this cycle repeat itself, I began to question why is this happening? I was asked to provide a Grand Rounds lecture to my Department and focused my presentation on Maryland's current mental health system and questioned if there was a need to rethink State Hospitalization. I went back and looked at the history of mental illness, State Hospitalization and De-institutionalization. It was while doing this research that I realized that Maryland did not need to reconstruct State Hospitals. I learned that Maryland was one of only three states that does not have Assisted Outpatient Treatment Programs. I learned that these programs, when managed successfully, are designed to help patients with severe mental illness, who through no fault of their own and because of symptoms that are part of their clinical disease process, find themselves lacking the insight or ability to appreciate that they have an illness that is treatable and worthy of treatment. Maryland's lack of an Assisted Outpatient Treatment has led to a population of patients with severe mental illness who are falling through the cracks. These patients are being denied the ability to receive life-saving, evidence- based treatment that can help them lead safe, healthy and dignified lives.

Mental illness are mental disorders that cause significant changes in thinking, emotions or behavior, causing problems in occupational, social and interpersonal functioning. One in five adults, or 19% of the US population, has mental illness. One in twenty or 4% of those with mental illness suffer from Severe Mental Illness (SMI); which causes significant functional impairment in one or more major life activities. It is 1% of patients with severe mental illness that are falling through the cracks of our mental health system and have become our "revolving door" of patients circulating in and out of our emergency departments, inpatient units and jails. It is this group that would benefit from Assisted Outpatient Treatment.

Our patients deserve better than what Maryland is currently offering. Patients with severe mental illness are at increased risk of dying by suicide or other preventable causes. They are patients whose rights are being impacted when they are emergency petitioned and brought to the emergency department or involuntarily hospitalized against their will. These are patients who have family members and loved ones who have had to estrange themselves or send them to other states that have Assisted Outpatient Treatment programs.

Our patients deserve to have voices at the table who are advocating for them because they can't advocate for themselves. They deserve to live in a state that is going to roll up its sleeves and figure out how we balance their well-deserved rights for autonomy and self-care with the right to life altering and lifesaving care. Our patients deserve an Assisted Outpatient Treatment Program in the state they call home.

Continuing to allow Maryland's mental health system to function in its current form is unacceptable. Our patients deserve better. Our exhausted medical and mental health providers deserve better. Our communities deserve better. Our taxpayers deserve better. I humbly ask for a favorable report on SB453.

If you have any questions or concerns regarding this testimony, please do not hesitate to contact me at cmajor@jhmi.edu.

Respectfully submitted,

Cynthia Major Lewis, MD
Assistant Professor
Director Johns Hopkins Adult Psychiatric Emergency Services

D.Bennett Favorable SB453.pdf
Uploaded by: Debra Bennett
Position: FAV

Favorable SB453
Debra Bennett
Charles County, MD

It's too late for my son, but assisted outpatient treatment could save the lives of others. I urge a Favorable Report for SB453

My name is Debra Bennett, I am a member of the Maryland Commission on Behavioral Health Care Treatment and Access, a volunteer Maryland Ambassador of Treatment Advocacy Center, a NAMI member, a nationally certified Family Peer Specialist, and a former caregiver.

In December 2023, my beloved 35-year old son, Ben, tragically died. He was diagnosed with a severe mental illness (SMI) at the age of 20, a recent substance use disorder, and a bilateral hearing disability. If Maryland had an assisted outpatient treatment (AOT) program it could have potentially altered the course of his life.

On December 4, four days before his death, he was found unconscious from an anoxic brain injury on a Baltimore street without identification and admitted as a John Doe to the same hospital where he had recently, and voluntarily, received psychiatric treatment for a month. Prior to discharge, he agreed to use three new voluntary outpatient services. Ben was always willing to start outpatient services but he was unable to remain engaged in treatment in the community. Over the years, he had started at least 11 different types. But his illness prevented him from recognizing his need for continuous treatment. This led him to go in and out of treatment programs, experience repeated psychiatric deterioration, and eventually to cycle in and out of hospitals.

From 2020 through 2023, he had 18 hospitalizations in six Maryland counties and Baltimore City. Only one was involuntary. August 2022, after leaving a crisis resident he was charged with trespassing at a local mall. Homeless – he was arrested, detained, and involuntary committed to a state psychiatric forensic hospital from October through November 2022. A month after committed, his charge was dismissed at his hearing for time served. Tehncially Ben was free to leave the hospital but he voluntarily remained for two months from November 2022 to January 2023. He was awaiting placement in a housing program. A week after discharge from the state hospital to the housing program, the cycle started over. He was admitted to a local hospital for two weeks and discharged from the housing program. The community treatment provider had to obtain housing in a different program.

In our last conversations together, Ben thanked me for supporting him and told me he was going to be successful this time. A little over a week later, he was deceased and his body was transferred to the State Anatomy Board as an unclaimed decedent. Six days after he was deceased, Ben's father, who lives out of state, received the devastating call from the Baltimore City Police Department (BCPD). Can you imagine my shock when I received the tragic call from Ben's father, and I live in Maryland? It was only by God's grace that Ben's fingerprint results were returned to the BCPD before he had to be cremated by the state. We would not have ever known what happened to him! The ultimate tragedy! No parent wants to experience the devastating loss of a beloved child or the awful ordeal of having to plan their child's funeral.

After the dreaded and unbelievable call, I felt a range of emotions. First, I was angry because just several months earlier, I had sought more intensive treatment options, and they had failed to engage Ben in sustained treatment. Then, I was grateful to some extent because he was no longer suffering and struggling to use Maryland's voluntary services. And then, I felt further empowered to continue advocating for AOT because I realized it was a vital program for those who are being failed by our current treatment programs. I have given personal testimony for AOT legislation in 2021, 2022, 2023 and 2024 to commissions, the gubernatorial administration, the Senate Finance Committee, and the House Health and Government Operations Committee. I hope this year, Maryland finally passes an AOT bill.

While Ben agreed to use voluntary services, had a supportive family, and an advocating mother – this was not enough to keep him engaged in treatment. He needed an AOT program. It is proven that an AOT program reduces hospitalizations, homelessness, arrests and incarceration, trauma, and suicide. **AOT saves lives.**

While it is sadly too late for Ben to benefit, passing such a bill will soothe my soul. It will be a testament that Ben's life was not in vain. I urge you to give a favorable report for SB453.

DonBennett Favorable SB453.pdf
Uploaded by: Debra Bennett
Position: FAV

Favorable SB453
Don M. Bennett, U.S. Marine Retired
9208 Fox Stream Way
Upper Marlboro, MD 20772

I am a Maryland citizen concerned about improving treatment for those with a serious mental illness (SMI) –one of our most vulnerable populations. Maryland needs to establish a strong, evidenced-based assisted outpatient treatment (AOT) program that reduces homelessness, hospitalizations, arrests, incarceration, trauma, and suicide for those with a SMI. AOT saves lives!

While it is sadly too late for some with a SMI, passing an AOT bill will save the lives of others with a SMI. Please see the February 5, Baltimore Sun Op-Ed about the tragic loss of my nephew's life at: https://www.baltimoresun.com/2024/02/05/maryland-assisted-outpatient-treatment.

It is time for Maryland to join the 47 other states that have laws to authorize an AOT program. Let's help to ensure that no Marylander will be left behind.

SB453_Burton_FAV.pdf
Uploaded by: Evelyn Burton
Position: FAV

SB453

From: Evelyn Burton, Maryland Advocacy Chair, Schizophrenia & Psychosis Action Alliance evelyn.burton@sczACTION.org 301-404-0680

POSITION: FAVORABLE

In One year

12 psychiatric hospitalizations
18 Emergency Department visits for psychiatric evaluation
4 Crisis Center visits for psychiatric evaluation.

Total Charges: **$509,000.00**

What the numbers above do not tell you is the unimaginable suffering and trauma experienced by my loved one and his family, because Maryland does not have Assisted Outpatient Treatment, for those who are unable or lack the insight to adhere to voluntary treatment.

My loved one was **terrified** each time he saw a policeman in Columbia Maryland because he **knew the officer was really a praying mantis, which could devour him alive.** John was confused and afraid wandering in a large parking lot, without any ID, not knowing how he got there and unable to remember his name, where he lived, or anything about himself. He was tormented with thoughts and plans of suicide.

What I do not have to image is the suffering of his family. I can tell you the pain I felt in the pit of my stomach each time he called saying he wanted to kill himself and he had a suicide plan. Would I be able to get him to the hospital in time? I can tell you of the sleepless nights and anxiety I felt when he was missing, wondering if he was in the hospital or jail, alive or dead. I can tell you of the desperation and feeling helpless to break the cycle and get him into treatment before tragedy.

The opponents of AOT said that the solution is Assertive Community Treatment (ACT) Teams and peer support persons. I applied for the Howard County ACT team. They went to his apartment to interview him and he slammed the door in their face. He did not think he needed their services. I hired at certified peer support person to live with him 24/7 and help persuade him to see a psychiatrist and take prescribed medicine but John refused,

became delusional, became afraid of the peer support person and accused him of being a NAZI.

After my loved one became homeless and almost got arrested, I gave up on Maryland and sent him to Arizona. There he was quickly put in an AOT program. Since then, he has complied with injectable medication, routine psychiatrist visits, and case manager appointments, and this week will be starting a day program and vocational counseling. There is nothing coercive about the program. His treatment team encourages him and takes his concerns and goals into account. He views them as his best friends. He takes the medicine out of respect for the judge's order and his relationship with his treatment team.

My heart still breaks when he calls and begs to come back to Maryland where his friends and family are. However, in Maryland without an evidence based AOT program, if he were again to stop treatment due to lack of insight, he would risk suffering, being incarcerated, homeless, and having brain damage from untreated psychosis. To protect him and other Marylanders, we need at evidence based AOT program to provide treatment to those who are unable through no fault of their own to adhere to voluntary treatment.

I know of at least 2 other families that sent their loved ones to another state and got the benefits of AOT. Unfortunately, I work with many more who cannot afford to do this and their loved ones suffer the consequences of denial of treatment: homelessness, incarceraton, hospitalization, victimization, suicide and premature death.

It is time for Maryland to join the 47 other states and the District of Columbia and enable AOT. Please give a favorable recommendation to SB480 and save lives.

SB453_Daniels_FAV.pdf
Uploaded by: Evelyn Burton
Position: FAV

Testimony for SB453

Feb. 20, 2024

From: Sue Daniels, Bethesda

Position: FAVORABLE

A Once-Promising Young Life Without Hope because Maryland has no AOT

Our son had a bright future, with a job that he loved as a lead software developer at a Fortune 500 corporation. He had close friends and a steady relationship with a wonderful young woman. Entirely through his own earnings and savings, he had a nice apartment and a car.

We were so happy for him. Then, suddenly, at the end of his twenties, he became ill with schizophrenia and lost everything, even his future, through no fault of his own. He lost his job, his friends, his girlfriend, all his possessions, and without the help of his parents, would have become homeless. In his psychotic state, he has unwittingly done things that were very dangerous to himself and others, and is currently facing a trial for breaking fire safety laws.

He has been hospitalized repeatedly, but because Maryland has failed to pass AOT protections for people stricken with severe mental illness, he has never received the treatment he desperately needs. We have begged the doctors to treat him, but they say their hands are tied without a change in the law, and that they cannot treat him unless he consents, even though he is not capable of understanding his disease and consenting until after he is treated.

It's a Catch-22.

When a person is psychotic, their thinking is confused, and usually the person doesn't realize they are ill and so they won't take the medication they urgently need. Instead, in the case of our son, he knows only that his life has become a shambles, that he is lonely and miserable, and that "I can't do the things I used to be able to do." In his despair, he has attempted suicide.

Our family lives in constant fear of him killing himself before the law changes and he can get treated. Whenever he doesn't answer our text messages, we miss work, drop everything and drive to his apartment, terrified of what we may find on the other side of the door. It is ongoing hell for him and for the whole family.

Feeling alone and tormented, he is afraid to take medication that would help him wake up from this nightmare. Alas, he believes his confusion and the horrible malignant voices he hears in his

head are caused by a conspiracy of evil beings who are controlling him with radio waves. His young brain, once so nimble and strong, is being ravaged year after year by the flames of psychosis. Science tells us that the sooner you treat psychosis, the more likely the person will be able to return to a more normal life. The longer this evil disease is neglected, the more it destroys the brain. Despite all our efforts to get our beloved son treated, it has now been nearly 8 years that he has been suffering without treatment – because Maryland is one of the last three states in America that has failed to pass AOT.

As parents, we are now begging you, our lawmakers, to help our son and thousands of other afflicted young Marylanders who need and deserve help. Nearly 1% of Marylanders suffer from schizophrenia. Another 2-3% suffer from other forms of psychotic illness. This is also an issue of public safety. People who are left to suffer the ravages of psychosis without any rational intervention of compassionate antipsychotic treatment can be a danger to others. My son has struggled against evil voices for years, voices that command him to do terrible things. He screams at them to shut up and leave him alone, but they always return, sooner or later.

As the mother of a beautiful and beloved young man who has been stricken by schizophrenia, I now recognize behaviors of certain homeless people I see on the street, behaviors that I once assumed were the result of some kind of intoxication, but that I now see as the struggles of another mother's poor abandoned child, who is tormented by evil voices that won't leave them alone. We have abandoned all of them. This is not the Middle Ages, when insane people were chained to a wall and left filthy and alone in their torment. Yet today we still fail to see the humanity in our mentally afflicted children, and callously leave them chained to their illness, when medication EXISTS that could free them of their chains. AOT will help not only my son, but so many sufferers. Thousands of young people and their mothers, fathers, sisters, and brothers.

If any lawmaker thinks it is cruel and unfair to give antipsychotic medicine to a person who is so afflicted that they cannot give consent, please come and meet with me on a fact-finding mission. Come with me to my son's apartment when we rush over late at night, afraid he may be thinking of committing suicide. Meet my son, a handsome young man with a sweet demeanor, except that he has large raw unexplained scars on his legs from 3rd-degree burns,

his skin is gray with grime because he no longer bathes, and if he smiles, you will see that his teeth are all rotting out, because, in his psychosis, he thinks he doesn't need to brush his teeth or go to the dentist, because when his teeth rot out, new and better ones will grow in.

If Maryland had AOT when my son got ill, this would never have happened. If AOT finally passes, my son will need to have all his rotten teeth pulled and replaced with artificial teeth. That's the least of the harms that have been done to him and others due to lack of AOT. It's the tip of the iceberg.

We have tried to get him to move to a neighboring state, because Maryland is behind the times regarding AOT and nearby states have all passed AOT laws that would help end his suffering and ours. However, he is already struggling against suicidal thoughts and voices that tell him to do horrible things, and does not even want to talk about moving.

He tells us that when the voices return, commanding him to do bad things, he feels immense anxiety and rage. He says he has learned that if he expresses violence on an inanimate object, such as furniture or a wall, that the voices go away for a while, and he can have some peace.

As a result, he has never harmed anyone, but he has been evicted from several apartments for violently banging the walls as he attempts to calm his unending torment. After his most recent eviction, he owed $2,000 in damages, having destroyed extensive areas of interior walls and two metal doors.

I was stunned when I saw he had stabbed a pair of scissors into a wall perhaps 20 times, leaving big gashes, like something out of a horror movie. I told him this looked pretty scary. He looked at me and said softly, "Mom, that shows how much I didn't want to hurt anybody."

Dear lawmakers, there's a better way to banish the cruel demons of psychosis. Violence against furniture and walls is not a solution. Violence against self and others is surely not a solution. Refusing to deal with the problem is not a solution – it is heartless abandonment of our most afflicted. AOT is a rational and compassionate solution. In the name of compassion and rational government, please pass the law. FAVORABLE.

SB453_Granados_FAV.pdf
Uploaded by: Evelyn Burton
Position: FAV

SB453 Testimony
Kristina Granados, Washington County
Support

My brother has been sick with schizophrenia for 22 years. His illness has resulted in 4 traumatic violent attacks: on my father, my grandfather, my aunt and my uncle, the permanent disability and loss of employment for my uncle, the loss of a son's relationship with his father, the suffering of my brother with paranoid fears for over 5 years and living homeless on the street for almost a year, the cost to the state of millions of dollars for over 5 years in the criminal justice system and at Clifton T. Perkins Forensic Hospital, and now my brother's homelessness for the second time and families with children, including mine, that continue to live in fear of harm every day.

In his early twenties my brother began hearing voices and became extremely paranoid. My parents could not get him help because he was over 18, and completely unaware that he was sick and refused treatment. **He attacked and choked my father severely**. He agreed to voluntary hospital admission but checked himself out after 2 days because **the inpatient doctors refused to certify him for involuntary admission.**

My husband and I lived with my parents at the time, and on one occasion, because of his delusions **he threatened to kill us in our sleep**. The next day he told us he slept with a butcher knife under his bed in case he decided he needed to kill us in our sleep. The hospital recommended we call the police, who took him to the hospital. However, the **Emergency Room doctors refused to certify him for involuntary hospital admission.**

For our family to be safe, we could not allow him to come home. He was **homeless and on the streets almost a year.** Then my aunt and her family took him in against our advice. My grandfather lived with my aunt, and **my brother attacked him** on one occasion. One evening, **he beat my aunt and her husband in the head with a baseball bat.** Then he calmly called the police and stated he intended to kill them, but couldn't go through with it. **Susan and John were both hospitalized and John will remain on full disability as a result of this attack.**

My brother finally received medication over objection at Clifton T Perkins Forensic Hospital which successfully treated his psychosis. After discharge to an inpatient center, he moved to a halfway house program called Vesta. He **got a job at a gas station which he held for over a year, bought a car, AND mended relationships with his son and the rest of the family.** When all was well in his life again, **He stopped taking his meds**. He moved out of the halfway house program, and got an apartment on his own, so he didn't have to answer to anyone about his mental illness.

Then he started having hallucinations and paranoid delusions again. he was accusing his roommate/landlord of cutting his hair while he was sleeping. He **posted psychotic incoherent words as well as violent and sexually explicit messages on social media including "Feeling cute, think I might kill".** He concocted a plan to be homeless and live in the woods near my family. This sent me into a terrified panic mode, knowing he could show up at my door at any minute while he is psychotic. It made me feel that my children and family would not be safe in our own home.

I called Clifton T Perkins to see if there was any way to have him brought back to the hospital if someone reported that he may be relapsing. I found that he had been released with no conditions, meaning they

had no recourse at this point because **Maryland does not have an Assisted Outpatient Treatment Program like other states, who use prior violence as one possible qualification for admission.**

Research shows that the strongest predictor of violence by a person with mental illness is prior violence.

How can a person who had proven to be violent in the past be released with no follow up or monitoring to make sure that they are not a danger to themselves or to the people around them? How can a person like me protect my family when there is no one who can help until it's too late?

Now my brother has been evicted because of his behavior and is living in his car. My family is still in grave danger and lives in fear.

It is absolutely SHAMEFUL that since 2001, families like mine have been pleading for help from Maryland legislators and administrators to change establish Assisted Outpatient Treatment in Maryland and nothing has been done for 23 years.

I am pleading with each one of you to give a favorable report to SB453 to establish Assisted Outpatient Treatment in Maryland this year to protect families like mine and enable those with serious mental illness to lead safe and productive lives.

SB453_Harris_FAV.pdf
Uploaded by: Evelyn Burton
Position: FAV

SB453 Testimony

C. Marie Harris

Prince George's County

Bowie, Maryland 20720

Position: FAVORABLE

My loved one has suffered more than 3 decades with serious mental illness (SMI) after an initial psychotic episode while serving in the U.S. Marine Corps. Since the bipolar disorder diagnosis in 1994, my ill family member has experienced years of relationship problems, financial losses, unemployment, periods of incarceration, numerous hospitalizations, and times of homelessness because Maryland does not offer Assisted Outpatient Treatment (AOT).

Because of anosognosia—the lack of understanding and insight into the illness and the need for treatment--there is a recurring struggle with adherence to medication and treatment. The gaps and delays in medication and treatment adherence results in the illness worsening and setbacks in mental health wellness and recovery. We have lived through many years of our loved one chronically struggling to succeed in the community with untreated symptoms and then end up cycling through jail and hospitals.

We filed many petitions for emergency mental evaluation through the Prince George's County Court System when circumstances and behavior were an imminent danger to others and/or to our ill-health family member. The emergency petition filing is not an easy decision for our family to undertake in part because the fear of law enforcement not having the training or understanding about erratic and bizarre behaviors that are common for persons with untreated mental illness and the possibility of negative consequences for all parties involved.

The process has been very exhausting for our family as the decision to file the petition is our final effort--last hope--for help and typically occurs after spending weeks or even months dealing with ill-behavior and trying to get medical assistance. On the other hand, it has been equally as traumatic for our loved one who lacked understanding about the circumstances during the peak of illness and was obviously very confused, highly manic, and out of control (yelling, cursing, punching holes in the walls, damaging property, aggressiveness, argumentative, threatening, etc.) These situations are very heartbreaking to witness and extremely difficult to control.

Most serious mental illnesses are treatable. Everyone, including persons with mental health conditions, wants and deserves a system of care and relevant interventions that will address their medical needs. Accessibility to timely treatment and services are critical to mental health recovery and wellness. According to SAMSHA, with early and consistent treatment, people with serious mental illnesses can manage their conditions, overcome challenges, and lead meaningful, productive lives.

The implementation of AOT in Maryland will help to foster better health outcomes for my loved one and other Marylanders with serious mental illness and improve the health, safety, and welfare of individuals under AOT and the public.

SB453_Kobler_FAV.pdf
Uploaded by: Evelyn Burton
Position: FAV

SB453 SUPPORT
Ellen Kobler, Carroll County
Senate Finance Committee

I am writing to voice my strong support for legislation to facilitate locally-based Assisted Outpatient Treatment (AOT) in Maryland jurisdictions.

My older brother, who has suffered from Schizophrenia all his adult life, could have benefitted tremendously from such a program just last year. Because AOT was not an option a few years ago, he suffered a terribly protracted and dangerous months-long decline, that included his losing his home and his job. This culminated in his being arrested and jailed for inappropriate public behavior.

Despite unanimous recognition among his family members, counselors, and healthcare practitioners that he was off his meds, suffering from psychosis, and headed for certain disaster; we had no ability to convince him to get adequate inpatient treatment. If there had been an AOT program in Baltimore or Harford Counties, I am very confident he would have complied with court-ordered treatment.

I can tell you from this recent, agonizing first-hand experience, that it is critically important that we as a society develop more effective approaches to help individuals with severe mental illness access the treatment they desperately need, but may resist due to their disease-related impaired thinking.

Despite numerous attempts, it was only after my brother's arrest that were we able to secure an Emergency Petition that directed him into inpatient hospital treatment, where he was stabilized enough to agree to participate in wraparound community-based services. Looking back, my brother agrees that, at the time, he was unable to make rational decisions for his own care. He did, however, respond in a respectful and compliant manner to the judge and court personnel during his criminal case proceedings, and I'm confident he would have been responsive months earlier if a judge had ordered treatment for him.

For the sake of mentally ill people, their families, and the community at large, I hope that you will choose to make AOT an available resource to the residents of Maryland. I am very impressed with the documented benefits of similar programs in other states and hope that we can offer AOT to encourage people to get the help they need but cannot necessarily request for themselves.

SB453_LizM_FAV.pdf
Uploaded by: Evelyn Burton
Position: FAV

SB453 Testimony

Liz (a Maryland mother)
Annapolis, Maryland
3rd Congressional District

Our family has lived in Maryland for the last 30 years. Our son, now almost 40 years old, began showing obvious signs of a mental illness in the fall of 2009. He was interning on Capitol Hill and started expressing beliefs that he could influence legislation with his eye movements. Unfortunately, my son had a neurological deficit called anosognosia that prevented him from understanding and accepting his illness. We knew that even if we were able to convince him to go to a Maryland hospital, it was unlikely he would be admitted nor be ordered to begin and continue treatment. Maryland requires people with serious mental illness to be of obvious danger to themselves or others nor does Maryland have Assisted Outpatient Treatment laws. In fact, it is only one of three states that do not have AOT laws.

After several months of trying to convince our son that he needed treatment, we made the difficult decision to ask him to leave our house. It was extremely risky to ask our son to leave home knowing he was very ill but we were not making any progress getting him into treatment and we needed to try something different. My son ended up in New York City in the middle of a snow storm without any outer garments to protect him from the weather. We found him in Penn Station and convinced him to go to an emergency room because he believed he had stomach cancer. Once inside the triage area, the NYC hospital was able to legally keep him for 72 hours for evaluation purposes and then involuntarily committed him within 24 hours based on his inability to take care of his basic survival needs. This process is very difficult to accomplish in Maryland because of the high bar for establishing a dangerous standard and the lack of court ordered Assisted Outpatient Treatment. Ultimately, he was kept in the hospital for almost a month where he was finally stabilized on medications.

We believe that if Maryland had less restrictive laws governing involuntary commitment and strong, efficient AOT laws, we would have pursued treatment sooner for our son. The earlier treatment starts, the better the long term outcome will be. That was true for my own psychiatric emergency almost 40 years ago. I was fortunate to have been placed in a psychiatric hospital within weeks of my first psychotic break, kept for almost three months and have never had another mental health incident. My son, unfortunately, was not as fortunate and will likely spend the rest of his life battling this horrendous illness. Please give a favorable report to SB453.

SB453_ZD_FAV.pdf
Uploaded by: Evelyn Burton
Position: FAV

SB453
From ZD, Bethesda, Montgomery County, MD
Position: **FAVORABLE**

AOT could have saved my son years of emergency room visits and hospitalizations, homelessness, arrest and trauma.

My 29-year old son has bipolar disorder, anxiety disorder and personality disorder. He has been ill for approximately 9 years, and has been to the emergency room and hospital many times because he does not adhere to treatment after discharge. Because of the illness itself, he lacks insight into his need for treatment.

In May, 2021 I petitioned for an Emergency Evaluation. He was taken to Suburban Hospital and agreed to voluntary treatment for 6 days and improved. At discharge, he agreed to cooperate in treatment, and signed a treatment contract, but after he was out he refused to go to outpatient treatment or take the prescribed medicine. He does not accept that he has a mental illness. Of course, he deteriorated.

In June we did the hardest thing a parent can do: we put him out of our house. He was angry, and destructive. Then he was homeless in Montgomery County. He had no money to eat and slept in the parks. He came to us very hungry and dehydrated on hot days. The first time he came to us, he looked so bad.

I was afraid to let him come home and I was afraid to leave him out there, homeless and hungry. I was afraid of what would happen to him or what he might do.

Several years before, he was charged with a misdemeanor and agreed to participate in the mental health court which is part of the criminal justice system. He had great respect for the judge that ordered him to take his medicine and adhere to the treatment plan. That was very successful in treating his illness and stabilizing him in the community. He graduated from the program and with continued voluntary treatment was able to get a job in the community and live in a shared home. However, when

Why we must wait for a crime to happen before we help someone who is clearly suffering serious mental illness? If AOT was available, then my son and I wouldn't be going through such a horrible experience after being released from the hospital.

There is no question in my mind that this experience has left a permanent scar on both my son and myself. Please pass the AOT bill as a first step to helping my son, myself and families like ours.

SB453_Albuquerque_FAV.pdf
Uploaded by: Janet Edelman
Position: FAV

SB 453 Testimony.
Trevor & Genevieve Albuquerque
7000 Cashell Manor Court
Derwood, MD 20855
POSITION: Support

We are the parents of a 40-year-old son who suffers from Paranoid Schizophrenia and who has experienced incarceration. Maryland's current policy of denying timely psychiatric hospital treatment when requested by a physician causes great suffering and urgently needs to be changed.

It is hard to describe the suffering we saw our son endure, while in the Frederick County Adult Detention Center while refusing medication because of his untreated psychosis. With **schizophrenia and no medication, he was deadly scared of all jail personnel. He was going through hell with his paranoia.**

It is also impossible to explain the agony and helplessness we felt as parents watching our son suffer. We fervently wish he had been transferred sooner to an inpatient hospital bed.

Our son, who I will call "John," was first diagnosed in 2005 when he was a senior at the University of Maryland. He responded well to medication completed undergraduate degrees in Mathematics and Computer Engineering. Despite obtaining an excellent job, he stopped his medication in 2012 and went downhill fast.

In October 2015, John spent a month in the Frederick County Adult Detention Center after being arrested and charged with disorderly conduct, disturbing the peace and second-degree assault. He was seen by a psychiatrist and offered medication but again refused.

He was considered a suicide risk. This meant that he was kept in an isolated open cell, with the lights and cameras on 24/7 with only a toilet bowl in one corner of the cell. He had to wear a poncho with nothing else. When removed from the cell for any reason, he was shackled hand and foot. He did not have the use of a phone. His only contact with the outside world was for 30 minutes a week across a glass security barrier via a phone that did not work too well. And all this for the major crime of being mentally ill.

We know that staff were trying to protect his life. We do not feel the staff mistreated him. Our aim is simply to **describe how extremely difficult and tortuous being in Restrictive Housing can be for someone with an untreated serious mental illness, even when humane care is given.**

Once in the hospital, with a calmer setting and experienced, trained staff, John did agree to medication and treatment. He was found not criminally responsible and today he is back in the community, currently living at home helping his aged parents and whenever needed taking care of his 18-month-old niece. As a parent it is a pleasure to see him smile again.

My wife and I strongly support SB 453. This bill is very important to saving our loved ones from a horrible existence of cycling in & out of hospitals, jails and homelessness and even dying by suicide. Treatment and hospitalization is the correct way to go and not incarceration or homelessness.

SB453_Blair_FAV.pdf
Uploaded by: Janet Edelman
Position: FAV

Kathryn Blair, MD
Resident Physician
Department of Psychiatry
Johns Hopkins University

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JOHNS HOPKINS
MEDICINE

To the Committee,

My name is Kathryn Blair and I am a fourth-year psychiatry resident at the Johns Hopkins Hospital. The views expressed in this letter are my own and do not represent Johns Hopkins. I am also a member of the Maryland Psychiatric Society (MPS) and am on the legislative committee of the MPS. **I am writing this letter in support of state legislation (SB453) to enable the establishment of Assisted Outpatient Treatment (AOT) programs in Maryland.** I am writing this letter independently.

Maryland is one of only three states that does not already have an established AOT program, which gives the ability to mandate outpatient treatment for the most vulnerable and psychiatrically ill patients. Multiple studies done in other states have demonstrated AOT programs reduce hospitalizations, reduce homelessness, reduce arrests, reduce suicidal behaviors, reduce violence towards others, reduce caregiver stress, and improve treatment compliance among these patients. Throughout the last four years at Hopkins caring for psychiatric patients, I have seen a large number of patients that are suffering because of a lack of such a program in our state.

One particular patient comes to mind. He is in his early 40s, has a history of schizophrenia and end stage kidney disease. He requires dialysis three times weekly to keep him alive. His schizophrenia is severe and difficult to treat. Part of his illness is that he does not believe he has schizophrenia. He also has the delusion that the staff at the dialysis center are trying to harm him, so he does not attend his dialysis sessions or his outpatient treatment for his schizophrenia. Over the two and a half years, I have played a part in his care from multiple angles. The revolving door starts when he is found unconscious, *near death*, by bystanders in the street due to missing dialysis. He is brought to the hospital in critical condition, requiring a prolonged ICU course to stabilize him. He is then admitted to psychiatry and given the proper treatment for his schizophrenia. But each time he is discharged, he does not attend his outpatient treatment and ends up back in the ICU a week or two later. I even believe he is currently hospitalized right now. If he leaves the hospital, what if no one finds him next time he is unconscious?

This is just one single example and I have many more in the shallow depths of my pocket after only a few years of practice in the state. In fact, I just learned a few weeks ago that a patient I cared for on multiple occasions, who also did not attend care voluntarily, died in the streets of Baltimore due self-negligence related to their illness. Another similar patient I cared for died in their 30s last summer from a drug overdose.

These patients are spending prolonged periods in psychiatric hospitals, jails, emergency departments, and on the streets when they could have much better outcomes if they were enrolled in an AOT program. Not to mention, millions of dollars are being spent to care for these patients in the acute setting, when what they really need is long-term support. I strongly believe the system is failing this population and that we have the chance to really make a difference in their lives by establishing an AOT program in Maryland. **I urge you to vote in favor of SB453.**

Thank you,

Kathryn Blair, MD

SB453_Custer_FAV.pdf
Uploaded by: Janet Edelman
Position: FAV

SB453 – Assisted Outpatient Treatment
From: Mary and Carl Custer, Montgomery County
Position: SUPPORT

My husband and I live in Bethesda, MD in Montgomery County. Our 40-year-old grandson was diagnosed with bipolar disorder at age 18 in 2002. We want to share his story and ask for your support for Assisted Outpatient Treatment for those who refuse voluntary outpatient treatment or discontinue their treatment. This legislation would enable family members to seek help for loved ones with severe mental illness before they get caught up in the revolving door of psychosis, arrests, and hospital admissions.

Our grandson was caught up in this revolving door from 2002 to 2007. There were a total of five hospital admissions and six arrests in Montgomery County. One of the biggest impediments to stopping the revolving door was the lack of Assisted Outpatient Treatment in Maryland. Each hospital stay occurred only after a significant deterioration in his mental health and significant efforts on the part of the entire extended family. The hospital stays were brief, resulting in minimal stability, and the lack of official follow-up would result in treatment discontinuation.

This revolving door finally came to an end in 2007, when the New Jersey Highway Patrol found our grandson on the shoulder of I-95 with no money, no credit cards, and no gas. They informed us that he had not done anything illegal, but appeared to be manic and in danger. I confirmed that he had a history of mental illness and hospitalizations. They said they would keep an eye on him. Within a few hours, we received a second call. He had been arrested in Phillipsburg, NJ, and taken to the jail in Warren County. We found this level of contact unique.

The following incarceration was also unique. The judge set a high bail to deter premature release, and the facility asked us to contact his psychiatrist to provide them with prescription information. We arranged for release after 30 days when he was sufficiently stabilized to continue treatment in the community.

New Jersey has an Assisted Outpatient Treatment law that was instrumental in a positive outcome for our grandson. Even though we lived in MD, the judge treated us as if we were NJ residents and warned our grandson, from the bench, of the consequences of discontinuing treatment.

There have been no arrests and no hospitalizations since "New Jersey." For years, our grandson has held a full-time job and has been a contributing citizen of Montgomery County. When he needed help, Assisted Outpatient Treatment came to his aid in NJ. The revolving door finally stopped. It might have stopped sooner, avoiding multiple hospitalizations and arrests, if MD had had Assisted Outpatient Treatment.

Assisted Outpatient Treatment in MD would remove barriers to sustained treatment and contribute to positive outcomes for Maryland citizens suffering from severe mental illness. This legislation would provide much-needed assistance to police, doctors, and family members who need help to ensure that a loved one with a severe mental illness continues their treatment plan after hospitalization or incarceration.

SB453_Edelman_FAV.pdf
Uploaded by: Janet Edelman
Position: FAV

SB453 Testimony, Senate Finance Committee
February 20, 2024
Janet Edelman
12038 White Cord Way
Columbia, MD 21044
Position: SUPPORT

I have been an advocate for people living with a mental illness for over forty years. I am currently vice-chair of the Howard County Behavioral Health Advisory Board, but I am testifying as an individual.

I have been helping some advocates for this bill prepare their testimony for submission. While I am comfortable creating a PDF, registering on the General Assembly site, submitting testimony and have time during the day to do so, many of our advocates do not. As a result, I have read around thirty personal testimonies that were submitted for this hearing in favor of the bill. Twenty people shared personal stories in their testimony about the toll of untreated serious mental illness and adverse situations that might have been avoided had Assisted Outpatient Treatment been available. The sad statistics from our testimony:

- 4 people have died
- 8 people were homeless for a period of time
- 13 people were in the Criminal Justice system for various crimes
- 5 testifiers described incidences of self-harm, attack on others, victimization, and child abandonment
- 3 testifiers saw successful outcomes only after their relative was placed in an AOT program in another state.

I will be addressing some of the objections presented by those who are opposed to AOT.

A common claim by opponents is that AOT is forced treatment and permits involuntary medication administration of outpatients. This is a misunderstanding and not true. **No AOT program in the country or SB453 permits involuntary outpatient medication administration.** In Maryland, medication over objection can only be done in a hospital after an involuntary commitment hearing before an administrative law judge and review by a medical panel of experts.

Some opponents state that many thousands of people in Maryland will be court-ordered under AOT, but Assisted Outpatient Treatment is intended to be limited to a very small group of individuals with serious mental illness, who meet narrow and specific criteria, such as a recent lack of compliance with treatment that resulted in serious violence, repeated hospitalizations or arrest, and are unlikely to adhere to voluntary outpatient treatment to the extent that they will come to present a danger to the life or safety of themselves or others. Opponents often forget that not just one, but all of the criteria must be met, and AOT must be the least restrictive alternative appropriate to maintain the health and safety of the individual. In addition, a jurisdiction has the option of limiting the enrollment numbers to match the available services and funding. I did a ballpark estimate of number of people that might be served in Maryland. Per the

New York State Office of Mental Health website on 2/15/24, 3,352 people are under active court order in New York state. https://my.omh.ny.gov/analytics/saw.dll?Dashboard&PortalPath=%2Fshared%2FAOT%2F_portal%2FAOT%20Assisted%20Outpatient%20Treatment%20Reports&page=Program%20Statistics%20-%20Court%20Orders Per the 2020 census, the population of NY State was 20,201,249 and the population of Maryland was 6,177,224. If Maryland had the same proportion of people under active AOT order as New York**, based on these figures, a well-established AOT program in Maryland would have approximately 1,025 people under active court order.** I believe that it will take several years for the AOT program in Maryland to be well-established and approach anywhere near this number.

The opposition states that the AOT process denies a person their civil rights. **SB453 includes due process protection for a person with SMI who is in need of treatment.** AOT is a constitutional method of bringing a person in need of treatment together with the mental healthcare system and the civil courts. Under AOT, the court can hold the mental healthcare system accountable for providing services and continuous efforts to engage the participant in treatment, while still safeguarding the rights of an individual with severe mental illness. Treatment can restore and maintain rational thought and the ability to meaningfully exercise their civil rights. AOT addresses the human rights to treatment and the pursuit of happiness and saves lives. Those with serious mental illness have a neurological brain disorder, that can be well treated. It is cruel to abandon them to the streets when AOT can be their path to treatment and recovery.

It is a myth that AOT causes participants to feel coerced into treatment and/or stigmatized **AOT participation need not lead to a heightened sense of coercion or stigma.** A New York study[1] found that AOT participants were no more likely to feel they had been coerced into treatment or stigmatized by the treatment system than were voluntary recipients of public mental health services. Stigma is mainly created by behavior caused by untreated serious mental illness. This behavior can result in incarceration, violence and death.

The opposition states that racial minorities are more likely to be court-ordered into treatment than their white peers. Candidates for AOT are largely drawn from a population in which blacks are overrepresented: psychiatric patients with multiple involuntary hospitalizations in public facilities. **A Duke study[2] found no evidence that the NY AOT program disproportionately selected African Americans.** In order to get the percentages of race of individuals in the AOT program to match the general population, people of color would have to be turned away from a path to treatment. That would be racist.

[1] Coercive Treatment in Psychiatry: Clinical, Legal and Ethical Aspects—Google Books. (n.d.). Retrieved October 8, 2021, from https://books.google.com/books?hl=en&lr=&id=Zftko2UkAvcC&oi=fnd&pg=PA33&dq=assisted+outpatient+treatment+satisfied&ots=TYqfBhzNl0&sig=lfWnfb1MNcPW8lBx-2fJU4pgJepU#v=onepage&q=assisted%20outpatient%20treatment%20satisfied&f=false

[2] Racial disparities in involuntary outpatient commitment: are they real? Jeffrey Swanson, Marvin Swartz, Richard A Van Dorn, John Monahan, Thomas G McGuire, Henry J Steadman, Pamela Clark Robbins. Retrieved February 19, 2024 https://pubmed.ncbi.nlm.nih.gov/19414892/#full-view-affiliation-1

AOT delivers outpatient treatment under a civil court order to a small, high-risk subset of individuals with severe mental illness (SMI). The court and the mental health system work collaboratively to assist individuals with SMI to engage in treatment and ensure that the mental health system is attentive to their needs. The order requires following an individualized treatment plan, designed with input from the AOT participant, and also orders the provider to continually work on engaging the AOT participant in treatment. It is monitored by the local mental health system. This allows time for lasting stabilization on medication and treatment.

In conclusion, the AOT program in SB453 addresses an unmet need in Maryland in caring for some of the sickest individuals. The arguments against AOT are filled with inaccuracies and present a case for maintaining the status quo which has failed this group of individuals for decades. Other states have made progress on this issue while we in Maryland, in an attempt to satisfy all advocates, have not implemented an evidence based practice. Maryland has completely neglected the needs of those who are the sickest and who, without AOT, continue to require costly services in the hospitals, jails, prisons and homeless shelters. **Please do not add amendments that will make it unworkable, full of loopholes, less effective or unavailable to many people who would need it. Please pass SB453 and give the sickest people something that they have long been denied in Maryland, a chance to recover.**

SB453_Fitzpatrick_FAV.pdf
Uploaded by: Janet Edelman
Position: FAV

Testimony for SB453 Mental Health - Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment Programs
Date: February 20, 2024
From: Terry Fitzpatrick, Bel Air, Harford County, MD
Position: SUPPORT

My son (Josh) was diagnosed in 2004 at age 18 with schizoaffective disorder. He has had 17 hospitalizations in 11 years. This includes two separate admissions of three months each in New York and NJ because hospitals in Maryland would never keep him until he was stable. The system has failed over and over at providing the long-term care he needs.

Trying to find outpatient treatment that he "qualifies for" has been hard. My son had taken himself to the hospital saying he felt extremely depressed and wanted help. He was evaluated at the hospital VOLUNTARILY only to be told, "You seem okay and don't meet the requirements for the day hospital."

After being discharged from a structured inpatient environment, my son starts to go downhill from not having the structure he needs. When he becomes less organized in his thinking, he misses appointments and then a therapist or psychiatrist will decide to "discharge him from care." This results in more deterioration and the frustration of trying to find a new doctor or therapist. With his frustration, anxiety and depression he will start self-medicating with alcohol and marijuana. This behavior completes the downward spiral, and he once again ends up in the emergency room.

Instead of the "revolving door" of short stay hospitalizations and unsupervised outpatient care, my son would benefit from longer inpatient treatment followed by **Assisted Outpatient Treatment** and if possible, housing.

Patients with other complex care needs, like those on kidney dialysis have elaborate and extensive outpatient plans put into place before discharge to the community to avoid deterioration and re-hospitalization. Those with serious mental illness require the same attention to detail. It is truly a "revolving door" of insanity for the patient and the family.

Targeted mandatory **Assisted Outpatient Treatment** for people like my son could help him succeed in his treatment and prevent the suffering that has been a part of his life of these last 18 years.

Please support SB453. I need the support it could bring to my son and my family. We need Assisted Outpatient Treatment available state-wide.

SB453_Harrison_FAV.pdf
Uploaded by: Janet Edelman
Position: FAV

SB453
POSITION: SUPPORT

Caroline Harrison
9591 Quarry Bridge Court
Columbia, MD

My adult son was on a ventilator in ICU for 10 days as a result of serious mental illness and because Maryland has no AOT. He's had 7 forced psychiatric hospitalizations in a period of 1 year, again, due to no AOT in Maryland. He's never adhered to a regimen of medication and he likely will relapse again. He's suffered a great deal as have I because when he hurts I hurt too.

Please, put an end to the revolving door hospitalizations, reduce incarcerations and homelessness among those who suffer serious mental illness! AOT has been proven to work and why Maryland is one of only three states without this on the books is beyond imagination.

Please, end the suffering of my son, myself, and multiple other families and bring hope and help so desperately needed by supporting this chance to move our state forward!

I respectfully ask for your strong and urgent support of SB453.

Sincerely,

Caroline Harrison

SB453_MartinN_FAV.pdf
Uploaded by: Janet Edelman
Position: FAV

SB453 TESTIMONY

MARTIN & CONSTANCE N.

MONTGOMERY COUNTY

MARYLAND

POSITION: SUPPORT

Our daughter is currently hospitalized at Shady Grove Adventist Hospital after expressing suicidal thoughts. Three weeks ago, she was hospitalized at Holy Cross Hospital in a medical emergency triggered by her mental health condition. She has been hospitalized twelve times (including overnight stays for observation) since 2017. My daughter and our family have suffered because Maryland does not offer Assisted Outpatient Treatment

We are the parents of a daughter who has had multiple episodes of hospitals stays, police, sheriffs, emergency responses, court appearances, evictions, job losses, since 2017 because she is non-compliant in following outpatient treatment. Over this time, we have witnessed a slow, steady but unmistakable deterioration in her mental, emotional, and physical health. Due to her condition, she has refused to enroll in or participate in any current programs and would not let us assist her in enrolling thereof. Although she has been aggressive and abusive throughout her illness, and threatening to do harm to herself or others, she is now increasingly talking about suicide. AOT could enable her to become compliant in her treatment options and thereby regain a measure of stability, control, and independence in her life not to mention relieving us the emotional and financial burden of caring for a person with a chronic and progressively worsening condition.

Our daughter first experienced mental health challenges when she was going to Law School in a nearby large city. She was discovered by the police wandering the streets at night in her night gown. We found her a week later as a “Jane Doe” in a Mental Health Hospital. She was discharged 4 months later. She tried to get her life back but complained about the side effects of the medications. Although the doctors tried different combinations, she became increasingly reluctant to take them. Which translated to more frequent breakdowns and hospital stays. We have had to go to the courts multiple times to get Temporary Guardianship to get her to treatment options. This had limited effect, as the Guardianships would last a few months, court processes were very draining, and she became adept at gaming the system. Her repeated cycling into mental health crises due to non-compliance exacted a heavy toll emotionally on the family; from frequent loud and angry outbursts and abusive language, property damage and trashing the house, hallucinations, threats, violent encounters with the Police and Sheriff’s department when they came to enforce court ordered relocations to treatment facilities. Our youngest son, who shared a Jack and Jill bathroom with our daughter bore a substantial portion of the abuse, so much so that he became angry, withdrawn and demanded why she had to continue living at home. Which brings up the other effect of her treatment non-compliance. She could not keep any job for longer than a few weeks, she ran up thousands of dollars in student debt trying to go to graduate school online several times and

dropping out every time, she has run up thousands of dollars in credit card debt, totaled our car and even the insurance car rental all in the same week, she has been evicted from apartments multiple times due to financial and behavioral issues; treatment non-compliance has led her to refuse services (housing, SSA rental assistance etc.) and she has refused to give us permission to pursue the same on her behalf. SSA has cut off her assistance (which we had been able to secure one time during one of the Temporary Guardianships) and now she is totally dependent on us. Apart from the emotional toll, cancelled vacations, family get togethers, constant tension and stress in the house- the financial burden on us has been enormous- we calculate over the period of 6 years to have spent over $15,000 because she will not accept to access services. This is not to mention time away from work that either one of us must take whenever she has an episode. The neighbors have had to get accustomed to the frequent police and emergency vehicles traffic around our home. With her worsening condition through each cycle, and associated lessening and coarsening of her mental abilities- she has long past exceeded our abilities to care for her or guide her to appropriate care.

In conclusion, we support AOT as it will create a path for sustainable treatment of our daughter's condition and others like her; and save her life.

In conclusion we ask the committee for a favorable report on HB576.

SB453_SMorris_FAV.pdf
Uploaded by: Janet Edelman
Position: FAV

SB453 Testimony
S.MORRIS, Montgomery County
Position: FAVORABLE

My daughter has been hospitalized eight times, (this also includes a suicide attempt in July 2023), and she is currently hospitalized, because Maryland does not offer Assisted Outpatient Treatment. I had to file an Emergency Evaluation Petition for her twice, because she destroyed her sister's room and her room. She took a bat and destroyed everything. She was missing for four days and was drinking and smoking. She does not believe she is not well. She was harassing people at gas station and threw stuff all over the floor. They had to shut down the gas station for about forty-five minutes to clean it up. Luckily, someone recognized, that she was unstable and called the police and they transported her to the hospital. This could have been worse, what if someone reacted, and attacked her? She could also have been arrested, when clearly, she is unstable.

She would be assessed at the hospital, they would call and ask me a million and one questions and agree that she needs help, but still discharge her in two weeks. This is an unsafe discharge because, she is still not well. One time, she was discharged to a Homeless Shelter, and I was not informed that she was discharged. She could have been killed, attacked, or picked up by a sex trafficker. It seems that the social workers are so desensitized and do not care about the individual patient. No one at the hospital has ever called to discuss what her illness is about and how we can help her. I called and leave messages for the doctor, therapist, social worker and no one returns my call.

It also appears, that even though, it is clear the person is still unstable, they are discharged without any follow up medical care and therapy. Discharging an unstable puts the person suffering from the illness and the community in danger. This reoccurring cycle of in and out of the hospital and discharged two weeks later and back again in the hospital the next, day, week, or month must end. This only creates additional stress on family members and create more mental instability. This also can create depression and anxiety in family members.

We must end this vicious cycle. Mental illness is not to be taken lightly, too many have died, abused, and imprisoned, this could be avoided. I know and believe that, establishing an Assisted Outpatient Treatment as supported by SAMHSA in Maryland is a GREAT step towards helping our community with mental illness. This Program has proven results, the statistics are there, revealing reduction of homelessness, incarceration, victimization, drug use and even hospitalization.

PLEASE GIVE A FAVORBLE REPORT TO SB453.

SB453_Weiss_FAV.pdf
Uploaded by: Janet Edelman
Position: FAV

SB453 Testimony

Naomi Weiss
William Halpern
13101 Scarlet Oak Drive
Gaithersburg, MD 20878

Position: FAVORABLE

Our nephew, an orphan, under our care was diagnosed with paranoid schizophrenia when he was 23, still in college. He lived with us in Gaithersburg, and attended On Track Maryland where he willingly complied with the medication regime, essentially Clozapine. This returned him to the nephew we knew him to be. He continued college and had a job. As is typical to schizophrenic patients, after two years, believing nothing was wrong with him, he refused medication, and for over 18 months he disappeared, wandered around the country, until he was arrested and jailed in Syracuse, New York, then in and out hospitals for the next six years, suffered financial losses and became homeless, wandering the streets stealing food, giving away his possessions until he ended up in a group home that provided him with services under an AOT program. Under this program, he agrees to take his medication, is treated as a human being, and attends monthly sessions run by the county AOT administrator, including his psychiatrist and therapist. We need this program in Maryland. This program means saving lives that otherwise would end up in terrible circumstances. Highly trained mental health professionals throughout Maryland should be allowed this tool to more effectively do their jobs by saving our children, friends, families and preventing unthinkable circumstance that might otherwise occur.

We ask for the committee to issue a favorable report on SB453.

SB 453, FAV, FCG OCE JF, 2024.pdf
Uploaded by: Jessica Fitzwater
Position: FAV

Jessica Fitzwater
County Executive

FREDERICK COUNTY GOVERNMENT

OFFICE OF THE COUNTY EXECUTIVE

SB 453 – Mental Health – Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment Programs

DATE:	February 20, 2024
COMMITTEE:	Senate Finance Committee
POSITION:	Favorable
FROM:	The Office of Frederick County Executive Jessica Fitzwater

As the County Executive of Frederick County, I urge the committee to give SB 453 – Mental Health – Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment Programs a favorable report.

This bill will require counties to establish an assisted outpatient treatment program and provides a framework for how to do so.

The State of Maryland is currently facing a behavioral health crisis which is impacting the wellbeing of our communities and putting a strain on our hospital systems and law enforcement resources. One pathway to easing this burden is to create Assisted Outpatient Treatment programs for those who may benefit from this approach rather than a detention center or hospital stay. Currently, Frederick County has a comprehensive system of care with a mix of traditional and alternative services. We have excellent working relationships with local agencies and community partners. Through our partnerships, we have demonstrated significant positive health outcomes for those with severe and persistent mental illness; yet we still struggle to serve a handful of individuals with complex behavioral and mental health needs.

SB 453 is a vital first step in assisting those who are struggling with behavioral health issues. This program, if funded adequately, may save lives, reduce hospitalization length of stays, reduce repeat emergency department use, and reduce the number of arrests and incarceration rates. By providing Counties with the frameworks and resources necessary to carry out these programs, the State has the potential to make a large impact on helping some of our most vulnerable residents.

Thank you for your consideration of SB 453. I applaud the Governor for this forward-thinking approach to addressing this crisis and I urge you to advance this bill with a favorable report.

Jessica Fitzwater, County Executive
Frederick County, MD

AOT Senate Bill 453 Letter of Support 2.19.24.pdf
Uploaded by: June Chung
Position: FAV

STATE OF MARYLAND
OFFICE OF THE GOVERNOR

WES MOORE.
GOVERNOR

STATE HOUSE
100 STATE CIRCLE
ANNAPOLIS, MARYLAND 21401-1925
(410) 974-3901
(TOLL FREE) 1-800-811-8336

TTY USERS CALL VIA MD RELAY

February 19, 2024

The Honorable Chair Pam Beidle
Chair, Finance Committee
3 East, Miller Office Building
Annapolis, Maryland 21401

RE: Senate Bill 453 - Mental Health - Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment Programs - Letter of Support with Amendments

Chair Beidle and Vice Chair Klausmeier and Members of the Finance Committee:

On behalf of the Moore-Miller Administration, with the partnership of the Secretary of Health and the Maryland Department of Health (MDH), I respectfully request a favorable report on Senate Bill 453 - Mental Health - Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment Programs.

Senate Bill 453 supports the Governor's priorities of leaving no one behind with this legislation intended to improve mental health services in Maryland. A large part of the bill establishes assisted outpatient treatment (AOT) in the State. Forty-seven states have some form of authorizing legislation for AOT. It is time for Maryland to follow suit. Under current law, the only court-ordered treatment is involuntary inpatient commitment through the criminal justice system.

The bill establishes court-ordered outpatient treatment at a county level for individuals with serious and persistent mental illness that demonstrate the inability to function in the community without intensive treatment. Programs must be approved and overseen by the local behavioral health authority, and annual reporting is required by the Behavioral Health Administration under MDH. The goal is local administration with centralized oversight. Court-ordered outpatient treatment provides one more tool to help individuals with serious and persistent mental illness and prevent repeated hospitalization, homelessness, and interactions with the criminal justice system.

With the growing need for mental health services, making AOT programs available statewide continues the Governor's and Maryland General Assembly's commitment to improving behavioral health care access and services. MDH is actively staffing and working on the charge of the Commission on Behavioral Health Care Treatment and Access, created by Chapters 290 and 291 and passed by the legislature in 2023.

Senate Bill 453 additionally makes changes to the authority of psychiatric nurse practitioners in the emergency evaluation process. In combination with the establishment of court-ordered outpatient treatment, this legislation is another step in improving and developing mental health access and care in the State.

With the leadership of the Secretary of Health and MDH, I respectfully ask for a favorable report on Senate Bill 453. Amendments to be discussed in the bill hearing.

Thank you for your consideration. If you have questions, please contact June Chung, Deputy Legislative Officer at june.chung@maryland.gov.

Sincerely,

June Chung

HB453 AOT Bill Testimony_Pogliano.pdf
Uploaded by: Laura Pogliano
Position: FAV

HB453 Testimony
February 8, 2024
From: Laura Pogliano, 4010 Linkwood Road, Baltimore, MD 21210
Position: FAVORABLE

My only son Zaccaria was stricken with schizophrenia in 2009 as a junior in high school. Unlike many who become seriously mentally ill, my son was mostly compliant with treatment but he was very affected by illness and became medication-resistant. In early 2012, he stopped taking medication because he believed I was poisoning him. There was no remedy for this. Neither his doctors nor I could convince him to continue care. As the weeks passed, he became critically ill. He stopped eating and drinking due to fears of being poisoned. His delusions told him his ankles were pulverized by a hammer-wielding alien, and that he had a brain tumor and broken back. By the time I was able to use Maryland's emergency petition to get him seen in the ER, he had been in bed for ten days, with only ice chips and small sips of water. He could no longer walk without assistance. *He entered the hospital in a wheelchair.* He was 20 years old, a former athlete, pianist and drummer.

Though hospitalized, he refused "poisonous" medication and he was allowed to. On day 11 of this inpatient stay, insurance tried to dismiss him before he had even had a single dose of medication. He was mute, catatonic, and in a wheelchair. The hospital petitioned the courts. I could only hope the courts declared him incompetent and forcibly medicated him. There were no laws to protect us if insurance dismissed him, and had the courts sided with the disability rights lawyer, who insisted my son could make his own medical decisions, I would have taken home a grown child who could not speak or move, in a wheelchair, and spoon fed him and ultimately, watched him die. The courts decided he was not competent and could be medicated. In total, he was hospitalized 86 days. That's how long it can take just to restore competency. As upset as I was over this incident, my son was equally baffled to discover he'd lost three months of his life due to illness and that he had never been poisoned or endured pulverized ankles and a broken back, etc. HIs exact words were: "What happened to me, Mom?"

When an individual is too sick to know he's sick, he absolutely needs family to be able to keep him in care. Instead of incurring *hundreds of thousands of dollars in medical bills over that three month stay*, and instead of letting his brain sustain more damaged without medication, my son could have been court ordered and resumed medication fairly quickly under an AOT order. We know medication works, but also that this takes time.

AOT can give the family and their loved one that time.

I host a weekly family support meeting for caregivers of those with schizophrenia. Nearly every family in my group of over 100 Maryland families is facing a dismal outcome because there is no way to access medication when circumstances are dire. *There are exactly two success stories in my support group* and they are directly related

to accessing AOT in NY and MI, keeping the patients on court ordered treatment long enough to regain competency and understand that they need medication to live successfully. Both families went from trauma, chaos, incarcerations, and despair, to watching their children become healthy, employed, loving individuals again. These two families “got their children back,” but because of AOT laws that are funded and correctly implemented in their states and counties.

Our “voluntary” system of care only works if you are already healthy in some capacity. And our streets and gutters and morgues are filled with the evidence of what happens when you’re too sick to ask for help. The irony is that if my son had had another brain disease, I would have been legally negligent in not seeking care. But with a psychiatric diagnosis, I was required to let him get as sick as he possibly could and encouraged to let him make his own medical decisions when he couldn’t even speak or move. The situation at the hospital was so desperate that 2 years later I ran into a doctor who’d treated him, and she tearfully asked me, “Remember when we almost lost him?”

My son’s illness was too much for him and he died in his sleep at age 23. It is too late for my son, but you have to do the right thing for other families facing this ruin. AOT has proven successes. It is not a means to railroad mental patients. It is relief from misguided laws that insist every patient is capable of asking for help and participating in care. Please don’t let other families experience this nightmare.

Sincerely,
Laura Pogliano
Families for Treatment, Maryland
Baltimore, MD 21210
815-953-3844

AOT Testimony for MD 2024 Senate Bill.pdf
Uploaded by: Leslie Carpenter
Position: FAV

SB453 Testimony

Position: SUPPORT

Leslie Carpenter

60 Spring Valley Dr, NE

Iowa City, Iowa 52240

My name is Leslie Carpenter and I am urging you to vote for SB453.

After tragedies in which someone with an untreated serious mental illness has killed someone or themselves, there are often outcries of "Where was the Family?" or "Why didn't they get him treatment?" or "Why didn't he choose treatment?"

So glad you asked. I can tell you, as the mom of a 33 year old son who lives with a very severe Schizoaffective Disorder, who has been hospitalized 26 times over the past 17 years.

We are doing everything we can to get their loved ones the treatment they need…but meeting barriers at every turn if our loved one is so sick they cannot "volunteer" for treatment.

Sadly, someone with an untreated psychosis often has no ability to recognize that they are sick and need treatment, due to changes in the frontal and parietal lobes of their brains, as part of the brain illness itself. Someone suggesting they take an anti-psychotic medication sounds as dangerous to them, as someone asking one of us to take Insulin when we don't have Diabetes.

This bill, if passed, would help by allowing for appropriate, collaborative and monitored treatment "in the community" so that the person can be helped beyond the walls of a psychiatric unit in a hospital.

Many people testify against these bills because of traumatic inpatient treatment they have received. I agree with them that trauma happens in hospitals. But these bills are <u>not</u> to get more of that inpatient treatment…they are to limit the need for that by allowing for treatment as outpatients, in the community.

We started Iowa's first AOT program and over the first 8 months of our program, we reduced hospitalizations by 81%, from 129 prior to AOT, to 3 after AOT. We reduced the hospital days by 78% from 699 prior to AOT to 29 after AOT. This was for the 12 patients helped so far.

Please vote for this bill to take the first step to save the lives of people who desperately need this medically necessary treatment. You can restore their HUMAN rights for treatment and sanity!

Respectfully submitted,

Leslie Carpenter

TAC Testimony SB 453 Dailey.pdf
Uploaded by: Lisa Dailey
Position: FAV

Testimony by Lisa Dailey, Executive Director of Treatment Advocacy Center
Submitted to Senate Finance Committee
Hearing regarding SB 453: February 20, 2024 at 1:00 pm
POSITION: STRONG SUPPORT

Thank you for the opportunity to submit written testimony. I am writing as the executive director for Treatment Advocacy Center, a national nonprofit focused on eliminating barriers to treatment for those with severe mental illness. I am also writing as the sibling of a person who was able to stabilize during a period of psychosis due to her enrollment in an AOT program in another state, Wisconsin, where outpatient civil commitment is a normal part of the continuum of care used to help people to return to their communities more quickly and retain the gains they achieve during inpatient treatment at a period of time when the extra support is critical.

While many focus on the fact that this treatment is court-mandated, the key thing to remember about assisted outpatient treatment is that it is *outpatient.* Testimony from opponents tends to focus on bad experiences from hospitalization without recognizing that AOT is designed to be a less restrictive alternative to hospitalization that allows individuals to stay in or return to their community support systems while receiving sufficient assistance and supervision to do so safely. It is fully consistent with the preference for delivering care in the least restrictive setting appropriate to need outlined in the holding for *Olmstead v. L.C.,*[i] in which the U.S. Supreme Court directed states to find alternatives to longer term placement in institutional settings.

Maryland, because it does not have authority for outpatient civil commitment, has created a situation in which the people with the most severe psychiatric illness but who lack the ability to perceive their need for continued treatment alternate between the highest level of restrictive care (hospitalization or criminalization) and no care, deteriorating in their communities until their symptoms can no longer be ignored. Every period of psychosis that goes untreated makes it less likely that the individual will be able to return to their prior level of functioning.

Civil commitment is not a step to be taken lightly, but some Marylanders are relying on intervention as their only hope to escape the mental torture of psychosis. It is our duty to provide a pathway to recovery for *all* Marylanders, not just those who are well and insightful enough to attend a hearing and give composed testimony.

Respectfully,

Lisa Dailey

[i] 527 U.S. 581 (1999).

Written Testimony in FAVOR of SB 453.pdf
Uploaded by: Maria DONNELLY
Position: FAV

Written Testimony in FAVOR of SB 453

Maria Dolores Donnelly
154 Fair Hill Drive
Elkton, MD 21921

I am both founder and director of a non-profit community outreach ministry. I serve those most
forgotten in our community such as those in our local Title 1 school, the local nursing home, and women in the local detention center. I am also the parent of a son with SMI or severe mental illness. In this capacity I give my testimony. I reside in Cecil County, Maryland.

My son suffers from a severe mental illness. He is, and has always been, a well-liked and gentle soul who was never in trouble with the law in the least. He was captain of the high school soccer
team, played baseball, basketball and soccer, and was chosen homecoming king in his senior year. In addition, Daniel always had a part time job, participated in youth groups, and applied, was accepted, and attended college until he was too ill to attend. He is now, at the age of 24, incarcerated in a forensic hospital because of not receiving the care he needed while at the height of a severe schizophrenic cycle. His name is Daniel.
Because of severe hallucinations and psychotic voices, Daniel, who I affectionately call Danny, tried to take his life with a gunshot wound under the chin at the age of 20. Miraculously, with the hand of God through good samaritans, city police, and the skilled care of oral maxillofacial surgeons, critical care doctors and nurses, my son survived. After more than one year and 11 surgeries later his mouth and face were restored. He could see, though not perfectly, could eat and speak close to baseline, and the wound in his face was mostly repaired without great tragic loss. Let me be clear with you that it was the psychotic thoughts and delusions that drove him to the point of suicide.

After that first year of Daniel's physical healing, the severe mental illness that drove him to the suicide attempt remained. Though he had biweekly psychological counseling using ERT (Exposure Response therapy) and CRT(Cognitive Behavioral Therapy) in addition to monthly psychiatrist visits, Daniel was constantly tormented in his mind. Daniel's condition worsened. From February to April of 2023, two years after his suicide attempt we took him to Christian Hospital, Wilmington Hospital, Union Hospital, and Sheppard Pratt Psychiatric Urgent Care seeking help for suicidal and even homicidal thoughts. He was hospitalized twice in mental

wards to make him stable, and each time was released after 7 and 10 days respectively.. At each release he was assigned to go to IOP -intensive outpatient programs. One social worker even told me, and I quote, “I wish we didn't have to allow him to leave.” Daniel had petitioned to get out. Daniel had come to the point of anosognosia and was not able to realize he needed Treatment.

The very evening Daniel was released from Sheppard Pratt as an inpatient, Daniel left home having delusions and would not return. We tried everything we could. Then Daniel was no longer heard from and found people who took him in but wouldn't tell us where he was.
Two weeks later, on May 7, 2024, Daniel allegedly broke into a friend’s home. The friend was not present, but the police were called. Daniel allegedly picked up the friend’s shotgun, went into the woods and began shooting it. Thankfully no one was seriously hurt. Three police officers were hit but
released the same day. Thankfully Daniel did not lose his life. Daniel was arrested, and while out of his mind, allegedly attacked a prison guard. My sweet son who previously had no record, never fought, was a friend to everyone was now on arrested, bound, and on 24 hour suicide watch. Daniel stayed on suicide watch for about three weeks. Daniel was started on medication after I informed the prison nurse of his condition. Several days later, a judge ordered Daniel incompetent to stand trial. When a bed became available Daniel was transported to Clifton T Perkins Psychiatric Hospital in Jessup Maryland. My son is still there today, February 12, 2024, and will be there until his trial date. His future is uncertain, and he faces very serious charges. If Daniel was given AOT he would not be in prison today. He would have received the diagnosis and medication that would have restored his mind to stability. Because AOT was NOT mandatory and enforced, he lost his freedom, his health, his family and his future. The schizophrenia cycle progressed because he did not have the care he would have received through AOT. He also now has increased brain damage because he did not receive necessary care. People who have SMI are often not well enough to know what they need. This bill is necessary to help those who cannot help themselves, to help them have health, their life, a community, and a future. Please, please, please vote in favor of House Bill 576.
Respectfully submitted,
Maria Donnelly

SB453 MJM written.pdf
Uploaded by: Marilyn Martin
Position: FAV

Favorable SB453
From: Marilyn Martin, 11509 Emmanuel Way, Solomons, MD 20688
Feb. 20, 1:00 p.m., Senate Finance Committee

My adult son had his first psychosis in 2008. He has been hospitalized at least 18 times up until 2016. That was the year of his psychosis-induced assault upon my then 71-year-old spouse. Assisted Outpatient Treatment (AOT) would have been enormously helpful in preventing his decline. My son had never been violent prior to this.

My son has never reacted well to change. When the nurse providing my son's monthly medication injection left his outpatient clinic, my son refused the prescribed injection from the new nurse. The only medication he agreed to take was one that had previously stopped working for him. That was when my son needed AOT. Studies show that AOT can dramatically improve treatment outcomes and substantially reduce the likelihood of repeat hospitalization and criminal justice involvement for its target population.

Instead, my son deteriorated so much that he assaulted my then 71-year-old husband, who ended up on the floor, bloodied from head wounds, and traumatized. My son now has a criminal conviction. Only after committing a crime could my son get court-ordered outpatient service. Statistics from other states show that the program works due to the "black robe effect" of going before a special judge provided by the AOT program. He received three years of probation but now has a criminal record.

My son has succeeded in remaining effectively medicated since that assault. So, the "black robe effect" did work in his case. However, an Assisted Outpatient Treatment program would have achieved that same outcome much more compassionately than the criminal justice system.

Not only does AOT work compassionately for those with brain disorders, but it also saves money. It reduces costs for police, incarceration, judicial systems, and hospitals.

SB453_Burgholzer_FAV.pdf
Uploaded by: Marilyn Martin
Position: FAV

SB453 favorable
Jill Burgholzer, DNP
112 Saint Claire Place, Suite 202
Stevensville, MD 21666
Health & Government Operations Committee, Feb. 20, 1:00 p.m.

I'm writing in support of state legislation (SB453) to enable the establishment of Assisted Outpatient Treatment (AOT) programs in Maryland to provide a path to treatment for the high-risk subset of those with serious mental illness (SMI), which our current system is incapable of treating.

As a psychiatric nurse practitioner working in emergency departments and acute inpatient psychiatric units in multiple hospitals in the Baltimore area, I wholeheartedly believe the addition of AOT programs would make a significant difference in reducing the suffering of our state's vulnerable citizens who are suffering from serious, chronic mental health disorders. I have reviewed data from other states that have been successful with an AOT program and urge your favorable vote.

SB453_Gieser_FAV.pdf
Uploaded by: Marilyn Martin
Position: FAV

SB453 SUPPORT
Nancy Gieser, Frederick, MD
Feb. 20, 2024, 1:00 p.m. -Senate Finance Committee

Passing AOT is a personal matter to me. I have family members who have or are suffering from severe mental illness and have tried to help my loved ones for decades. I have watched as family members go to the hospital (because of being a danger to themselves and possibly others), only to be discharged the same day, or after a few days, even a week, and return with little or no improvement in outcome.

AOT would help those who suffer from severe mental illness and their families get much needed and effective community resources. AOT would reach out to people who experience symptoms (such as delusions, hallucinations, paranoia, anxiety, hearing voices, or extreme mood changes) and often have no insight into their illness or the need for treatment. They often refuse treatment or are unwilling to access treatment.

AOT would help family members who have tried to help, but are overwhelmed by a system that lacks sufficient pathways to get help. Often crises emerge that lead to hospitalization, but such stays are short and patients are discharged after several days with only a prescription and follow-up suggestions to seek treatment. AOT could help to get treatment before hospitalization and to reduce hospital visits.

The societal benefits of AOT would include reducing the number of police responses in the community, the number of hospital visits (in an already overwhelmed system), the number of inpatient stays, and the number of arrests and incarcerations. Studies have found that AOT is effective, and that it reduces costs of treatment. Providing AOT and resources for treatment teams would be a benefit to many in Maryland.

I urge that the committee prepare a favorable report on AOT.

SB453_Kerr_FAV.pdf
Uploaded by: Marilyn Martin
Position: FAV

SB453 FAVORABLE
Amy Kerr
592 Riverside Dr, Pasadena, MD
Assisted Outpatient Treatment
February 14, 2024 – Senate Finance Committee

My son is currently sitting in Sheppard Pratt Hospital refusing medication because he has anosognosia (the inability to see that he is ill). He finally met the archaic criteria to be hospitalized as he became a danger to society. He bought a switchblade online, played with kitchen knives, and he also slept with them in his room. He was determined to protect his inner voices and would often do knife play in the air throughout the neighborhood. Once he is stabilized and deemed not a threat to society, he can return to our home. The single component that will keep him stabilized and not a threat to society is medication compliance and going to his psychiatrist and therapist. With Assisted Outpatient Treatment services, it will guarantee his success, and in fact will protect society while being fiscally responsible with tax payer dollars. It has been proven that AOT prevents frequent hospitalizations, jail time and homelessness. Not to mention, it allows the caretaker a vital support system and it allows me to work my full-time job, not missing days, and keeps me healthier knowing there is a team that will not allow my son to become a danger to himself or society again. Operating from a treatment before tragedies happen is a win-win. Fiscally its responsible and mentally it supports the health of both caretaker and the person living with the illness. Finally, it's the humane thing to do.

Sincerely,

Amy Kerr

SB453_KLSmith_FAV.pdf
Uploaded by: Marilyn Martin
Position: FAV

SB453 - FAVORABLE
Kathleen Smith, Waldorf, MD, Charles County
Senate Finance Committee, Feb. 20, 2024 – 1:00 p.m.

My name is Kathleen Smith; I am a resident of Charles County Md. I am a Member of Southern Maryland NAMI and the mother of an adult son who has severe mental illness as well as developmental disabilities. If AOT had been in place, I believe that my son's incarceration in a Maryland prison for 20 years, with sixty years suspended, would have not been his outcome. My son was sentenced to 80 years with 60 years suspended; so, he was to serve 20. He served 10, but we had to obtain guardianship during his incarceration. Then he was conditionally released. He now lives with us and is on multiple injectable and oral medications.

As Paul grew older, his mental illness worsened, and his behaviors deteriorated at an alarming rate. His inability to control his actions and his rising level of oddness, suicidal tendencies, and destructive behaviors towards himself, his family, and society became hard to manage.

Since 2001, I have contacted many state agencies, legislators and limited private agencies about my son, pleading for help, guidance and explaining the difficulties with obtaining care for him. My son was placed in a residential treatment facility and was discharged per our insurance company's instructions, disregarding the facility's recommendation for his staying longer to be stabilized. He was discharged, and our insurance coverage for him was exhausted for the fiscal year. Within months from his discharge, my son deteriorated, and immediate services were not available as he needed residential treatment again. At this time, my son was a school age teenager. The Calvert County LCC held a meeting and recommended that if we had him arrested as a teen that then the Dept. of Juvenile Justice would be able to create a paper trail to prove that he needed treatment and could get him treatment. This was the worst and most devastating chain of events to my son's mental health. This action worsened his paranoia, broke the parent-child trust bond, and introduced him to worse criminal behaviors within the walls of a juvenile detention center while waiting over six months or more for an available bed. The Dept. of Juvenile Justice felt this was appropriate, but I disagreed due to his coexisting developmental disabilities,

Once he was released from the Dept. of Juvenile Justice at the age of 18, my son knew that he had the right to refuse medication and treatment because no judge was mandating that he adhere to either.

If AOT had been in place for Paul as a teen into adulthood, it would have spared him a felony conviction. Not having AOT has further damaged his future and impacted ours as older parents. He can barely find a job, and nobody will rent him housing or accept him into an RRP housing program. So, as elderly parents, we are now burdened with the ramifications of MD not having AOT.

SB453_KristinaRolfes_fav.pdf
Uploaded by: Marilyn Martin
Position: FAV

SB453 – FAVORABLE
Kristina Rolfes, 13021 Gent Rd., Reisterstown, MD 21136
Senate Finance Committee, Feb. 20, 2024, 1:00 p.m.

AOT CAN SAVE LIVES

My family is one of many who have loved ones that suffer from severe mental illness and, when in psychosis, are unable to recognize that they have a disorder and need assistance. My family member has been hospitalized numerous times. Due to his illness, he has difficulty maintaining steady employment and making good decisions for himself. During periods of psychosis, he does not believe anything is wrong with him and therefore does not see the need for treatment. During these periods, he suffers from delusions that put him and others in danger. Each time he is hospitalized, he is discharged in 7-10 days with no follow-up care. The hospital's idea of a discharge plan is to provide him with the locations of homeless shelters.

Assisted Outpatient Treatment (AOT) is a much-needed, evidence-based tool that would allow families like mine to help their loved ones. Without it, individuals too often cycle in and out of the hospital, homelessness and jail, and families are unable to intervene to get them treatment. AOT is a tool that could greatly help my family member and so many others like him live a happy and productive life.

We do not let people with other brain illnesses, like dementia, wander the streets, refuse treatment, and slip into homelessness. There is no reason why severe mental illness should be different. We must realize that some people, due to the nature of their illness, are unable to advocate for their own best interests. That leaves us family members to advocate for them. You must take into account the lived experiences of family members who are desperately trying to help their loved ones access treatment but have their hands tied.

When my family member is on medication, he is a hardworking, productive, thoughtful young man. But if he stops taking it, which he has done before, we could very easily lose him to homelessness or death. AOT has been proven to reduce hospitalizations, arrests, homelessness and incarceration. It gives mental health professionals and families another tool to help treat people with serious mental illness in a community-based setting. Studies show that AOT can dramatically improve treatment outcomes and substantially reduce the likelihood of repeat hospitalization and criminal justice involvement. Please listen to family members like mine and find it in your heart to support AOT.

Please give a favorable report on SB453.

SB453_Mulreany_FAV.pdf
Uploaded by: Marilyn Martin
Position: FAV

SB453 - FAVORABLE
Melissa Mulreany, Howard County
Health and Government Operations Committee, Feb. 20, 2024, 1:00 p.m.

The availability of evidence-based Assisted Outpatient Treatment (AOT) could be a life changing tool for our family and friends with serious mental illness (SMI). My personal experience involved a relative who was unaware of his illness due to anosognosia, a neurological cognitive deficit caused by the mental illness, which prevents recognition of one's illness and the need for treatment. Therefore, he refused voluntary treatment.

For twenty years my relative struggled to get and keep a job, but without medications and ongoing psychiatric assistance he was not able to maintain gainful employment or independent living. Had evidence based AOT been available in Maryland to provide treatment, he would not have suffered for so long and been unable to achieve his goals.

After finally getting on medication and psychiatric care, he has gained the ability to understand his illness and the benefits of treatment. He is also now able to hold a job.

Our family could have been spared over twenty years of grief and uncertainty as we struggled to protect him from himself and the ravages of an untreated serious mental illness.

Please support SB453 to add evidence-based Assisted Outpatient Treatment to the options available to mental health professionals and give individuals with untreated SMI (and their families) hope for life as a healthier and contributing member of society.

SB453_MVSmith_FAV.pdf
Uploaded by: Marilyn Martin
Position: FAV

SB453 SUPPORT
Mary Virginia Smith, Ph.D.
1615C Piccard Dr Apt. 1404
Rockville, MD 20850
Feb. 20, 1:00 p.m. –
Senate Finance Committee

My son, now 47, suffers from ASD and PDD with co-occurring Bipolar Disorder NOS and Schizoaffective Disorder Bipolar Type.

He has been homeless.

He has been hospitalized seven times on emergency crisis intervention criteria - dangerously staying over 18 hours in ER rooms waiting for nearly non-existent mental health division beds, costing the already poorly funded mental health care system exorbitant amounts of public funds, and disrupting his life and that of his family over and over and over and over and over and over and over (that's seven, isn't it?).

As his Social Security Representative Payee and life-time family case manager, I can testify that his homelessness and all hospitalizations could have been averted were AOT assisted outpatient treatment programs available to us in Maryland (and Virginia) during these horrific decades.

For this reason, I am writing urgently and strongly to support SB453 for immediate authorization of assisted outpatient treatment (AOT) programs in Maryland.

AOT serves those with severe mental illness, such as schizophrenia, bipolar disorder, and other serious mental illnesses, who, as a result of the illness itself, are unwilling or unable to consistently engage in voluntary treatment.

Maryland ignominiously is one of only three U. S. states that does not authorize AOT. Studies show that AOT can dramatically improve treatment outcomes and substantially reduce the likelihood of repeat hospitalization and criminal justice involvement for its target population. AOT also reduces cost and strain to treatment systems struggling to serve individuals “caught in the revolving door” of repeat hospitalizations, homelessness, and incarcerations.

My son and I are living testaments of the requirement to pass SB453 for immediate authorization of assisted outpatient treatment (AOT) programs in Maryland.

My son and I trust you as our elected officials to support authorization of SB453.

SB453_Pickar_FAV2.pdf
Uploaded by: Marilyn Martin
Position: FAV

David Pickar, MD

Adjunct Professor of Psychiatry
Johns Hopkins School of Medicine
Uniformed Services University of the Health Sciences
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Maryland Medical License D0039290 NPI 1053456343

SB453 FAVORABLE
David Pickar, MD
4915 Dorset Avenue
Chevy Chase, MD 20815
Senate Finance Committee, Feb. 20, 2024, 1:00 p.m.

After 47 years of practicing psychiatry, including over two decades as a scientist and Branch Chief in the National Institute of Mental Health Intramural Research Program charged with running the schizophrenia research unit at the NIH Clinical Center, I continue to be progressively concerned about the care and safety of our mentally ill patients.

Schizophrenia is the most serious of the mental illnesses affecting approximately 1% of the population of the entire world. And like Bipolar I disorder, involves symptoms of psychosis, i.e., loss of touch with reality.

Psychosis can be manifested by a range of disturbed behavior, some of which may result in danger to the self-and/or to other people. Most patients receive treatment under voluntary conditions in outpatient and inpatient services. Weeks or months are often required to experience good clinical response and many patients go on to reach good stability, even in the face of illness.

Unfortunately, a substantial number of patients with schizophrenia and psychosis, often in relation to the presence of paranoia and a myriad of delusional symptoms, do not maintain medication treatment. This often results in unmodulated psychosis and dangerous behaviors. Although most patients with psychotic illnesses are not violent, the role of serious mental illness in tragic acts throughout the country is a very well documented fact.

Involuntary hospitalizations carried out when there is risk of danger to self or others have long been part of the management of patients with serious mental illness. As a psychiatrist who often works with patients with schizophrenia, involuntary hospitalization is not a rare occurrence. It is difficult for the patient and, on a personal note, very difficult for the clinician and, of course, the family. An unfortunate reality in Maryland is the principal way

in which treatment is administered to these seriously ill patients; it is in jails or court ordered treatment in state hospitals.

Assisted Outpatient Treatment (AOT) enables treatment to be administered under a civil order to a small but highly meaningful number of patients with serious mental illness on an outpatient basis. The order requires an individualized treatment plan for one year monitored by the local mental health system. This carefully managed outpatient treatment enables a patient to optimize medication response and psychosocial support.

Non-adherence to treatment includes an appearance in court for status review, reassessment of treatment plan, or if necessary, evaluation for hospitalization. AOT is practiced in 47 states and the District of Columbia. Maryland is one of 3 states without the availability of this critical tool. Most of us who take care of seriously mentally ill patients here in Maryland deal with the deficiency of no AOT on a regular basis. I encourage the Maryland legislature to pass the currently proposed legislation that would legalize AOT. I am a very proud citizen of Maryland and sincerely hope our elected legislators correct this indefensible deficiency.

I am asking respectfully that you support SB453, to institute this positive life-altering treatment.

SB453_SRao_FAV.pdf
Uploaded by: Marilyn Martin
Position: FAV

SB453 SUPPORT
Swaroop Rao, M.D, PhD, Montgomery County
Assisted Outpatient Treatment
Feb. 20, 2024, Senate Finance Committee

My name is Swaroop Rao. I am an Internist living in Rockville, Maryland. My son who has Paranoid Schizophrenia, has been ill for the past 25 years. I ask you to support the Assisted Outpatient Treatment bill for Maryland as I believe this resource might have made my son's prognosis much better and would have helped him avoid multiple incarcerations.

My son, diagnosed at age 12, has demonstrated all the signs of paranoia, including suspicions of being poisoned, hallucinations, anxiety, and insomnia. Over the years, because he has anosognosia and does not understand that he is ill, he often refused to take his medications and even refused to go to appointments that I arranged.

My background as an Internist afforded me no advantage in accessing care for him. The eventual result was that he encountered the Criminal Justice System again, and again, and again. Jail cells do not provide a safe therapeutic environment for needed psychiatric care.

Today my son is a 32-year-old man who lives with his mother. Although he takes his medications now, he is still chronically frightened. He has no friends and has had no meaningful life since middle school.

Research indicates that more frequent and prolonged periods of psychosis are directly related to decreased response to treatment and worse clinical and social outcomes. Timely Assisted Outpatient treatment might have helped my son avoid multiple prolonged psychotic episodes, stabilize earlier, recover, and become a useful member of society.

I ask you to support SB453 and Assisted Outpatient Treatment (AOT) in Maryland. This would commit the State Mental Health System to provide an outpatient treatment option for those with anosognosia who refuse voluntary treatment. It would also address the current lack of coordination between the primary care physician, psychiatrist, social services, the criminal justice system, and the caregiver. My son might have cooperated earlier and avoided multiple incarcerations and psychotic episodes if a judge had told him that he must accept outpatient treatment to avoid hospitalization.

Serious mental illnesses require long-term treatment. AOT provides the long follow-up period needed to determine the best treatment for those unwilling to accept voluntary treatment. AOT provides integration in the community and preferable to the isolation of repeated hospitalizations and incarcerations and makes financial sense.

SB 453 Mental Health.pdf
Uploaded by: Mary Moran
Position: FAV

SB 453, Mental Health - Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment Programs
Date: February 20, 2024
From: Mary Ellen Moran, Bowie, Maryland 20716 (District 23)
Position: SUPPORT

As an individual with bipolar disorder and with a son with schizophrenia and a deceased mother who had schizophrenia, I am pleased to support SB 453. As a taxpayer I am entitled to treatment. This Bill would ensure that I receive treatment in the least restrictive setting in the event I ever meet the criteria for Assisted Outpatient Treatment.

My mother frequently stopped taking her medication and was committed to psychiatric hospitals at least 18 times before she died at the age of 43. I recall that when I was school age I would call my favorite Aunt and say "Mom is talking funny again." My Aunt and other family came to the rescue. I really missed her when she was hospitalized. When well she was a wonderful Mom. She made the most delicious chocolate chip cookies on earth, She did have a lot of respect for the law and judges; and I am certain had a judge ordered her to take her medication she would have. My childhood would have been happier without her absences from my life.

According to Maryland State Law, Health - General, §10–102:
"It is the policy of this State:
"(1) To the best of its ability, to foster and preserve the mental health of its citizens; and
"(2) To that end, to provide without partiality care and treatment to citizens who have mental disorders."

SB 453 reflects the above-cited statutory policy, and. It ensures that treatment is provided in the least restrictive setting The Bill ensures a treatment plan that is comprehensive and considers all aspects of living successfully in the community. Respondents are given a reasonable opportunity to participate in the plan development.

SB 453 also allows for an emergency evaluation of whether I need involuntary admission to a hospital. All aspects of what is in my best interests are covered by this bill and it ensures that I get the treatment I need. It is critical that I receive treatment as soon as possible when I need it and am unable to make a rational and informed decision to seek it.

SB 453 reflects evidence-based practice and, as written, needs no amendments. Therefore, I respectfully request that you give SB 453 a favorable report with no changes.

SB0453 support.pdf
Uploaded by: Matthew Brandt
Position: FAV

SB0453 testimony

Matthew Brandt

Baltimore City

Position: Support

I used to think medications made people zombies or in some way less of themselves. In my years working in mental health, first as a Mental Health Specialist now as a resident physician training in psychiatry I have come to appreciate how wrong I was.

Medications can allow people to be their true selves, and even more importantly it can allow people to live the lives they want to live and avoid the horrific repercussions of untreated mental illness. Practicing psychiatry in Maryland I have already seen countless instances where people succumb to their untreated illness and face grave outcomes. One patient has been readmitted to the hospital countless times, each time sicker than the last, in the throws of psychosis. One patient now in prison after hearing voices telling them they were in danger and in the midst of that fear, assaulting a stranger. Another patient languishing in jail, awaiting trial for a crime that stemmed from their disorganized behavior. All of whom were untreated.

A crux of this issue is that all of these patients have the symptom anosognosia, a blindness to their illness that is in fact a symptom of that very illness. (also seen in stroke where a person is paralyzed but believes that they can still move their body willingly). Around 50% of patients with serious mental illness have this symptom that means they are completely unaware of their illness, and thus unable to see the need for treatment.

These patients often end up in jail, with repeat hospitalizations, or in the worst cases- dead. Without a means to provide treatment to individuals at the intersection of serious illness, a lack of awareness of this illness and a system that can criminalize this combination, these patients will continue to suffer the grave consequences of their disease- a loss of freedom, rights, and life- taken from them by their illness.

I am writing in support of SB0453, thank you for your time and consideration.

Morgan AOT Testimony (1).pdf
Uploaded by: Morgan McCulley
Position: FAV

SB453 Testimony

Morgan McCulley, Montgomery County

Position: FAVORABLE

Hello, My name is Morgan McCulley. I have been working with individuals with severe mental illness for 10 years. I have worked with individuals that have benefited from AOT in the District of Columbia where this is referred to as a Civil Outpatient Commitment. I had one client specifically that would not have been compliant with his treatment due to the severity of his mental illness. For the purpose of this testimony I will refer to him as Mark. Mark was diagnosed with Schizoaffective Disorder and presented as a child. His cognitive functioning was at the level of a 10 year old and he loved superheroes. Mark was only compliant with his treatment team and group home due to his Civil Outpatient Commitment. Without this, he would have been living on the streets as he did not understand how to manage his finances or the need for stable housing. He did not understand that his medications would help his symptoms and prevent him from being hospitalized. One of the best things that the commitment for treatment order did was allow for his treatment team to establish a representative payee for his funds to ensure that he did not have large sums of money on him in the community and also ensured that his housing was paid every month. We would meet with him weekly to get some money out and support him back to his home as drug dealers would follow him to the ATM on days that they knew he would be paid. He did not understand that these people were taking advantage of him and would freely give them his money. Without the security of housing in which his medications and meals were supervised, he would have died on the streets. His mental illness was so severe that he did not have insight into his needs and personal safety. His Civil Outpatient Commitment was the reason that he was alive and cared for. I think that it is vitally important for individuals like Mark to have AOT in the state of Maryland so that others' lives can be saved.

In my research on ethical based practices with this population of adults, it is vital that clients feel a sense of efficacy and autonomy over their own lives. YES, and it is instructive to note that when applied well, AOT improves quality of life. 81% of patients in New York's program, for example, said AOT helped them to get and stay well; 75% said it helped them gain control over their lives. I hope that soon, Maryland will be able to report similar statistics and not numbers that reflect the higher incarceration, arrest, violence and escalating health care costs that the current revolving door perpetuates. We must protect the most vulnerable in our society and AOT is one step in achieving that goal which is why I am asking for your support in passing SB453.

SB453 FAV.pdf
Uploaded by: Morgan Mills
Position: FAV

NAMI Maryland
National Alliance on Mental Illness

February 20, 2024

Chairwoman Beidle, Vice Chair Klausmeier, and distinguished members of the Finance Committee,

The National Alliance on Mental Illness, Maryland requests a favorable report on HB576. NAMI Maryland and our 11 local affiliates across the state represent a network of more than 58,000 families, individuals, community-based organizations, and service providers. NAMI Maryland is a 501(c)(3) non-profit dedicated to providing education, support, and advocacy for people living with mental illnesses, their families and the wider community.

SB453 would establish an Assisted Outpatient Treatment Program in the State of Maryland. Maryland is one of three states without this program that helps vulnerable people access lifesaving healthcare when they need it the most.

Assisted Outpatient Treatment (AOT) is a practice utilized in most states where civil courts may require participation in treatment for people with serious mental illness (SMI). AOT is for a very specific subset of individuals living with SMI that get caught in a cycle of recurring hospitalizations, incarcerations, and homelessness. Relying solely on voluntary engagement leaves out a small percentage of people that lack the insight into their own mental health condition necessary to engage in voluntary care. AOT was established in 47 states and D.C. to ensure that people who are experiencing the severest negative consequences of SMI participate in treatment.

NAMI MD believes that all people should have the right to make their own decisions about medical treatment. However, we're aware that a small percentage of people living with serious mental illnesses such as schizophrenia, bipolar disorder, and schizoaffective disorder at times, due to their illness, lack insight or judgment about their need for medical treatment. When people with SMI remain untreated, they are left to deteriorate needlessly. It is unacceptable for Maryland to remain one of only three states without this important piece in the continuum of care.

AOT, should be a last resort, only after people living with life threatening SMI have had every opportunity to engage in voluntary treatment. It is a less restrictive, more compassionate, and less costly treatment alternative to involuntary hospitalization.

AOT should be utilized when an individual:
- presents a danger to themselves or another;
- likely to substantially deteriorate if not provided with timely treatment and is unlikely to adequately adhere to outpatient treatment on a voluntary basis;
- lacks capacity, which means that, because of the nature of their serious mental illness, the person is unable to fully understand or lacks judgement to make an informed decision about his or her needs for treatment or care.

Kathryn S. Farinholt
Executive Director
National Alliance on Mental Illness, Maryland

Contact: Morgan Mills
Compass Government Relations
Mmills@compassadvocacy.com

We know that AOT works when it is done right. Opponents of AOT claim that it doesn't work, that it is coercive forced treatment. However, we've seen in states that have implemented AOT carefully, like New York, that it does work; both in improving medical outcomes and in reducing costly and harmful consequences of lack of treatment.

It is important to emphasize that this is not "forced" treatment. AOT is not forced care—it is a system to engage people in services and commit the mental health system to serve those most in need. If an individual does not comply with their treatment plan under AOT, they are not found in contempt of court. They do not face criminal charges.

AOT should be used judiciously for people who meet legal criteria like repeated hospitalizations and arrests, a history of non-participation with voluntary care, include strong due process, and more. Even in states that actively use AOT, relatively small numbers of people are under AOT orders. AOT is a missing piece of Maryland's continuum of mental healthcare. Ultimately, the goal of AOT is to help people take more active roles in their own care.

For these reasons, we urge a favorable report.

Kathryn S. Farinholt
Executive Director
National Alliance on Mental Illness, Maryland

Contact: Morgan Mills
Compass Government Relations
Mmills@compassadvocacy.com

Senate Bill 453- Mental Health – Emergency Evaluat

Uploaded by: Pegeen Towsend

Position: FAV

Maryland
Hospital Association

Senate Bill 453- Mental Health – Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment Programs

Position: *Support*
February 19, 2024
Senate Finance Committee

MHA Position

On behalf of the Maryland Hospital Association's (MHA) member hospitals and health systems, we appreciate the opportunity to comment in support of Senate Bill 453.

With the dramatic decline in the number of psychiatric beds available to treat individuals with serious mental illness, rates of imprisonment of the mentally ill went up just as dramatically. Today, people who have been diagnosed with mental illness are six times more likely to be incarcerated than hospitalized.

Assisted outpatient treatment allows a judge to order certain people with serious mental health conditions to stay in up to one year of court-supervised treatment while they live in the community. It is arrest, incarceration only for a small subset of individuals with serious mental illness who have multiple episodes of homelessness, arrest, incarceration, or hospitalization that affect their ability to comply with treatment while living in the community.

Extensive research shows assisted outpatient treatment reduces homelessness, arrests, and hospitalizations by 70% and cuts cost to taxpayers by 50%. Assisted outpatient treatment works by compelling the recipient to receive specific treatment that will prevent their condition from worsening and by committing the mental health system to provide treatment.

We commend the Secretary of Health and Governor Moore for bringing this important issue forward.

For all of these reasons, we ask for a ***favorable*** report on SB 453.

For more information, please contact:
Pegeen Townsend, Consultant
Ptownsend@mhaonline.org

LBH Testimony RISHI SB453 -Session 2024.pdf
Uploaded by: Rishi Gautam
Position: FAV

LIFEBRIDGE HEALTH

Date: 2/19/2024

To: Chair Beidle, Vice Chair Klausmeier and The Finance Committee

Reference: Senate Bill 453 - Mental Health - Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment Programs

Position: FAVORABLE

Dear Chair Beidle and Committee Members:
On behalf of LifeBridge Health, we appreciate the opportunity to comment on Senate Bill 453.
LifeBridge Health is a regional health system comprising Sinai Hospital of Baltimore, an independent academic medical center; Levindale Hebrew Geriatric Center and Hospital in Baltimore; Northwest Hospital, a community hospital in Baltimore County; Carroll Hospital, a sole community hospital in Carroll County; Grace Medical Center (formerly Bon Secours Hospital), a freestanding medical facility in West Baltimore; and Center for Hope a center of excellence focused on provided hope and services for trauma survivors in Baltimore City.

My name is Dr. Rishi Gautam. I am a psychiatrist and serve as the Chair of the Department of Psychiatry and Behavioral Health at LifeBridge Health. I am here today representing my organization LifeBridge Health in support of Senate Bill 453 along with the amendments offered by Secretary Herrera Scott.
Severe mental illness (or SMI) has a profound impact on the lives of people suffering from it. It pervades almost every aspect of an individual's existence and function including work, relationships, and has an enormous impact on society. Decades of medical research has empowered us with the ability to treat and manage it - giving hope to millions of people. Despite of great strides there still is a subset of people impacted by SMI who never receive that chance. Unfortunately, these are also some of the most under served, disenfranchised and a clinically vulnerable group, with limited ability and means to advocate for themselves.
Working in acute care settings for over 12 years I have seen countless individuals stuck in a quagmire of hospitalizations, emergency room visits, substance use, homelessness, incarceration, poverty, and loss of relationships & livelihood due to an untreated SMI.
I would like to use this opportunity to highlight a very significant but underappreciated aspect of SMI called Anosognosia or lack of insight. It is a neuro-psychiatric syndrome where the person suffering is unaware of their disease process and hence unable to appreciate the need for treatment.
AOT can be a life-saving opportunity for such people. Research demonstrates it is very effective when implemented with robust individualized community-based supports in the form of housing, transport, access to public benefits, employment, and other social determinants of health.
Maryland is a pioneer in many ways in promoting disease prevention, health equity, and population health through the Total Cost of Care (TCOC) model. It holds health systems accountable to minimize hospitalizations and ER visits, while it also remains one of the only 3 states in the country to not facilitate

a program like the assisted outpatient treatment. It is a tool that truly adheres Maryland's tenets of community mental health promotion, and allows health care providers in empowering people with SMI to live their life to the fullest potential.

I would like to close my testimony in support of SB 453, and by re-emphasizing that a program like the AOT is not for everyone with mental health conditions, but rather a very small percentage of highly vulnerable adults suffering from life altering clinical conditions like Schizophrenia, severe bipolar & schizoaffective disorder who are unable to advocate for their needs in the current systems of care. I urge the committee to support the passage of this legislation.

For all the above stated reasons, I request a Favorable report for Senate Bill 453.

For more information, please contact:
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Rishi Gautam, M.D.
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SB 0453 MD TESTIMONY SHM.pdf
Uploaded by: sabah muhammad
Position: FAV

Testimony by Sabah Muhammad, Senior and Legislative Policy Counsel for Treatment Advocacy Center
Submitted to Senate Finance Committee
Hearing regarding SB 0453: February 20, 2024, at 1:00 pm
POSITION: SUPPORT

Thank you for the opportunity to submit written testimony. I am writing as policy counsel for Treatment Advocacy Center, a national nonprofit focused on eliminating barriers to treatment for those with severe mental illness. I am also writing as an expert in criminal defense and racial and social justice.

Since my last testimony one year ago two Maryland family members lost loved ones who would have benefitted from AOT. There is no justifiable reason death and deterioration must be a catalyst for advancing mental health legislation. AOT is not controversial, it is law in 47 states.

As a former public defender, I represented clients who lacked the competency to participate in their own defense and in their own wellness. On all accounts they lacked the mens rea to be considered legally competent, they were not criminals, they were unwell, and found their way to me due to upstream volunteer only treatment options for individuals too sick to volunteer. My clients didn't simply need a lawyer, they needed a legally accountable treatment adherence team. That is what AOT offers. AOT won't flood Public defenders with new faces but will finally offer them a least restrictive and just tool to help the innocent individuals they are currently failing. AOT participants in New York reported an 87 percent reduction in incarcerations. Where there's a lack of upstream treatment options criminalization becomes the default. AOT can help to break that cycle.

The reality of Racism is a smog that sits over all of us. Over representation of BIPOC individuals in AOT is a reflection of their neglect earlier in the system. While I would love to see those disparities addressed, it should not be the excuse for failing to make this tool available to provide to those who have been left behind by our current system. We must take every single opportunity that we can to prevent people with mental illness from being pushed into our criminal legal system. In our broken mental health system AOT model law has built in protections against the harms that plague every part of American life. AOT model law features a participant bill of rights, legal representation, and the right for participants to file grievances. AOT is race neutral lifesaving treatment for individuals too sick to volunteer for treatment on their own.

Vote favorably for SB0453

Cordially,

Sabah Muhammad

Sabah Muhammad

WRITTEN Van Remmen SB0453 Testimony.pdf
Uploaded by: Sarah Van Remmen
Position: FAV

SB0453 Testimony
Dr. Sarah Van Remmen, MD
Position: SUPPORT

I am a board-certified emergency psychiatrist and the Medical Director of Psychiatric Emergency Services for University of Maryland Medical Center. The views reflected below are my own. I have also worked as an inpatient attending psychiatrist who cares for patients with severe mental illness. Too often my team in the psychiatric emergency room learns that another one of our patients has died or been incarcerated because they did not have the opportunity for assisted outpatient treatment.

D- young person with living with schizophrenia who was murdered while attempting to find food and a warm place to sleep.

J- a young person living with schizophrenia and traumatic brain injury who was incarcerated for exposing themself in public. Later that same year they were resuscitated after accidental overdose and was hypothermic due to homelessness.

D- a young person living with schizoaffective disorder who was just released from state hospital where she was sent after assaulting one of our psychiatrists. They have already become homeless again and are no longer taking medications.

J- a young person living with schizophrenia who went missing for weeks before being brought to our hospital by police. They were so catatonic that they couldn't tell us their own name. Their family was terrified that they had been killed.

I have more stories than it is possible to tell in a short testimony. And they all have the same theme- these people were directly harmed because their illness prevented them from receiving outpatient psychiatric treatment. Their inability to recognize their own need for treatment has led to direct harm. I am writing as an advocate for this group of individuals because their untreated illness has robbed their ability advocate on their own behalf. It's impossible to advocate for oneself when you're living on the street looking for your next meal, when you're incarcerated, or when you're dead. The ability to advocate is a privilege and power that my patients do not have due to the severity of their illness. I appreciate the fears of the opposing patient's right advocates, however I feel that SB453 actually improves patients rights to treatment by creating a path to care for the sickest patients.

We get to know our patients in PES because of how frequently we see the same faces- in 2023 just ten individuals accounted for 17% of all PES visits. Through the lens of public health, it is staggering to consider how many emergency room visits could be prevented if we had an mechanism (AOT) to ensure that these individuals participated in outpatient mental health services.

It is important to emphasize that it is a small group of individuals who would meet the criteria for AOT due to their illness's severity. For most individuals with mental illness, voluntary treatment is more than adequate when they are given access to resources. The group of patients that I care for who would benefit from AOT currently have NO other available tool that allows me to successfully treat their symptoms in the community. In Medicine there is an important concept known as “Standard of care”. It is care that any reasonable medical professional would provide if faced with a clinical situation. Ie. Checking for a heart attack if a patient arrives in the ED with chest pain. Currently, we are one of 3 states that does not have legislated AOT. We are providing sub-standard care to Marylanders. This needs to be rectified immediately.

My colleagues and I feel very strongly that AOT is necessary to help this small group of vulnerable individuals. Under the current system, these people are held captive by illness. Being able to provide them with adequate treatment allows them to regain autonomy over their own lives again. Research on AOT programs in other states shows overwhelming evidence for effectiveness.

It is heartbreaking to see the patients we care for being harmed while we are powerless to intervene until after it’s too late.

Until after they’ve assaulted their psychiatrist again.

Until after they’re found in an alley frozen again.

Until after their family files a missing person's report again.

Until another is murdered.

We have the ability to treat these individuals, Please vote in favor of HB576 so that we can. My patients cannot keep waiting to be treated with the dignity and respect that they inherently deserve.

240219_SB453_Mental Health - Emergency Evaluation

Uploaded by: Sonny Holding

Position: FAV

DAVID TRONE
6TH DISTRICT, MARYLAND

APPROPRIATIONS COMMITTEE

BUDGET COMMITTEE

JOINT ECONOMIC COMMITTEE

UNITED STATES
HOUSE OF REPRESENTATIVES

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February 19, 2024

The Honorable Pamela G. Beidle
Chair, Finance Committee
Miller Senate Office Building, 2 East Wing
11 Bladen St., Annapolis, MD 21401

The Honorable Katherine A. Klausmeier
Vice Chair, Finance Committee
James Senate Office Building, Room 123
11 Bladen St., Annapolis, MD 21401

Dear Chair Beidle and Vice Chair Klausmeier,

I am writing in support of *Senate Bill 453 - Mental Health - Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment Programs*, which concerns mental health emergency evaluations, involuntary admission procedures, and assisted outpatient treatment programs.

Currently, Maryland is one of only three states without the ability to connect our constituents with evidence based, least restrictive, compassionate care through assisted outpatient treatment services.

Assisted outpatient care is a necessary addition to providing our constituency with a smooth mental health continuum of care that provides protection from harm, increases health, and reduces unnecessary incarceration and emergency hospitalization of Marylanders. Passage of this legislation will ensure that we can keep our cherished community members in our community, while providing them with the care and resources they need.

I strongly urge this committee to give *Senate Bill 453 - Mental Health - Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment Programs* the highest consideration.

Sincerely,

David Trone
Member of Congress

SB453_Villani_FAV.pdf
Uploaded by: V Susan Villani
Position: FAV

SB453

V. Susan Villani, M.D.
103 Longwood Rd.
Baltimore, MD 21210

Position: SUPPORT

Our daughter, who had a serious mental illness, died in 2022 at the age of 37, the result of a fall down the steps of a boarding home where she was residing. Her father and I are both board certified child and adolescent psychiatrists with connections to the Maryland mental health system. Although we could ensure that she got to the hospital when needed, without assisted outpatient treatment she would relapse. Her illness prevented her from recognizing the need for continuing treatment in the community. She was unable to adhere to needed medications on her own and unwilling to accept existing services. For her, AOT could have been life saving. It would have encouraged her treatment adherence and required providers to consistently encourage engagement and provide services.

When she was a young child she was delightfully creative, played soccer, took piano lessons, and on Mother's Day made me cards telling me how much she loved me. She became moody as an adolescent, worried about her weight, and was anxious about her relationships with peers. We thought she was going through a tough developmental phase and sought help for her through the best child and adolescent psychiatrist we could find. Although concerned about what her symptoms possibly meant, we were confident that with the help of professionals, she would learn to manage her moods, and build a happy adult life.

We were wrong. Her mental illness got worse and worse through her adolescence and her young adult years. She had residential treatment out of state in a well-regarded treatment facility which probably saved her life, however, when she returned to Maryland she had aged out of transition to adult-life programs and went into the adult system of care. Again, my husband and I thought that certainly with all our professional knowledge and connections within the mental health system, she would surely get back on track, learn a trade or skill to be able to construct a life and be able to move forward.

Again we were wrong. She bounced in and out of hospitals with over 50 hospitalizations, multiple medication trials, and ECT. She would get better only to be discharged and be unable to take care of herself. Living with us was untenable due to her wanderings at night, inability to comply with basic requirements of living with others, and a developing hostility towards us and her younger sister. She was inconsistent with taking her medications, would sleep all day, and refuse to be involved with recommended therapy, be it individual or group. She was becoming severely and persistently chronically mentally ill before our eyes, but as an adult she was allowed this as her choice. It did not matter that her brain was deteriorating. We could see her losing cognitive abilities, but she could not be ordered to take her medications or be in any meaningful treatment.

As time went on, she became increasingly paranoid, argumentative, and hostile towards us. This would get better when she was taking her medications, but she did not like them and unfortunately saw little connection between taking them and the positive effects. She denied that they helped and saw us as interfering parents trying to control her. She could not give a

reliable history when she showed up in ER's, and those caring for her were fearful of violating her confidentiality so did not seek information from us. Being knowledgeable health care professionals we understood that our giving information was in fact not a violation of HIPPA and so we often used this knowledge to work our way into being involved with her care.

But our love and our persistence was not enough to save her. She needed a system of mental health care that provided beyond what parents can do. She needed a treatment system that would surround her, make sure she took her medications, and work through her paranoia and self-sabotaging behaviors. During her last year of life my husband and I each found her in her apartment near death and had to call 911. She was hospitalized over and over, each time discharged back to the apartment near our house that we helped fund, even though we told the inpatient teams she could not manage there. We finally had to say she could not go back there. After one prolonged hospital stay at Johns Hopkins, she was less paranoid and seemed to be developing some insight into needing to take her medications. But without AOT within a few weeks she began to deteriorate once again. A group home with medication supervision was the best there was to offer. But that was not enough to engage her in treatment. She was her own worst enemy and there was nothing we could do.

I am convinced that if Maryland had AOT our daughter would be alive. There would have been another tool in the toolbox to help us help her with her struggles. I am certain she would have respected the order of a sympathetic judge to engage with a treatment team and adhere to treatment. At our daughter's memorial service, I spoke about her struggles and mentioned that 47 other states have AOT and Maryland does not. Many in attendance were shocked to hear this and shook their heads in disbelief. It is my hope that you will give HB576 a favorable report to provide AOT for the citizens of Maryland who suffer with serious mental illness. I do not want anyone else to unnecessarily lose a loved one because the state has not added this service to the mental health care system.

V. Susan Villani, M.D.
Board Certified Child and Adolescent Psychiatrist
February 18, 2024

LBH Testimony YELENA SB453 -Session 2024.pdf
Uploaded by: Yelena Gimelshteyn
Position: FAV

LIFEBRIDGE HEALTH

Date: 2/19/2024
To: Chair Beidle, Vice Chair Klausmeier and The Finance Committee
Reference: Senate Bill 453 - Mental Health - Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment Programs
Position: FAVORABLE

Dear Chair Beidle and Committee Members:
On behalf of LifeBridge Health, we appreciate the opportunity to comment on Senate Bill 453.
LifeBridge Health is a regional health system comprising Sinai Hospital of Baltimore, an independent academic medical center; Levindale Hebrew Geriatric Center and Hospital in Baltimore; Northwest Hospital, a community hospital in Baltimore County; Carroll Hospital, a sole community hospital in Carroll County; Grace Medical Center (formerly Bon Secours Hospital), a freestanding medical facility in West Baltimore; and Center for Hope a center of excellence focused on provided hope and services for trauma survivors in Baltimore City.

My name is Yelena Gimelshteyn, MD. I am here today representing LifeBridge Health in support of Senate Bill 453 along with amendments offered by Secretary Herrera Scott.
As a psychiatrist, for over 11 years, I have walked alongside some of our most vulnerable citizens on their journeys through inpatient and outpatient psychiatric care. Many of these individuals grapple with severe mental illness and the complexities of adhering to treatment plans in the community. While we achieve significant progress within the structured, supportive environment of the hospital, often restoring patients to their baseline functioning, the true challenge lies in sustaining that progress upon their return to the community. The unfortunate reality is, many patients struggle with follow-up after discharge. They fall through the cracks of the outpatient system, neglecting their medication and care plans. This often leads to a heartbreaking regression, with patients returning months later in a drastically compromised state. Many arrive malnourished and near organ failure, having gone months without vital medication. Some sustain serious injuries from altercations, while others face legal repercussions for harming strangers, loved ones and caregivers. It's a devastating cycle, one we can break.
This is where Senate Bill 453, presents a solution to bridge this crucial gap, ensuring the hard-won gains made in the hospital are not lost upon reintegration into the community. I urge you to consider its immense potential and its ability to transform the lives of countless individuals battling severe mental illness.

For all the above stated reasons, I request a Favorable report for Senate Bill 453.

For more information, please contact:
Jennifer Witten, M.B.A.
Vice President, Government Relations & Community Development
jwitten2@lifebridgedhealth.org, Mobile: 505-688-3495

Yelena Gimelshteyn, M.D.
Department of Psychiatry, LifeBridge Health
ygimelsh@lifebridgehealth.org

SB 453_Emergency Evaluation and Involuntary Admiss
Uploaded by: Dan Rabbitt
Position: FWA

Behavioral Health System Baltimore

February 20, 2024

Senate Finance Committee
TESTIMONY IN SUPPORT WITH AMENDMENTS
SB 453 Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment Programs

Behavioral Health System Baltimore (BHSB) is a nonprofit organization that serves as the local behavioral health authority (LBHA) for Baltimore City. BHSB works to increase access to a full range of quality behavioral health (mental health and substance use) services and advocates for innovative approaches to prevention, early intervention, treatment and recovery for individuals, families, and communities. **Baltimore City represents nearly 35 percent of the public behavioral health system in Maryland, serving over 77,000 people with mental illness and substance use disorders (collectively referred to as "behavioral health") annually.**

BHSB supports with amendments SB 453 Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment Programs. This legislation would establish an involuntary commitment program in every jurisdiction and require local behavioral health authorities to oversee and participate in administering the Assisted Outpatient Treatment (AOT) program at the local level.

BHSB respectfully request the following amendments:

Page 6, line 10, insert "LOCAL ADDICTIONS AUTHORITY." BHSB requests this amendment to ensure the right the system managers for that local jurisdiction are included to support the administration of the AOT program and to further integration mental health and substance use.

Page 7, in line 10, strike "IF RESOURCES PERMIT" to require people with lived experience to be part of the care coordination team.

Page 8, in line 27, insert "LOCAL ADDICTIONS AUTHORITY" to be consistent that the right system managers for that local jurisdiction are involved.

Page 9, in line 11, strike "36-MONTH" and insert "12-MONTH". BHSB believes a three-year period is too long to determine if a person has not been well served by the public behavioral health system. If a person has not been hospitalized frequently within a 12-month period, that is a sign that they are managing their mental illness effectively.

Page 9, in lines 13-14, strike "OR RECEIPT OF PSYCHATRIC SERVICES IN A CORRECTIONAL FACILITY;" BHSB believes this language is unfit for the AOT program eligibility criteria. We should not consider what an individual does in a correctional facility, as incarceration often exacerbates mental illness.

Page 9, in line 15, strike "36-MONTH" and insert "12-MONTH" to have a consistent time period for program eligibility.

Page 9, in line 17, strike "CREDIBLE THREAT OF" and insert "PATTERNS OF THREAT"

Page 10, line 2, strike "36-MONTH" and insert "12-MONTH" to have a consistent time period for eligibility.

Page 10, in lines 9-11, strike "(B) TIME THAT THE RESPONDENT SPENT HOSPITALIZED OR INCARCERATED 10 MAY NOT BE INCLUDED WHEN CALCULATING THE TIME PERIOD UNDER SUBSECTION 11 (A)(3)(I) OR (II) OF THIS SECTION." BHSB opposes this language, as it would unnecessarily prolong the time period for eligibility in the program.

Page 10, line 31, strike "CONSIDER" and insert "HONOR." This proposed amendment ensures that Psychiatric Advance Directives will not be undermined through the AOT program.

Page 13, lines 4 strike "THE CONSIDERATION GIVEN TO" and insert "HOW." This ensures that Psychiatric Advance Directives will be honored for participants who have them.

Page 13, lines 19-24 strike "(I) IS LIMITED IN SCOPE TO THE ELEMENTS INCLUDED IN THE TREATMENT PLAN PRESENTED TO THE COURT UNDER § 10–6A–05 OF THIS 21 SUBTITLE; AND (II) INCLUDES ONLY THOSE ELEMENTS THAT THE COURT FIND BY CLEAR AND CONVINCING EVIDENCE TO BE ESSENTIAL TO THE MAINTENANCE OFTHE RESPONDENT'S HEALTH OR SAFETY."

Page 13, line 18 insert "SHALL BE LIMITED TO THE TREATMENT PLAN DEVELOPED BY THE CARE COORDINATION TEAM" after "PLAN THAT." This proposed amendment clarifies that the court must follow the direction of the Care Coordination Team and may not add additional requirements to a treatment plan for the court order.

Page 18, line 3 insert "WITH ASSISTANCE FROM THE ADMINISTRATION" before "EACH COUNTY SHALL…" The State will need to support the counties with data collection as the data for the reporting is collected through several different systems. This proposed amendment will ensure that counties and the state collaborate on data collection.

LBHAs would need to be adequately resourced to support AOT. This program would require staff time to convene and support the Care Coordination Team, monitor the participants in the program, coordinate with the courts, and collect and report on data. BHSB urges the Department to plan to resource LBHAs to take on this new tasks.

Involuntary commitment should be used judiciously, reserved only for individuals with serious mental illness that the Public Behavioral Health System has not engaged well in treatment. Often, these individuals end up involuntarily hospitalized or unnecessarily involved in the criminal justice system, resulting in poor overall health outcomes. For some, involuntary admission into community-based treatment can be an effective approach to engaging people into care. As such, **BHSB urges the Senate Finance Committee to adopt these proposed amendments for SB 453 and provide a favorable report.**

Contact
Adrienne Breidenstine
Vice President, Policy & Communications
Adrienne.Breidenstine@bhsbaltimore.org
443-908-0503

Dan Rabbitt
Director, Policy
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SB0453_FWA_MDACEP_MH - Em. Eval. & Involuntary Adm

Uploaded by: Danna Kauffman

Position: FWA

Maryland Chapter
AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

TO: The Honorable Pamela Beidle, Chair
Members, Senate Finance Committee
The Honorable Senate President Bill Ferguson (Administration)

FROM: Danna L. Kauffman
Pamela Metz Kasemeyer
J. Steven Wise

DATE: February 20, 2024

RE: **SUPPORT WITH AMENDMENT** – Senate Bill 453 – *Mental Health – Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment Programs*

The Maryland Chapter of the American College of Emergency Physicians (MDACEP), which represents the interests of emergency physicians and their patients throughout the State of Maryland, **supports with amendment** Senate Bill 453.

Among other provisions, Senate Bill 453 authorizes a psychiatric nurse practitioner to evaluate an emergency evaluee for purposes of involuntary admission and authorizes the Maryland Department of Health (MDH) to require the admission of an emergency evaluee to an appropriate facility, rather than requiring the Department to provide for the admission within six hours. In addition, the bill requires each county to establish an assisted outpatient treatment program.

MDACEP supports the goals of the bill and supports the inclusion of a psychiatric nurse practitioner. However, in addition to psychiatric nurse practitioners, these evaluations are also often completed by licensed-clinical social workers. We recommend that the statue reflects the health care professionals who are currently working within their scope of practice and performing these evaluations. We do question the removal of the requirement that MDH provide admission to an appropriate facility within six hours. We recognize the challenges of this requirement, but the process is now unclear, and the burden seems to shift back to the emergency department to find a placement at a time when the emergency departments are already overwhelmed. We recommend that the current law stays intact.

For more information call:
Danna L. Kauffman
Pamela Metz Kasemeyer
J. Steven Wise
410-244-7000

SB 453- FIN - MDH - LOSWA .pdf
Uploaded by: Jason Caplan
Position: FWA

February 20, 2024

The Honorable Pamela Beidle
Chair, Senate Finance Committee
3 East Senate Office Building
Annapolis, MD 21401-1991

RE: Senate Bill 453 - Mental Health - Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment Programs

Dear Chair Peña-Melnyk and Committee Members,

The Maryland Department of Health (Department) respectfully submits this letter of support with amendments for Senate Bill (SB) 453 entitled "Mental Health - Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment Programs." This bill creates an Assisted Outpatient Treatment (AOT) program, which allows for court-ordered mental health treatment to be provided in a community setting. Such a program would serve a small subset of individuals with serious mental illnesses who are unable to voluntarily seek care due to a lack of insight into their mental condition. The bill also contains several changes to law that are important to supporting Maryland's behavioral health crisis system of care.

Under current law, the only way for individuals in Maryland to receive court-ordered outpatient mental health treatment is through entry into the criminal justice system.[1] Indeed, many individuals with serious mental illness who do not engage in treatment experience homelessness, frequent hospitalizations, increased contact with law enforcement, and ultimately incarceration. In Maryland, it is estimated that **nearly 40% of people in jail had a current mental health disorder, and 1 in 4 suffered from a serious mental illness.**[2] Moreover, the Department operates five adult psychiatric hospitals[3], and the vast majority of patients are there under court order as they have been found to be Incompetent to Stand Trial & Dangerous (IST) or Not Criminally Responsible (NCR) due to the nature of their mental illness.

[1] Maryland can only provide court mandated treatment in inpatient hospital settings through the State's emergency petition process which requires stringent clinical criteria.
[2] https://goccp.maryland.gov/wp-content/uploads/Maryland's-Behavioral-Health-and-Public-Safety- Center-of-Excellence-Strategic-Plan-7-24-23.pdf
[3] Thomas B. Finan Center, Spring Grove Hospital Center, Springfield Hospital Center, Eastern Shore Hospital Center and Clifton T. Perkins Hospital Center).

As currently designed, the State's system criminalizes mental illness, stripping individuals of their civil liberties and dignity. The Department supports SB 453 because it creates a less restrictive alternative for individuals with serious mental illness, ending reliance on jails and emergency departments, and encourages individuals to engage in behavioral health treatment in their community.

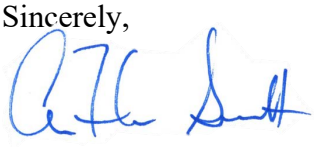
Governor Moore's fiscal 2025 proposed allowance includes $3 million to support the implementation of an AOT program. These funds are in addition to significant investments in the public behavioral health system. These investments bolster access to community-based care for individuals with serious mental illness through continued investments in mobile crisis and crisis stabilization services, as well as a three percent rate increase for community-based behavioral health providers. The Governor's allowance also makes a statewide investment ($5.4 million in General Funds) to improve access to housing for vulnerable Marylanders, particularly those with mental health conditions. This investment will take a current pilot statewide, offering housing and tenancy-based services to qualifying individuals experiencing housing insecurity.

Establishing an AOT program in Maryland creates an avenue for those who lack insight into their mental illness to engage in treatment. This will move us closer to our goal of ensuring Maryland has a world-class health system for all.

In addition to establishing an AOT program, the legislation contains changes to improve crisis care. The bill would authorize psychiatric nurse practitioners to complete specified steps in the emergency evaluation process. Without this inconsistency addressed, there is an increased risk in delays in care at crisis stabilization centers and other psychiatric emergency facilities, due to the workforce shortages of psychiatrists and an increasing number of 24/7 crisis stabilization centers in the State.

If you have further questions, please contact Sarah Case-Herron, Director of Governmental Affairs at sarah.case-herron@maryland.gov.

Sincerely,



Laura Herrera Scott, M.D., M.P.H.
Secretary

SB 453 - MoCo_Elrich_FAV (GA 24).pdf
Uploaded by: Marc Elrich
Position: FWA

OFFICE OF THE COUNTY EXECUTIVE

Marc Elrich
County Executive

February 20, 2024

TO: The Honorable Pam Beidle
Chair, Finance Committee

FROM: Marc Elrich
County Executive

RE: Senate Bill 453, *Mental Health - Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment Programs*

I support Senate Bill 453 with amendments to ensure that counties receive fiscal support from the State for the creation and administration of assisted outpatient treatment (AOT) programs.

Among other provisions, Senate Bill 453 establishes AOT programs in the State for the treatment of serious mental illness and mandates that counties establish an AOT program. Under the bill, serious mental illness is defined as a substantial disorder of thought, mood, or orientation that significantly impairs judgment, behavior, or capacity to recognize reality or to reason or understand, and if not treated, creates a substantial risk of serious harm to the individual or others. The bill also establishes that a petition for AOT may be made by a director of a mental health program receiving state funding or by an individual 18 years or older who has legitimate interest in the welfare of the respondent.

Currently in Maryland, AOT is available only through a Baltimore City pilot program (created by CH576 of 2017), exclusively available to individuals transitioning out of involuntary inpatient treatment and who have a mental illness diagnosis. Maryland is one of only three states in the country without comprehensive AOT laws. Assisted outpatient treatment has reduced rates of hospitalization, arrest, and incarceration in states where it has been implemented. I support AOT as a means to keep individuals with serious mental illness safe and to create an additional path to access much-needed treatment.

I respectfully urge the committee to issue a favorable report with amendments to Senate Bill 453 to provide State funding to counties to establish and operate AOT programs.

cc: Members of the Finance Committee

SB0453-FIN_MACo_SWA.pdf
Uploaded by: Sarah Sample
Position: FWA

Senate Bill 453

Mental Health – Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment Programs

MACo Position: **SUPPORT WITH AMENDMENTS**

To: Finance Committee

Date: February 20, 2024

From: Sarah Sample

The Maryland Association of Counties (MACo) **SUPPORTS** SB 453 **WITH AMENDMENTS**. This bill mandates that county governments establish an assisted outpatient treatment program in the Maryland Circuit Courts. Additionally, it requires collaboration from the courts, the Office of the Public Defender, and each local behavioral health authority.

Assisted outpatient treatment has been authorized in forty-eight other states and the District of Columbia. It has been shown to divert individuals with severe mental illness into the appropriate care and treatment and away from emergency rooms and detention centers. This bill would substantially enhance the ability of local detention centers, law enforcement, health departments, and social services teams to more fully and efficiently use their limited resources to assist and support those in their charge. Counties and residents have a great stake in the success of SB 453 but have operational and financial concerns regarding the establishment of such a program falling on counties.

Local governments support the overall effect and intent of the bill but would offer two amendments to ensure the bill fulfills its intended outcomes:

1. ***Circuit Courts and the Administrative Office of the Courts are the rightful administrators of this program, not counties.***

   Assisted outpatient treatment is a circuit court procedure and therefore the circuit courts, in conjunction with the Administrative Office of the Courts, are the appropriate agencies to establish these procedures. While counties fund the circuit courts in Maryland, they have no authority or control over the procedures and operations of the courts. Local governments cannot mandate any actions to judges or court staff and there is no existing mechanism or legal precedent for counties to do so. As such, there is no process or infrastructure in place for what the bill proposes, and even were it established, the

repercussions could be dire and create a host of inconsistencies and conflicts when it comes to the separation of power between governments and courts. Additionally, local governments have vastly different procedures and operational modes. Involvement as the bill outlines would likely lead to the kind of variability in practices that could lead to serious issues if adopted in a court setting.

2. ***Appropriate state funding should be allocated to implement this program.***

   As the bill is drafted, even with the appropriate primary actor for the establishment of these programs identified, the counties would still suffer the financial burden of funding a new circuit court program. Through detention center operations, law enforcement, emergency services, and local health department engagement, counties are currently covering a substantial cost to help meet the needs of the severely mentally ill, at a time when county financial resources are stretched perilously thin. For this program to be successful – a shared goal among most involved – there must be state funding allocated to the circuit courts and the Administrative Offices of the Courts to fulfill the charge of this bill. It's very likely the Maryland Judiciary and the Office of the Public Defender will also need resources, as 90 percent of the likely defendants will be their clients. SB 453 has great potential, but without resources, the state agencies' success – which counties must be able to rely on – will be in jeopardy.

Counties – and the communities they represent – need assisted outpatient treatment to be implemented successfully. SB 453, with the two changes offered above, can be the vehicle to achieve this goal. Accordingly, MACo urges a report of **FAVORABLE WITH AMENDMENTS** for SB 453.

12b - SB 453 - FIN - MACHO - LOSWA (1).pdf
Uploaded by: State of Maryland (MD)
Position: FWA

2024 SESSION
POSITION PAPER

BILL:	**SB 453 – Mental Health – Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment Programs**
COMMITTEE:	**Senate Finance Committee**
POSITION:	**Letter of Support With Amendments**
BILL ANALYSIS:	**SB 453 would require each county to establish an assisted outpatient treatment program to provide treatment for untreated seriously mentally ill individuals and provides the courts with a mechanism to mandate outpatient treatment for them.**

POSITION RATIONALE: The Maryland Association of County Health Officers (MACHO) submits a letter of support with amendments for SB 453. The bill proposes that Local Behavioral Health Authorities (LBHAs), which in most jurisdictions are in local public health departments (LHDs), would approve and oversee the assisted outpatient treatment (AOT) programs. LBHAs would be required to provide oversight of the care coordination teams tasked with developing a treatment plan for program participants. Further, many jurisdictions may look to their LHDs to provide technical assistance and staffing support with program planning and development.

The program will require significant investment and coordination among multiple agencies to establish an AOT by July 1, 2025. Given the scope of the initiative, this timeline may not be sufficient to fully develop and implement a program capable of providing the quality of care and necessary care coordination to ensure that individuals engaged in the program receive appropriate services. In some instances, it may take 18 months or more to establish a new program including identification of third-party vendors, securing location or space, hiring sufficient behavioral health staff given acknowledged professional shortages, completion of the credentialing process to allow billing for healthcare services, and to complete any needed agreements, including data sharing.

Staffing is anticipated to be difficult within the proposed timeline. SB 453 requires the inclusion of a psychiatrist on the care coordination team (page 7, line 7). Hiring behavioral health professionals is a significant challenge already, even for well-resourced entities and is more pronounced in the more rural jurisdictions in the state. This bill should allow a psychiatric nurse practitioner to fulfill the role. It is important to note that a psychiatrist cannot bill for court-related time, and this could have costly implications for local programs. The ability to have another trained professional who could provide services will provide more program efficiency and improve ability to bill.

MACHO supports this effort to better serve residents with serious mental illness. To ensure the successful development and implementation of AOT in MD, we recommend the following amendments:

1. Section 2: Amend the language of this section such that all psychiatrist references are changed to "psychiatrist or psychiatric nurse practitioner"
2. Section 3: Change the implementation date to July 1, 2026. Jurisdictions can move ahead sooner if they are ready. A July 1, 2026 date:
    - Accounts for the realities of capacity building, cross-agency coordination, hiring, and staff credentialing at the local level across Maryland
    - Provides time for the State to work with local jurisdictions to establish the program and ensure financial sustainability given:
        - The need to pay clinical staff for months prior to the ability bill for services
        - That billing revenue will cover only a small portion of mandated requirements
        - No means of independently generating revenue for LBHA oversight responsibilities

For these reasons, the Maryland Association of County Health Officers submits this letter of support with amendments for SB 453. For more information, please contact Ruth Maiorana, MACHO Executive Director at rmaiora1@jhu.edu or 410-937-1433. *This communication reflects the position of MACHO.*

SB0453_FWA_MedChi_MH - Em. Eval. & Involuntary Adm

Uploaded by: Steve Wise

Position: FWA

MedChi

The Maryland State Medical Society

1211 Cathedral Street
Baltimore, MD 21201-5516
410.539.0872
Fax: 410.547.0915

1.800.492.1056

www.medchi.org

TO: The Honorable Pamela Beidle, Chair
Members, Senate Finance Committee
The Honorable Senate President Bill Ferguson (Administration)

FROM: J. Steven Wise
Pamela Metz Kasemeyer
Danna L. Kauffman
Andrew G. Vetter
Christine K. Krone

DATE: February 20, 2024

RE: **SUPPORT WITH AMENDMENT** – Senate Bill 453 – *Mental Health – Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment Programs*

The Maryland State Medical Society (MedChi), the largest physician organization in Maryland, **supports Senate Bill 453 with amendment**.

The purpose of the bill is to establish a better and more effective mental health system in Maryland, something that MedChi strongly supports. The principal issue raised with the bill during MedChi's discussions is that it would change the location to which a peace officer would take an emergency evaluee for evaluation.

Under current law, the evaluee is to be taken to the "nearest" emergency facility for an evaluation. However, the bill would alter this to require that the evaluee be taken to "a nearby" emergency facility. There is concern that this proposed change would cluster emergency evaluees at certain facilities rather than spreading them out among all emergency facilities and would exacerbate wait time problems at certain emergency facilities that received a disproportionate number of evaluees. While well-intended, MedChi does not believe this change is needed and believes the current law should be left intact.

Thank you for your consideration of our position on this important bill.

For more information call:
J. Steven Wise
Pamela Metz Kasemeyer
Danna L. Kauffman
Andrew G. Vetter
Christine K. Krone
410-244-7000

SB 453 - FWA - MPS WPS.pdf
Uploaded by: Thomas Tompsett
Position: FWA

February 14, 2024

The Honorable Pamela Beidle
Senate Finance Committee
Miller Senate Office Building – 3 East
Annapolis, MD 21401

RE: Support – Senate Bill 453: Mental Health - Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment Programs

Dear Chair Beidle and Honorable Members of the Committee:

The Maryland Psychiatric Society (MPS) and the Washington Psychiatric Society (WPS) are state medical organizations whose physician members specialize in diagnosing, treating, and preventing mental illnesses, including substance use disorders. Formed more than sixty-five years ago to support the needs of psychiatrists and their patients, both organizations work to ensure available, accessible, and comprehensive quality mental health resources for all Maryland citizens; and strive through public education to dispel the stigma and discrimination of those suffering from a mental illness. As the district branches of the American Psychiatric Association covering the state of Maryland, MPS and WPS represent over 1000 psychiatrists and physicians currently in psychiatric training.

MPS/WPS support with amendment Senate Bill 453 Mental Health - Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment Programs (SB 453). Assisted outpatient treatment (AOT) programs, also known as outpatient commitment, refer to court-ordered treatment for individuals with severe mental illness who may have difficulty adhering to treatment plans on their own. Some of the benefits of AOT programs include:

- **Improved treatment adherence:** AOT programs can help individuals with mental illness stick to their treatment plans, leading to better symptom management and overall health outcomes.

- **Reduced hospitalizations:** AOT programs decrease the need for hospitalizations and emergency room visits by helping individuals stay on their medication and attend appointments with mental health professionals.

- **Reduced homelessness:** AOT programs can also reduce homelessness among individuals with severe mental illness by ensuring they receive the necessary treatment and support to remain stable in the community.

- **Improved quality of life:** By providing individuals with access to ongoing treatment and support, AOT programs can help them achieve and maintain a higher quality of life.

- **Increased public safety:** AOT programs can help prevent individuals with untreated severe mental illness from engaging in behavior that could harm themselves or others, which can improve public safety.

MPS/WPS believe that the following amendments are needed, however, to make this good bill a great one:

- **Where To Go:** A peace officer should take an emergency evaluee to the closest emergency facility to better distribute those experiencing a mental health crisis throughout the healthcare system. By codifying nearest, officers will take an emergency evaluee to those facilities where they believe the evlauee will have the best chance of being committed. By not addressing this distinction, some emergency departments will be overwhelmed with emergency evaluees while others will see little to no evaluees. Therefore, the amendment should read: **On page 3, line 2 strike the brackets; in the same line strike "A" down through "NEARBY" in line 3.**

- **How to Proceed:** The procedure, beginning on page 8 at line 16, should be an **administrative model** rather than a judicial one. Spending a day in a courthouse waiting to testify in a single hearing is an unfair request of community doctors who should otherwise be attending to many patients. Furthermore, most doctors are not trained or comfortable in doing this. Under an administrative model, the evaluee is already admitted, a team social worker develops a plan, and an administrative law judge (ALJ) is present for a retention hearing.

- **AOT as a condition of involuntary admission:** The process should be limited to the inpatient realm, where the administrative procedure is already in place and familiar to healthcare practitioners. The amendment should read: **On page 7, strike beginning in line 21 with "BY" down through and including "Respondent" in line 23 and substitute "A PSYCHIATRIST WHO HAS EVALUATED THE RESPONDENT WITHIN 30 DAYS BEFORE THE DATE OF THE PETITION."** This is a logical correction as later in the bill, a psychiatrist "shall" testify as a fact witness in support of AOT commitment.

- **Funding:** Finally, the funding of AOT is paramount. Unfunded or underfunded AOT programs prove time and again to be less effective or even ineffective. Should the Maryland General Assembly (MGA) pass this law, the MGA should look to Medicaid, the Maryland Department of Health, community mental health block programs, private insurance, and philanthropic sources to achieve the appropriate funding for this much-needed program. While the $3 million that the Administration has set aside for this bill

is a nice start, New York City's AOT Program, "Kendra's Law," which has an upfront investment of $125 million and is costing the City about $10,000 per person. Baltimore's Involuntary Outpatient Treatment cost about $40,000 per person in the first year with only 9 people on orders. Combining those experiences, Maryland is home to 6.2 million and 3% have schizophrenia with only 2% of them needing AOT, which is a very conservative estimate. The first year of the program would cost roughly $148 million. While this figure may seem staggering, the benefits to the individual, the community, and the healthcare system more than offset this investment.

With the above amendments adopted, MPS/WPS ask this committee for a favorable report on SB 453. If you have any questions concerning this testimony, please contact Thomas Tompsett Jr. at tommy.tompsett@mdlobbyist.com.

Respectfully submitted,
The Maryland Psychiatric Society and the Washington Psychiatric Society
Legislative Action Committee

NARPA-Testimony-Opposing-SB453-UNF (2).pdf
Uploaded by: Bill Stewart
Position: UNF

NARPA

NATIONAL ASSOCIATION FOR RIGHTS PROTECTION AND ADVOCACY

Re: Senate Bill 453 (Unfavorable)

The National Association for Rights Protection and Advocacy is an independent member-supported organization of advocates, people who have experienced psychiatric intervention, lawyers, civil rights activists, academics and mental health service providers. For forty years our mission has been to protect people's right to choice and to be free from coercion, and to promote alternatives so that the right to choice can be meaningful. We believe outpatient commitment is inherently violative of people's autonomy, dignity and choice. We are writing to voice our opposition to the proposed legislation that would introduce it to the State of Maryland.

The euphemistically mis-termed "assisted outpatient treatment" is not about assistance but rather, coercion and force through the vehicle of civil commitment. The bills' proposed findings refer to people who "struggle to engage voluntarily in treatment." In our experience people often struggle to effectively refuse unwanted and unhelpful treatment — or conversely, to access wanted but unavailable services.

Despite its federal listing as an evidence based practice there is significant evidence suggesting outpatient commitment is ineffective in practice. What has been successful is the intensive services provided rather than judicial coercion accompanying them. Nor has it been demonstrated to be cost effective. One systemic review (Compulsory community and involuntary outpatient treatment for people with severe mental disorders, Kisely et al, 2011) concluded: "In terms of numbers needed to treat, it would take 85 outpatient commitment orders to prevent one readmission, 27 to prevent one episode of homelessness and 238 to prevent one arrest." (https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD004408.pub3/full)

Framing the choice to reject proposed treatment and avoid the mental health system as a result of lack of insight denies even a possibility of reasonable refusal.* But for many people psychiatric treatment is ineffective or harmful or both. A system of care that overrides choice, incorporates community coercion and diverts scarce resources to effect it undermines the therapeutic alliance between providers and clients and drives people further away from services. Transforming carers into enforcers and creating a self perpetuating system of monitoring and control will not create high quality equitable care.

We ask that you closely examine the evidence and reconsider this proposed legislation. If you decide to move forward we urge you to narrow it to a pilot project in one county, with an independent study of its outcomes to be reported back. Thank you for your consideration.

Bill Stewart, Board President, National Association for Rights Protection & Advocacy
320 Sycamore Rd, Lexington KY, 40502

* Please see the accompanying brief article Anosognosia: How Conjecture Becomes Medical "Fact" by psychiatrist Sandra Steingard

https://www.psychologytoday.com/us/blog/bipolar-advantage/201208/anosognosia-how-conjecture-becomes-medical-fact

Psychology Today
Sandra Steingard, MD

PSYCHOSIS
Anosognosia: How Conjecture Becomes Medical “Fact”
How ideas become mainstream without any research basis.

Posted August 30, 2012

I was so moved by this article that I asked Sandra Steingard MD for permission to repost it. I do so here without changes.

Neurologists use the term anosognosia to describe a peculiar syndrome in which a person has a profound lack of awareness of an obvious deficit. For instance, a person who has a stroke on the right side of his brain and is paralyzed of the left side of his body has no awareness of the problem. He might not recognize his left arm as his own. When given a page to read, he might only read the words on the right side of the page. He would only put his shirt on his right arm but when asked if he was adequately dressed, he would answer, yes. This phenomena is regularly associated with damage to the right side of the brain in the section called the parietal lobe.

In the 1990′s, a psychologist, Xavier Amador, began to use this term in the context of describing a person who was experiencing psychotic symptoms and did not believe that his problems were due to an illness. For instance, if a person heard voices that no one else heard, he might conclude that he was communicating with dead relatives. When his doctors or family told him that he was sick, he would disagree. Doctors would call this “lack of insight” and Amador was one of the first to appropriate the neurological term anosognosia to describe this.

There is a history in neuroscience of trying to apply what has been learned from studying the cognition and behavior of people who have had strokes to develop a more general understanding of the connection between brain function and behavior. In that spirit, there have been multiple studies to address whether there were changes in the brains of people who were psychotic and were described as having a “lack of insight” that were similar to the changes found in people who had right hemisphere strokes.

Readers on this site have wondered how the notion of a “chemical imbalance” could have been accepted by so many when the research did not actually support the concept. A recent paper from the Treatment Advocacy Center that summarizes studies of anosognosia in psychosis gives some clue as to how this type of thinking becomes entrenched and accepted.

The paper reviewed 18 studies of brain imaging of people who were identified as having this syndrome. This is from the conclusion to that study:
"Regarding localization, it is now clear that anosognosia is not caused by damage to one specific area. Rather a person’s awareness of illness involves a brain network that includes the prefrontal cortex, cingulate, superior and inferior parietal areas, and temporal cortex and the connections between these areas. Damage to any combination of these areas can produce anosognosia, but damage to the prefrontal and parietal areas together make anosognosia especially likely.

Anosognosia, or lack of awareness of illness, thus has an anatomical basis and is caused by damage to the brain by the disease process. It thus should not be confused with denial, a psychological mechanism we all use."
This conclusion, which will now likely be repeated in TAC publications and elsewhere as a definitive statement of scientific “fact”, involves some slight of words. What the paper reports is that 15 of 18 studies found group differences between the study subjects and the controls but the findings were highly variable between studies. In the summary above, they mention that differences were found in multiple brain regions but the findings did not overlap much between the studies, i.e., although 15 studies had “positive” findings, they were often different findings in each study. My assumption from reading this review is that, despite this research, if one were to show a scan to a doctor, he would not be able to make a diagnosis from the scan. In other words, the differences are subtle and do not clearly distinguish a person with “lack of awareness” of psychotic symptoms from any one else.

If one were to do a similar study of patients who had strokes and subsequently had the classic form of anosognosia, the findings would be strikingly different. In every study, there would be profound abnormalities in the brain and they would all be found in the right parietal lobe of the brain. If you showed me a series of scans of people with left sided neglect due to strokes and those of people who did not have this syndrome, I believe I could

easily pick out those with left neglect. In this case the brain damage would be obvious and the resulting deficit would be easy to predict.

In the TAC summary, the use of the word “damage” is misleading. Abnormalities – or in this case group differences – do not equal damage. I am left handed. I imagine that with some types of brain imaging, my brain would look different from my right handed friend but that does not mean my brain is damaged; it only means my brain is different.

The final statement in this conclusion, that anosognosia “should not be confused with denial, a psychological mechanism we all use,” makes no sense to me. Why do they believe that there are no brain changes underlying the so-called psychological condition of denial? In most of the studies reviewed, they would ask people questions while they were in the scan. A sample question was “If someone said I had a mental illness they would be right.” The type of “psychological denial” that the authors want to distinguish between this so-called anosognosia would presumably be something along the lines of someone who has lost a loved one but does not report being sad. The only way one could conclude that the findings in the psychosis studies were different and somehow distinct would be to scan the brains of people who were found to have “psychological denial” and compare those to brain scans from individuals who had “good insight” and as well as those who are identified as having lack of insight of psychosis. As with the notion of “chemical imbalance”, the term anosognosia has crept into the psychiatric lexicon. Its use confers a certain sophistication of understanding and knowledge that is not supported by the data.
Sandra Steingard, M.D. is the Medical Director of HowardCenter and Clinical Associate Professor of Psychiatry at the University of Vermont College of Medicine in Burlington. She was educated and trained at Harvard and Tufts Universities in Boston and received her specialty certification in psychiatry from the American Board of Psychiatry and Neurology in 1986.
Her areas of interest include community mental health and the diagnosis and management of psychotic illnesses. She was named an Exemplary Psychiatrist by the National Alliance for the Mentally Ill of Vermont in 1996, and has been listed in the Best Doctors in America since 2003.

About the Author

Tom Wootton founded Bipolar Advantage with the mission to help people with mental conditions shift their thinking and behavior so that they can lead extraordinary lives.

SB453_ConstanceLesold_UNF
Uploaded by: Constance Lesold, MSW
Position: UNF

Senate Finance Committee, February 19, 2024:
Testimony in opposition to SB453 - UNFAVORABLE
Health and Government Operations Committee
From: Constance Lesold, MSWSmith College SSW, 1965.

Only 3 states have no AOT laws, Maryland, Massachusetts, and Connecticut. As these laws are very controversial, it is essential that Maryland remain without AOT laws as a state where comparisons can be made as to what works and what does not work!

I am 86 years old with 78 years of observing a wide variety of psychiatric practices, as a family member and a professional social worker. My father returned from World War II in Italy in 1945 with what you might cal SMI . The treatments he endured included ECT and lobotomy. You may be aware that the person who invented lobotomy won the Nobel Prize for medicine. The history of psychiatric treatment is full of terrible mistakes. It is your responsibility as legislators, not just Drs. to First Do No Harm. Please take a cautious , long visioned approach to mental health planning and give voluntary treatment efforts , well Funded, in at least three states. As the coordinator of the Brooklyn Mental Hygiene Court Monitors Project I witnessed the first AOT case in Brooklyn, a black, middle aged , female veteran with a long history of alcoholism. She only asked for the Social Worker for AOT to be black. Neither white lawyers or the judge paid any attention to this request. So much for cultural competence! In Brooklyn the court clients are mainly black or immigrant background. I don't know about Maryland. I don't know of good outcomes and I have followed many. Thanks for paying some attention. You can contact me with questions. Give people a chance for dignity in court. Try voluntary in the three states for scientific and human purposes. Also take a look at the UN Treaty on the rights of people with disabilities. Forced treatment is not popular there. In colonial days in the Americas, with slavery, everyone was "crazy" who didn't support slavery. How do you want to be seen in history?

Sincerely, Constance Lesold, MSW

Cbergan_SB 453_Oppose.pdf
Uploaded by: Courtney Bergan
Position: UNF

Courtney Bergan, J.D.
Baltimore, MD 21212
cbergan@umaryland.edu

February 20, 2024

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.

DRM_SB453_OPPOSE.pdf
Uploaded by: Courtney Bergan
Position: UNF

Disability Rights Maryland

Empowerment. Integration. Equality.

1500 Union Ave., Suite 2000, Baltimore, MD 21211
Phone: 410-727-6352 | Fax: 410-727-6389
www.DisabilityRightsMD.org

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.

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WRITTEN TESTIMONY IN OPPOSITION OF
SB453 - Mental Health - Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment Programs
Health and Government Operations Committee

Thank you Chair, Vice Chair, and committee members for taking the time to read my testimony today.

My name is Hannah Dixon, I am a social worker who has lived experience with bipolar disorder, a condition that has previously led me toward psychiatric hospitalization. I am standing before you today because in my research, my client base, my studies, and my first-hand lived experiences, I have seen the benefits of choice-based mental health care, just as I have seen the harms and collateral consequences of involuntary mental health care. I am writing today to express my opposition to Senate Bill 453.

Unlike a large percentage of individuals, I am a person that received care that was not forced. It is because of this I was able to pursue my recovery at my own pace, pursue a career in behavioral health, and an education in social work. I wholeheartedly attribute all of my successes to being given the choice to pursue voluntary treatment.

In 2019, I experienced a psychiatric crisis after ending an abusive relationship that I had been too scared to leave for over a year. I went to the hospital to be admitted inpatient but I was told I did not meet the criteria to be admitted. I began to yell and scream. Within minutes I was surrounded by hospital security. The clinical director entered the room. I spoke to her about how was feeling suicidal. She listened attentively and referred me to a facility voluntarily.

I knew I needed support but If I were admitted involuntarily, this would have exacerbated my depressive symptoms, and risked my ability to graduate college, which I ultimately did three months after this event.

Today - because I had choice, autonomy, and credibility in my treatment decision - I am doing very well. With regular outpatient therapy and medication management, I have been able to successfully manage my moods and my symptoms. I have worked in the psychiatric rehabilitation field for almost five

years, where I support individuals much like myself. In just weeks, I will sit for my licensure exam to become a fully licensed social worker.

Everyone involved in mental health policy needs to seriously consider reframing the way we think about court-mandated mental health treatment. We need to think critically about what forced or involuntary treatment does to a person, on an individual level. Forced treatment leads to damaged trust of the mental health system. Perception of coercion in treatment has been linked to post-discharge suicide attempts and poorer quality of care compared to voluntary treatment[1].

We need to take a deeper look at the potential for harm and recidivism within coercive interventions like AOT and ask ourselves why we currently consider the idea of AOT to be less restrictive than involuntary commitment, when both of these are involuntary forms of treatment. I was granted choice, autonomy, and credibility during a mental health crisis.

AOT will take away this choice for people like me, increasing their chance of a severely damaged relationship with the system, making it so that they may never trust another clinician again. Trust is integral to recovery, and AOT promotes neither trust nor recovery.

How can we expect those who have been court-mandated to treatment of any level to wholeheartedly participate in their own recovery? We need to seriously reconsider the effectiveness of these involuntary systems of care. The implementation of forced, involuntary interventions must change if we are to expect the outcomes we want to see in behavioral health crisis intervention care. The power is vested within you to make these changes.

I urge you to oppose Senate Bill 453.

[1] Chung, D. T., Ryan, C.J., Hadzi-Pavlovic, D., Singh, S.P., Stanton, C., & Large., M. M. (2017). Suicide rates after discharge from psychiatric facilities: A systematic review and meta-analysis. JAMA Psychiatry.

HD ORAL SB453 Testimony.pdf
Uploaded by: Hannah Dixon
Position: UNF

ORAL TESTIMONY IN OPPOSITION OF
SB453 - Mental Health - Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment Programs
Health and Government Operations Committee

Thank you Chair, Vice Chair and committee members for being here today.

My name is Hannah Dixon. I am a social worker with bipolar disorder. In my lived experience and my client base, I have seen the benefits of choice-based treatment and the harms of involuntary treatment. I am here to express my opposition to Senate Bill 453.

I am a person that received voluntary crisis care. Because of this I was able to pursue my recovery at my own pace, and my education and career in social work. I attribute all of my successes to being given the choice to pursue voluntary treatment.

In 2019, I experienced a psychiatric crisis after ending an abusive relationship that I had been too scared to leave for over a year. I went to the hospital to be admitted inpatient but I was told I did not meet the criteria to be admitted. I began to yell and scream. Within minutes I was surrounded by hospital security. The clinical director entered the room. I spoke to her about how was feeling suicidal.

[PAUSE]

She listened attentively and referred me to a facility voluntarily.

[mini pause]

If she had not listened to me, I would have gone home and taken my own life. I knew I needed support but If I were admitted involuntarily, this would have exacerbated my depressive symptoms, and risked my ability to graduate college, which I ultimately did three months after this event.

[mini pause]

Because I had a choice in my treatment decision - I am in recovery. With therapy and medication, I have maintained wellness, and I will soon be a fully licensed social worker.

I urge you to think critically about the potential harm and trauma of expanding coercive, forced interventions like AOT when there are voluntary, recovery-oriented services available.

I was granted choice and credibility with my treatment during a crisis. AOT will take this choice away from people like me and damage trust with their providers and the services they receive. Trust is integral to recovery, and AOT promotes neither trust nor recovery.

I urge you to oppose this bill.
Thank you for your time.

SB 453 - AOTOppose - Testimony (J. Carlo) .pdf
Uploaded by: Jake Carlo
Position: UNF

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WRITTEN TESTIMONY IN OPPOSITION OF
SB 453 - Mental Health - Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment Programs
Finance Committee

Thank you Madam Chair and committee members. My name is Jake Carlo. I am a Baltimore resident and a trauma survivor.

I'm writing to urge you to vote against SB 453. I myself have received forced psychiatric treatment that was both damaging to my standing in the community and a significant setback on my own path to recovery.

In April of 2021, three close friends had come to the decision, without consulting me, that confinement and forced treatment was what was best for me at that time, and called on the police to help them enforce their decision. I had not done anything that would warrant detainment under normal legal circumstances and my friends were aware that I had both a medical prescriber and a therapist that I was working very closely with at the time. But rather than attempt to engage and support me through my own, very robust, recovery process, they chose instead the quickest way to address their own feelings of discomfort with my situation.

What I really needed in this moment was a calm environment and someone who would listen and support me, but instead my friends called the police. They came to my home and surrounded me. I felt terrified. I was taken away to the hospital in the back of a police car.

In previous years, when I was struggling and didn't know where else to turn, I had myself sought treatment through hospital emergency rooms and crisis centers. I was always either turned away or offered a form of treatment that was economical for the hospital but not appropriate to my situation. It was never a positive experience, and always led to more stress and hardship. I told my friends I would not subject myself to that same experience yet again, particularly when I was already receiving voluntary care.

I didn't want to lose all control over my mental health treatment, and I didn't want to surrender my rights as a citizen. At the hospital I refused to sign any of the admission forms I was presented with for fear of signing my rights away. I did not learn until later that simply by the act of refusing to sign those forms, I became subject to a rule requiring immediate confinement to their locked ward, and lost the very rights I had sought to protect.

I was held on the ward for ten days pending a medical review board hearing to be involuntary admitted to an inpatient unit. During that time I was not allowed to access my phone to look up the numbers I needed to contact friends and family. I was cut off from the world almost entirely during that time.

I learned that by rule I had access to the hospital's care advocate, but regular and repeated requests to meet with that advocate, made over the course of days, were not followed up on by staff.

At one point, a duty nurse became angry at my insistence on accessing the care advocate, and called in security to have me physically restrained, so that she could inject me with a powerful sedative – although to this day I don't actually know what I was given.

I literally begged the staff not to do this to me as they pinned me in a chair, and one of my only positive memories of this time is of the tears I saw in a young guard's eyes as she watched them put the needle in. It was the single moment of empathy that I experienced during that time, and the only indication I was given – albeit silent – that I was something more than a recalcitrant mental patient. Sadly, this one small moment of humanity was granted me by someone who themselves had little to no power within the institution.

I later learned that the nurse's actions violated Maryland state law, that it is, in fact, illegal to administer drugs against a patient's wishes outside of a threat to life and limb.

No therapeutic services were available to those confined on the ward; there was no 'treatment' happening. It was in essence a holding cell. After one ten-minute review with a psychiatrist, I was told that my medication would be drastically changed. I knew that there were very real dangers associated with such drastic changes, because I had suffered through them before. But my concerns were ignored.

Back on the ward, however, what I learned was that in order to survive the next ten days, and avoid a further 90 day minimum of incarceration, I needed to stay quiet or comply, that I couldn't ask for what I truly needed without being seen as defiant.

In the end, and with the assistance of a legal advocate provided by the good offices of Disability Rights Maryland (DRM), I was provided with a conditional release, contingent on an agreement to take the new medications, despite the risks. I succumbed to the coercion, I took the medications, and waited another day for my release.

I later learned, again through DRM's efforts, that the diagnosis in my hospital chart was wrong, was in fact provided initially by the very people who had called the police to detain me, and that my own medical provider was never consulted.

In other words, the assumption that I lacked insight into my own mental state and was treatment noncompliant directly resulted in the harmful care that I received.

The consequences of that incarceration haunt me to this day, and are what have motivated me to reflect on my experiences today with you, Maryland's leaders, so that we as a state do not subject even more of our citizens to these experiences than we already do.

You and I know, anyone who has had any contact with the system knows that we need more supports for those who have survived trauma – people this bill labels “mentally ill.”

But even more importantly, **we need the *right kind of supports***.

Cloaked in seemingly benign language that says “We want to help those who most need it,” this bill in fact is an attack on the very foundation of mental health recovery: self-regard and self-determination.

This bill’s answer to the brokenness of our public mental health system is to pile on an even greater burden on that system, and to rob our citizens of their fundamental rights – in short, to make matters worse by the same means that brought us to this point.

This bill perpetuates the notion that trauma survivors are bettered by being treated as incapable of participating meaningfully in their own care.

We are your residents, your citizens, your voters, and we are not less than human.

So I urge you again to vote against SB 453, and thank you for your time.

CLRP testimony in opposition to MD SB 453.pdf
Uploaded by: Kathleen Flaherty
Position: UNF

CONNECTICUT LEGAL RIGHTS PROJECT, INC.

TESTIMONY OF KATHLEEN FLAHERTY, ESQ.
EXECUTIVE DIRECTOR, CT LEGAL RIGHTS PROJECT, INC.
FEBRUARY 20, 2024

In opposition to: SB 0453, An Act Concerning Mental Health – Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment Programs

Good afternoon. My name is Kathy Flaherty and I am a lawyer and the Executive Director of Connecticut Legal Rights Project (CLRP), a statewide non-profit agency that provides legal services to low-income adults with serious mental health conditions. CLRP was established in 1990 pursuant to a Consent Order which mandated that the state of Connecticut provide funding for CLRP to protect the civil rights of clients of the Department of Mental Health and Addiction Services who are hospitalized, as well as those clients who are living in the community. I am someone subjected to involuntary inpatient care at a psychiatric hospital via civil commitment and who engaged later in voluntary treatment, on both an inpatient and an outpatient basis. I am submitting this testimony against SB 453 because it simply will not accomplish its stated purpose. This bill would divert state funding to create a structure to enable coerced treatment instead of using state dollars to meet the need for a broader range of voluntary services and supports. Instead of helping people with mental health conditions, this bill would hurt them. I urge the committee to reject this bill.

1

Your colleagues in the Connecticut state legislature have considered, and rejected, various proposals to institute involuntary outpatient commitment over the last quarter of a century. In 1996, a public act established a task force to study involuntary outpatient commitment in Connecticut. Their report was issued in January 1997 and can be found here: http://www.narpa.org/reference/task.force.report Notably, the task force did not

recommend either adoption or dismissal of the concept of involuntary commitment. They noted that "[t]he question remains, "Is there a case for some form of involuntary outpatient commitment for a very narrow target population considered to represent a risk of violence in the community?""

In 2000, Connecticut's Judiciary Committee held public hearings on two bills and referred them to Appropriations, where they died. In 2012, the Judiciary Committee raised a bill for a public hearing; that bill never made it out of committee. In 2013, the Young Adult Behavioral Task Force issued their report and could only encourage "further study" of IOC. The Sandy Hook Advisory Commission (on which I served) stated in its final report, issued in 2015, that it was "unable to arrive at a recommendation concerning adopting IOC as an option short of involuntary hospitalization in Connecticut." In 2016, yet another bill had a hearing in the Judiciary Committee, and never made it out of committee. In 2020, the Public Safety & Security Committee raised a bill and had a public hearing. That bill died when the 2020 session ended due to the Covid-19 pandemic. Bills proposed by individual legislators in the sessions since then have not even made it to a public hearing.

Three times the Connecticut legislature requested research reports from the Office of Legislative Research: in 2001 (2001-R-0866), 2011 (2011-R-0438), and 2013 (2013-R-0105) on what other states do regarding involuntary outpatient commitment. Much time and effort has been expended on examining IOC, only to have the legislature reject it each time it is proposed.

Expansion of involuntary medication to the community is a step backward.

It has long been recognized that all people have a constitutional right to bodily integrity, which includes the right to refuse medical treatment including psychiatric medications. "An individual has a constitutionally protected liberty interest in avoiding involuntary administration of antipsychotic drugs. . ." Sell v. United States, 539 U.S. 166, 178-79 (1992). When forced medication is used "to alter the will and the mind of the subject, it constitutes a deprivation of liberty in the most literal fundamental sense." Washington v. Harper, 494 U.S. 210, 237-38 (1990).

Presently, the law allows for involuntary medication in a psychiatric hospital under certain limited circumstances and with strict due process protections. It mandates procedures that protect patients' rights, including notice to the patient of available advocacy services, advance notice of any proceedings, the right to representation and the right to question witnesses.

Expansion of involuntary medication into the community is not only a limitation of constitutional rights; it is unnecessary. Maryland has other options available that include peer support, recovery learning communities, advance directives and Housing First models. Forced medication in a community setting would be counter to a patient-centered approach.

Maryland resources would be much better spent increasing access to supportive housing and other voluntary community treatment and support options, such as peer-run respites. Involuntary outpatient commitment would divert resources desperately needed by the community-based system of mental health services into the court system.

No Magic Pills

It is important to note that while psychotropic medications help some people, there are others for whom they are not helpful. The diagnosis and treatment of psychiatric conditions is not an exact science. It may take trial and error over time to discover an effective regimen. As with any medical condition, sometimes something that was once working stops working. Some people are accused of not taking their medication when in fact, it is a matter of their medication simply not working. Sometimes people develop adverse effects that require changes in medications. Psychotropic medications are powerful and can cause severe and irreversible side effects. It is therefore not unreasonable for an individual to refuse to take medication in accordance with a doctor's clinical recommendation. Failure to comply is not a psychiatric symptom or evidence of a psychiatric disorder.

Despite the fact that Connecticut does not have involuntary outpatient commitment, I had to comply with my psychiatrist's recommendations for treatment because my admission to practice law in Connecticut was conditional on my compliance with mental health treatment. For nine years, I had to submit an affidavit

every six months saying that I remained compliant with treatment, and my psychiatrist had to submit a letter as well. I took the medications my psychiatrist recommended, even though they often did not work. I also attempted suicide several times during that time frame. Thankfully, I did not succeed. Eventually, the conditions on my admission were removed and I had true freedom to make choices about my psychiatric care.

Trusting and respectful relationships encourage sharing of these concerns and discussions of options. Forcing treatment encourages avoidance of treatment providers.

Discrimination

This bill singles out people with psychiatric disabilities for loss of self-determination with no proven benefits to them or to the public. I understand that there are some people whose conditions are difficult to treat and whose situations frustrate and worry their family members, treatment providers and judges. However, sacrificing the rights of many people to deal with a few complex situations, using an ineffective methodology, is wrong. It is also likely to increase health disparities. There is substantial evidence that involuntary outpatient commitment is used disproportionately against Black and Brown people.

International Law from the United Nations has found that forced psychiatric treatment may amount to torture.

I am someone who has been subjected to forced psychiatric treatment, including forced hospitalization, seclusion, restraint, and forcible medication. That intervention occurred more than 30 years ago. The trauma that resulted from that intervention still remains. It is not merely psychiatric survivors who say that forced treatment is harmful: The U.N. Special Rapporteur on Torture recently submitted a report on torture and other cruel, inhuman or degrading treatment of punishment. In paragraph 37 of the report, the following was noted (emphasis added)

> 37. **It must be stressed that purportedly benevolent purposes cannot, per se, vindicate coercive or discriminatory measures.** For example, practices such as involuntary … psychiatric intervention based on "medical

necessity" of the "best interests" of the patient (A/HRC/22/53, para.20, 32-35; A/63/175, para.49), … generally involve highly discriminatory and coercive attempts at controlling or "correcting" the victim's personality, behaviour or choices and almost always inflict severe pain or suffering. In the view of the Special Rapporteur, therefore, if all other defining elements are given, such practices **may well amount to torture**. (Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment of punishment - A/HRC/43/49, available at: https://www.ohchr.org/EN/HRBodies/HRC/RegularSessions/Session43/Documents/A_HRC_43_49_AUV.docx)

Conclusion: The Committee should reject this bill.

SB 453 should be rejected. If Maryland needs additional critical community health services, this legislature should focus on setting up that service delivery system first and build it in a way such that people will want to engage with it. Setting up the mechanism to force people into an already over-burdened system is backwards.

It is unconscionable that in a time when people cannot access community-based services because they are not available as a result of lack of funding that there would be a proposal to set up a system in which treatment is forced on someone who doesn't want it, and depends on monitoring and supervision by under-resourced and over-stretched agencies to ensure an individual subject to an order of involuntary outpatient commitment takes their medication.

This bill does not center the people who need access to services and supports. I can guarantee you, as a former patient, that the likelihood of establishing rapport and earning trust when treatment is coerced is next to nil. Forced outpatient treatment does not work better than or in the absence of an influx of voluntary community services. Evidence increasingly shows that acts that include force actually increase risk of suicide, violence, and other poor outcomes.

Unless and until people have a legally enforceable right to the community-based services and supports they need, and until the state adequately funds the agencies that provide the services and supports, this state has no business instituting involuntary outpatient commitment. Please reject this bill.

OOOMD - 2024 - SB 453 - OPP - AOT (Written).pdf
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WRITTEN TESTIMONY IN OPPOSITION TO SB 453 - Mental Health - Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment Programs

Thank you Chair Beidle, Vice Chair Klausmeier, and committee members for your commitment to improving the quality and accessibility of healthcare services for Marylanders, especially community members who experience significant behavioral health challenges. 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 recovery. Our affiliated network of 16 peer-operated Wellness & Recovery Organizations throughout Maryland offer free, voluntary recovery support services to nearly 8,500 people, many of whom live with serious mental illness and socioeconomic barriers.

OOOMD strongly opposes SB 453, which would establish a statewide involuntary outpatient mental health civil commitment program ("assisted outpatient treatment (AOT)"). Since our founding, OOOMD has remained fundamentally opposed to any expansion of involuntary treatment as a core tenant of our mission. Our goal in this testimony is to illuminate the serious flaws with the AOT model and the specific program proposed in SB 453, and to highlight the availability of effective viable alternatives. Our major areas of concern include:

1. **Lack of Evidence:** Multiple rigorous research studies show that involuntary outpatient programs do not produce better outcomes than voluntary services.

2. **Inherent Harm & Race-Based Disparities:** Involuntary treatment creates significant and long-lasting negative impact, creating further barriers to engagement and recovery. People of color experience higher rates of involuntary and forced treatment, including chemical (forced medication) and physical restraints.

3. **Broad Eligibility Criteria:** Broadly scoped eligibility criteria invite unnecessary petitions, and may enable use of AOT instead of less restrictive options.

4. **Implementation Expectations:** The AOT process proposed is not well aligned with the realities of care coordination and service delivery.

5. **Lack of Consideration for Non-Clinical Needs:** Structural and logistical barriers to seeking and receiving effective services are not addressed.

6. **Better Alternatives Exist:** Evidence-based and best practice program models already exist in Maryland and in other states, which can achieve the same or better results without infringement on civil rights.

Comparison to 2023 HB 823

Last year, OOOMD was grateful to participate in the 2023 HB 823 working group, which resulted in many important updates to bill language ensuring appropriate civil rights and legal due process protections, narrowing of eligibility criteria, and required outcome data reporting.

As submitted, SB 453 does not match the substantially amended bill from last session, but instead contains many extremely concerning provisions. We have been informed that amendments are forthcoming to restore the protections instituted in last year's bill, and we look forward to being able to review those when they are made available. At this time, our testimony responds to the bill language as it appears in the MGA portal.

Lack of Evidence

Rigorous independent research studies and randomized control trials have not shown convincing evidence that outpatient civil commitment programs achieve results they claim:

- 6 large systematic research literature reviews conducted between 2001-2013 show very limited to no evidence that mandating outpatient treatment reduces hospital readmissions or improves social functioning or psychiatric symptoms.[1,2,3,4,5]
- In a 2001 randomized control trial study in North Carolina, the number of hospital readmissions and arrests measured 1 year after discharge did not differ between those court-ordered to outpatient treatment and those who received services voluntarily.[6]
- The 2001 Bellevue Outpatient Commitment Study from New York concluded that those provided with voluntary enhanced community services "did just as well" as those under commitment orders who had access to the same services. Researchers also found no

[1] 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

[2] 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

[3] 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.*

[4] 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

[5] 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.

[6] Swartz, M. S., Swanson, et al (2001). A randomized controlled trial of outpatient commitment in North Carolina. Psychiatric Services. https://doi.org/10.1176/appi.ps.52.3.325

additional improvement in patient treatment compliance, no difference in hospitalization rates or lengths of stay, arrest rates, or rates of violent acts. [7]

- A 2013 randomized control trial study published in The Lancet found "no difference in the proportion of patients readmitted to hospital between study groups, nor in the time to readmission over a 1-year follow-up. The overall duration of hospital care did not decrease nor did clinical or social functioning improve despite an average of 6 months additional compulsion. These findings confirm previous evidence that CTOs [Community Treatment Orders] do not confer benefits on patients with a diagnosis of psychosis"[8]

- 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."[9]

Inherent Harm & Race-Based Disparities

Involuntary commitment is rejected by leading health policy organizations including Mental Health America, Bazelon Center for Mental Health Law, and the World Health Organization.[10,11,12] Research has shown that forced treatment can negatively impact individuals' future experience with behavioral health care, including voluntarily sought services, and can result in a loss of social support and "increased stigma stress [that has] a long-term negative effect on recovery."[13,14]

Non-engagement or refusal of treatment is a rational response for many people living with serious mental illness who have experienced inaccessible, inconsistent, ineffective, coercive, or harmful treatment from our fragmented healthcare system, such as:

- Previous experiences with the mental health system that have been alienating, traumatic, or led to broken trust, such as being subject to Emergency Petition, involuntary evaluation or hospitalization, seclusion, restraint, or forced medication. Inpatient units, which can

[7] Steadman HJ, Gounis K, Dennis D, Hopper K, Roche B, Swartz M, Robbins PC. (2001). Assessing the New York City involuntary outpatient commitment pilot program. Psychiatry Serv. ;52(3):330-6. doi: 10.1176/appi.ps.52.3.330.
[8] Burns, T., Rugkåsa, et al (2013). Community treatment orders for patients with psychosis (octet): A randomised controlled trial. The Lancet. https://doi.org/10.1016/s0140-6736(13)60107-5
[9] 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
[10] Mental Health America. Position Statement 22: Involuntary Mental Health Treatment. https://www.mhanational.org/issues/position-statement-22-involuntary-mental-health-treatment
[11] Bazelon Center for Mental Health Law. Forced Treatment. https://www.bazelon.org/our-work/mental-health-systems/forced-treatment/
[12] 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
[13] 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
[14] 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

have highly regimented protocols that violate personal integrity (e.g. being stripped, searched, restrained, watched, coerced to take medications, etc.) can be actively (re)traumatizing, particularly for survivors of assault or abuse.

- Clinical treatment that has been ineffective or harmful, such as intense negative side effects from prescribed medications, not being believed when reporting positive or negative experiences, and clinicians being unequipped to support complex trauma, co-occurring substance use, somatic conditions, other disabilities (cognitive, developmental, or physical), or specific demographic, cultural, or language needs.

- Lack of available or accessible treatment due to long waitlists, limited program operating hours, narrow eligibility criteria, maximum length of stay limits, and logistical barriers such as housing instability, food insecurity, lack of transportation, lack of social support, and financial cost of care with limited or no insurance.

To illustrate the intensity and negative impact of forced treatment experiences, we offer these personal examples from peers engaged with our statewide network:

"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 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. 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. I have a pre-existing thyroid condition and my psychiatrist had never prescribed Lithium 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."

Unfortunately, these types of experiences are not rare for Marylanders who who experience self-harm or thoughts of suicide, or who disagree with and refuse treatment. Many individuals living with serious mental illness who would be targeted for an AOT program will have had repeated exposure to this type of treatment by outpatient clinicians, crisis services providers, emergency and hospital staff, and law enforcement officers. As a 2021 *SMI Adviser* report, published by SAMHSA and the American Psychiatric Association, explains: "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."[15]

Race-Based Disparities in Involuntary Treatment: Across the country, there is a startling lack of available and transparent data or consistent evaluation regarding use of involuntary interventions (inpatient and outpatient) and results in general or analyzed with a racial equity lens. However, recent research continues to confirm that higher rates of involuntary hospitalization and use of restraints are used against people of color:

- **Use of Restraints During Emergency Psychiatric Evaluation (2021):** This study examined emergency psychiatric evaluations performed between 2014-2020 at a large academic medical center in Durham, NC. Findings showed "Black patients undergoing psychiatric evaluation were at higher odds of experiencing physical or chemical restraint compared with White patients, which is consistent with the growing body of evidence revealing racial disparities in psychiatric care."[16]

- **Involuntary Hospitalization (2022):** This study analyzed data collected over a 6-year period on all admissions to a general inpatient psychiatric unit in a large general hospital in Boston. Findings showed "patients of color were significantly more likely than White patients to be subjected to involuntary psychiatric hospitalization, and Black patients and patients who identified as other race or multiracial were particularly vulnerable."[17]

- **Use of Restraints During Hospitalization (2023):** A sample study of medical records of youth and adult inpatient psychiatric hospitalization (2012-2019) found that Black patients were 85% more likely to be physically restrained or force medicated than White patients, and often for longer periods.[18]

[15]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.
[16] Smith CM et al. (2021) Association of Black Race With Physical and Chemical Restraint Use Among Patients Undergoing Emergency Psychiatric Evaluation. Psychiatric Services. 73(7), 730-736. doi: 10.1176/appi.ps.202100474
[17]Shea T et al. (2022). Racial and Ethnic Inequities in Inpatient Psychiatric Civil Commitment.. Psychiatric Services. 73(12), 1322-1329. doi: 10.1176/appi.ps.202100342
[18] Singal S et al. (2023). Race-Based Disparities in the Frequency and Duration of Restraint Use in a Psychiatric Inpatient Setting. Psychiatric Services. https://doi.org/10.1176/appi.ps.20230057

Broad Eligibility Criteria

People living with serious mental illness already face high levels of stigma that result in a perceived lack of credibility.[19] 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.

We have serious concerns about SB 453's proposed eligibility criteria, particularly:

- **Definition of "Harm to the Individual:"** The bill proposes four aspects of harm, each of which are overly broad and lack clarity:
    - *Self–harming behavior or an attempt at suicide:* Many individuals engage in self-harming behaviors as a means of coping. Numerous research studies have shown that receiving involuntary inpatient treatment following an act of deliberate self-harm significantly increases the risk for repeated self-harm and suicide.[20]
    - *Failure to protect oneself from danger:* This is not sufficiently defined.
    - *Inability to meet one's basic needs:* This does not address socioeconomic barriers and social/healthcare services network inadequacy which prevent, delay, or complicate basic needs being met.
    - *Failure to obtain medically necessary treatment to prevent serious physical or psychiatric deterioration:* This is open to interpretation and biased prediction.

- **3 Year Lookback Period:** Any incidents of voluntary hospital use, "threat" or enacted self-harm, suicide attempt, disagreement with a treatment plan or refusal of treatment within a three year period becomes evidence for forced treatment. This discourages individuals from voluntarily seeking help for fear of it being used against them.

- **Insufficient Medical Health Status and Capacity Assessment:** There is no requirement for formal 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."[21]

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[19] 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

[20] Olfson M, Wang S, Blanco C. National trends in hospital-treated self-harm events among middle-aged adults. Gen Hosp Psychiatry. 2015;37:613–619

[21] 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

- **No Assessment of Available Less Restrictive Alternative:** There is no requirement for a comprehensive evaluation of all current or available support services that could meet the individual's needs, without which an accurate assessment of whether AOT is truly the "least restrictive alternative" cannot be made.

- **Sole Evaluators Are Vulnerable to Bias:** Sole evaluators are undeniably vulnerable to bias, whether explicit or unintentional, and Maryland's current Involuntary Admission certificate requires agreement between two evaluators, one of whom must be a physician. This bill seems to propose much lower standards for civil commitment:

    - Only one clinician (treating psychiatrist) is required to participate in the initial evaluation to determine AOT eligibility. This is inconsistent with the current regulations on involuntary admission (IVA) (COMAR 10.21.01.04), which requires evaluation by two clinicians, including at least one physician.

    - A completely different clinician (psychiatrist) may lead the treatment plan design without having actually met the individual.

    - An emergency psychiatric evaluation may be conducted by a physician OR by a nurse practitioner. It is unclear how this interfaces with current IVA regulations (COMAR 10.21.01.04), which require agreement between two clinicians, including at least one physician.

Implementation Expectations

We ask the committee to carefully consider the underlying assumptions that are being made about how implementation of an AOT program will take place within the reality of our overstrained, understaffed, and resource-limited behavioral health and judicial systems.

- **Statewide Implementation:** The bill requires all jurisdictions in Maryland to establish an AOT program without clear assessment and minimum requirements for local capacity and service network adequacy. The *Fiscal and Policy Note* accompanying SB 453 also describes some lack of clarity regarding the role and resourcing of the Local Behavioral Health Authority in oversight or operation of the proposed AOT program.

- **Lack of Training:** In 2021, the Maryland Behavioral Health Administration's *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," and recommended both "comprehensive training around the dangerousness standard" and collection of "additional data elements about civil

commitment."[22] The addition of an outpatient civil commitment program with significantly different criteria is likely to increase confusion and potential misuse.

- **Unclear Controls for Treatment Plan Changes:** The bill appears to allow for changes to the treatment plan which may ordinarily require a hearing to be implemented "as circumstances may immediately require" at the sole discretion of the treating psychiatrist. This may create substantial confusion and lack of transparency.

- **Exclusion of MH Advance Directive and Guardians/Healthcare Agents:** *(We understand this item is to be amended and look forward to reviewing proposed new language.)* There is no requirement for the individual, their guardian, or their health care agent to be involved in any treatment plan decisions, including medication. Only "a reasonable opportunity to participate" must be offered, and the timeline between petition and hearing is undefined. A Mental Health Advance Directive (MHAD) may be disregarded at the discretion of the care coordination team, who are only required to "consider" its provisions.

- **Volume of Petitions:** Included in the 2021 BHA report referenced above were statistics from the Maryland Office of the Public Defender showing nearly 10,000 Involuntary Admission (IVA) cases referred to their office in 2020. Notably, this figure does include many more individuals for whom an Emergency Petition was filed but who were found not to meet IVA criteria upon evaluation.

- **Expected Enrollment Rate:** As potential comparison, a retrospective evaluation of New York's AOT program performed in 2005 shows that over 10,000 individuals were referred to local AOT coordinators for investigation of eligibility in the first five years of implementation (1999 - 2004). Of these, only 37% of these individuals were ultimately issued a court order to undergo AOT; the majority of individuals referred did not meet the criteria.[23] The time, effort, and funding required for these investigations could have been invested toward further developing comprehensive services and supports that would better engage and serve the community. Notably, New York has recently expanded its INSET program, which was specifically created as an alternative to AOT. *See **Better Alternatives Exist** below.*

[22] Behavioral Health Administration (2021). Involuntary Stakeholder's Workgroup Report.
[23] Pataki G.E., Carpinello, Sharon E. (2005). Kendra's Law: Final Report on the Status of Assisted Outpatient Treatment. New York State Office of Mental Health. https://mentalillnesspolicy.org/wp-content/uploads/kendras-law-study-2005.pdf

Lack of Consideration for Non-Clinical Needs

While SB 453 lists case management as a required service in an AOT treatment plan, it is unclear how or if the bill intends to create access to critical non-clinical services which are the foundation of sustained engagement in services. Many individuals who are likely to be targeted for AOT may be experiencing multiple barriers to accessing effective treatment, such as:

- **Basic Needs:** housing instability, food insecurity, lack of transportation, limited social support, limited income, uninsured or underinsured for behavioral healthcare services
- **Cultural and Language:** member of a historically marginalized community experiencing discrimination, stigma, and/or health inequities; need for culturally specific care (ex: immigrant, asylee, or refugee) or language services.
- **Disability:** experiencing a perceived or active disability which entitles the individual to reasonable accommodations under federal law, including but not limited to: mental health disorders, diabetes, HIV, autism, Deafness or hearing loss, blindness or low vision, mobility disabilities, intellectual disabilities, and traumatic brain injury.[24]

Better Alternatives Exist

Recovery is possible for persons who live with Serious Mental Illness, even if clinical symptoms continue to be experienced. Numerous research studies have found that engaging individuals with serious mental health conditions requires the following core components: "therapeutic alliance between staff and clients, persistence and consistency, the provision of practical assistance and support rather than a sole focus on medications, the team decision making process, acceptance of clients as they are, and flexibility."

SAMHSA recognizes the four major dimensions that support recovery are health, home, purpose, and community,[25] and a 2018 cross-sectional survey on recovery and remission from Serious Mental Illness found that "contrary to traditional beliefs about a consistently deteriorating negative outlook… . High levels of quality of life and community participation (e.g., work, school, parenting, leisure and recreation) occur even when impairments are present."[26]

We are glad to highlight several choice-based, trauma-informed, and recovery-oriented models actively in use across the country which we believe are better viable alternatives to AOT.

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[24] US Department of Justice, Civil Rights Division. Introduction to the Americans with Disabilities Act. https://www.ada.gov/topics/intro-to-ada/

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

[26] 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

Peer Support and Recovery Support

A 2014 study published in the journal *World Psychiatry* identifies 10 empirically-validated interventions that support recovery, including: peer support workers, advance directives, wellness recovery action planning, illness management and recovery, strengths model, recovery education programs, individual placement and support, supported housing, and mental health trialogues.[27]

A number of these are already actively used in Maryland, including through OOOMD's statewide network of peer-operated Wellness & Recovery Organizations. Peer support and recovery support programs are high quality, low-barrier, open access, and cost-effective options which can be delivered independently or in partnership with clinical services, and can be shaped to meet the specific needs of a local community or target population. Unfortunately, many of these community-based support programs are not yet sufficiently resourced and so limited in capacity for outreach, engagement, and service delivery.

Intensive & Sustained Intensive Engagement (INSET) Model

Launched in New York in 2018, this program model is an entirely voluntary, peer-led, trauma-informed approach that specifically engages with individuals who meet criteria for AOT. Multi-disciplinary teams provide mobile support by meeting individuals and providing consistent wraparound support to meet basic needs, access resources, establish recovery goals, and connect with additional services or treatment. Based on its success, the New York State Office of Mental Health made additional funding available in 2023 to expand the model over 5 years.

Peer Respite Model

Peer respites are voluntary, short-term, non-clinical crisis residential programs where individuals at risk of psychiatric hospitalization can receive 24/7 peer support in a home-like setting. Peer respites currently operate in 15 states across the US, and adoption of the model continues to expand. Peer respites have been effective in reducing Medicaid expenditures, reducing hospitalizations, improving mental health symptoms, and improving quality of life when compared to inpatient hospitalization.[28,29,30] While Maryland does not currently have any peer respite programs, a recent feasibility study commissioned by Behavioral Health Systems Baltimore found strong interest and supportive conditions for launching this type of program in Central Maryland.

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[27] 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.

[28] Pelot, M., & Ostrow, L. (2021). Characteristics of peer respites in the United States: Expanding the continuum of care for psychiatric crisis. Psychiatric Rehabilitation Journal;

[29] Peer Respites as an Alternative to Hospitalization. Legislative Analysis and Public Policy Association. (2021).

[30] Bouchery, E.E., Barna, M., Babalola, E. (2018). The effectiveness of a peer-staffed crisis respite program as an alternative to hospitalization. Psychiatric Services.

Mental Health Self-Directed Care (SDC) Services

This person-centered approach provides individualized support and financial resources for individuals living with serious mental health conditions to foster resilience, stability, and autonomy. Participants create a partnership with a support broker who assists them with the development and implementation of a self-directed recovery plan. The support broker also assists with facilitating access to services and financial resources to help meet the participant's unique mental health, social, and somatic needs. Not only does this model emphasize choice, but it also instills a sense of personal responsibility for one's recovery.

Self-Directed Care Services currently exist in Maryland, but only individuals with developmental disabilities are able to access this program model. People who live with a sole diagnosis of a mental illness are explicitly excluded. Mental Health SDC has successfully been implemented in 6 states, and the evidence for this approach is strong. When compared to those who received services as usual, those who received Mental Health SDC services experienced significantly better clinical outcomes, ability to maintain employment, increased self-esteem and confidence related to their ability to manage challenges related to their mental health, and improved satisfaction.[31,32]

Conclusion

There is a dire need to increase access and decrease barriers to services for Marylanders living with behavioral health challenges. Unfortunately, SB 453 will not create more appropriate and accessible services, but would instead entangle individuals living with disabilities and complex challenges into a complicated legal process that dismisses and silences their voice and choice.

Forced treatment is inherently harmful, and should only ever be used as the very last resort in situations with clear and present risk to life and safety. 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 453. Thank you.

[31] Cook JA et al (2019). Mental Health Self-Directed Care Financing: Efficacy in Improving Outcomes and Controlling Costs for Adults With Serious Mental Illness. Psychiatr Serv; 70(3):191-201. doi: 10.1176/appi.ps.201800337. Epub 2019 Jan 11. PMID: 30630401.

[32] Smith GP & Williams TM (2016). From providing a service to being of service: advances in person-centered care in mental health. *Curr Opin Psychiatry* (5):292-7. doi: 10.1097/YCO.0000000000000264. PMID: 27427855.

SB0453_KM Testimony_OPPOSE.pdf
Uploaded by: Kelsey McClain
Position: UNF

February 19, 2024

Pamela Beidle, Chair
Finance Committee
3 East
Miller Senate Office Building
Annapolis, Maryland 21401

Re: **SB453– Mental Health - Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment Programs – OPPOSE**

Dear Chairman Beidle and Members of the Committee:

My name is Kelsey McClain and I am a person with lived experience of being subjected to forced psychiatric care and involuntary hospitalization. I am writing this testimony to strongly **OPPOSE SB453– Mental Health - Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment Programs**. Implementation of assisted outpatient treatment (AOT) programs would rob people of autonomy, inhibit their ability to be advocates in their own recovery, and could potentially be used inappropriately within a system of care that often ignores the voices of people being treated for psychiatric illnesses. I would like to illustrate the seriousness of subjecting a person to forced psychiatric care by sharing my own story of involuntary inpatient hospitalization.

I have been a resident of Baltimore since 2018 when I moved here to earn my master's degree in public health from Johns Hopkins University. Since graduating I have worked in Maryland as a public health professional in positions that have focused on public health policy and program development. I have depression and anxiety. I also struggle with non-suicidal self-injury, which in my case means I cut myself. My self-injurious behavior has never been an act of suicide and has never had suicidal intent behind it. Often people who self-injure do not do it as a suicidal act.[1] For me, it is a way I have understood and coped with difficult thoughts and emotions.

In April 2023, I was involuntarily hospitalized because of self-harm. I had cut my arm deeper than intended and needed stitches. Needing stitches is not a frequent occurrence for me, but it does happen occasionally. Since it was late evening, I knew urgent care clinics were closed and I would need to go to the emergency room. Even though I only needed stitches, the fact that the injury was self-inflicted would mean I would be categorized as a psychiatric patient, which would impact how my treatment was handled. When I arrived in the emergency room, I was not in a mental health crisis and was experiencing **no** suicidal ideation.

When a psychiatric patient comes into the ER, the first thing that happens is they are asked to get undressed. Emergency room staff take their clothing and belongings, including shoes, wallet, and phone. Patients do not have access to any of these items until they are discharged and cannot choose to leave

[1] S1 E1. Dr. Nicholas Westers, host, "Why do People Self-Injure?" The Psychology of Self-Injury (podcast), January 1, 2021, accessed December 3, 2023, https://the-psychology-of-self-injury.simplecast.com/episodes/why-do-people-self-injure

the hospital before then. By simply showing up, psychiatric patients are often put into a position where they are both vulnerable and powerless.

The doctor who stitched up my arm showed obvious discomfort with my self-harm wound, mentioning this was the first time he had seen a self-inflicted cut that required stitches. At the time, I was unaware of how he would later document our interaction in my medical record. Even though I was not feeling suicidal, and never reported any suicidal ideation to hospital staff, in my chart the physician wrote: "Patient states she was trying to cut herself and also was having suicidal thoughts and trying to harm herself."

As a patient, I have seen providers sometimes show discomfort around the topic of suicide. They are nervous to mention the exact word "suicide" and therefore often use euphemisms when asking about it. This can be a problem because it makes communication between provider and patient unclear, and because the euphemisms are generally the same words you might use to discuss self-harm. Physicians and medical staff will sometimes ask, "were you trying to harm yourself?" when what they are actually asking is, "were you suicidal?" More than once I have had to carefully navigate situations where providers showed a lack of proper training and awareness about how to have conversations about suicide and self-harm. My case is an example of how a breakdown in communication around those topics can have enormous negative consequences for a patient.

I was kept in the ER overnight and received a behavioral health assessment from the ER social worker the following morning. I told her, truthfully, that I did not think I would benefit from an inpatient stay, I was not suicidal, and I was already well connected to outpatient care. In my chart, the social worker recorded our conversation by describing me as "guarded" and "manipulative" and claiming I showed no insight into my behavior. At no point did she discuss the possibility of an involuntary stay or explain the differences between voluntary and involuntary admission.

After completing the assessment, the social worker left my room. With growing anxiety, I waited the rest of the day without receiving any further information. When I finally asked one of the nurses for an update, they responded: "Oh, they already decided to admit you. I'm arranging transport for you right now." That was how I found out I was being involuntarily hospitalized.

A second provider would have needed to sign the paperwork certifying my need for an involuntary admission. That provider signed the paperwork without ever speaking to me. Nobody from the ER tried to consult with my outpatient providers. I arrived at the inpatient unit with no idea how long I was going to be kept there and no control over anything that was happening.

Hospital staff on the unit told me I would eventually realize this hospitalization was for my own good. Sure, I was upset now, but over time I would see I needed this treatment. It was assumed I believed I didn't need to be there because I was incapable of insight into my own state of mind. I simply didn't know any better. Once it is decided you lack insight into your illness and behavior, any time you disagree with your treatment providers or try to advocate for yourself it can be interpreted as evidence to support this conclusion. My voice, my knowledge of my illness, and my experience with outpatient treatment that had been helping me get better were all ignored or disbelieved.

I was kept in the hospital for a week. During this time, I was employed as a contract employee. I lost my income for the entire week. Additionally, forced care resulted in an increase in my depression and anxiety symptoms which made it more difficult to complete my normal working hours and my income was negatively impacted for months afterwards. I also walked away with a $7,000 hospital bill that I am still

trying to pay. I still struggle to feel safe in healthcare settings and attending appointments can create extreme anxiety. When I interact with new mental healthcare providers, I feel afraid the conversation could end with me being sent back into involuntary care. If AOT programs were to be implemented, this fear would increase. I have become very aware that simply meeting with a provider can result in the loss of my freedom and autonomy. It is unlikely I would go to an emergency room now, even if I needed help. I still regularly struggle with anxiety and anger as a result of my admission and have had to increase my level of outpatient care because of it, a process that was made even more difficult given my increased distrust of providers.

My story shows many aspects of involuntary care that can go wrong. Short-staffed behavioral health units where patients aren't given the care and attention they need, stigma that exists around certain behaviors and diagnoses, and providers who do not have proper training on how to speak to patients about mental illness are all examples. Loss of income and decreased feelings of safety around accessing care are common results. Psychological harm and traumatization of patients are essentially inevitable. Involuntary care is a decision that should be approached with respect for the terrible impacts you are almost certainly creating for a patient. It should be arrived at with care, attention, and empathy, all things our current healthcare system does not often support or encourage. If AOT programs were to be implemented, they would create an environment where the decision to subject someone to forced care is easier, more casual, and more common.

Robbing a person of their autonomy and control is an extremely serious act to commit against another human being. We need to be careful about under what circumstances and in what situations we decide that is an acceptable thing to do. I believe that if we see it occurring in cases where we do not think it is ethically sound, we have a responsibility to speak up. I am hopeful that by sharing my story, I can help those who are shaping our policies understand the gravity of decisions they make around what we in the State of Maryland say is an acceptable way to treat people with mental illness.

I urge you to **OPPOSE** SB453– Mental Health - Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment Programs.

Sincerely,

Kelsey McClain

Brenninkmeyer_SB453_Oppose.pdf
Uploaded by: Kimberly Brenninkmeyer
Position: UNF

Kimberly A. Brenninkmeyer, Ph.D.
1414 Key Highway, Suite 300P
Baltimore, Maryland 21230
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February 20, 2024

The Honorable Pamela G. Beidle, Chair
Senate Finance Committee
Miller Senate Office Building
11 Bladen St.
Annapolis, Maryland 21401

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

Dear Madame Chair and Members of the Senate Finance Committee:

I am submitting this testimony in strong opposition to SB 453, which would authorize the creation and implementation of Assisted Outpatient Treatment (AOT) across the state, putting many of my clients at risk of being subject to forced treatment by family members or other clinicians who don't take the time to consider the valid concerns many may have about various mental health treatments. As a licensed psychologist with over 20 years of experience treating the very individuals AOT is targeting, I am extremely concerned that such a bill is even under consideration.

AOT is merely a form of legally compelled treatment. Forced and/or coerced treatment is rarely beneficial and has caused the most harm to my clients of all the traumas they have experienced in their lifetime. It has harmed them psychologically, in that they are left completely demoralized, humiliated, and full of shame, it has increased suicidal ideation and attempts during and following coerced and forced treatment, and has led to significant mistrust and reluctance to engage with any mental health treatment. As mental health professionals, our most sacred ethical obligation to any potential client is to do no harm. Forced and coerced treatment such as AOT causes significant harm that far outweighs any potential benefit.

We are also obligated to treat every potential client with respect, dignity, autonomy, and to include them in treatment with their fully informed consent. In my experience treating adolescents in residential settings, adults in inpatient facilities, and adults in outpatient settings and private practice, individuals are at the most desperate when they believe there are no other options and resources to help them, and that is precisely how this bill frames severe mental illness. Forcing individuals with severe mental illness into treatment is not a viable option; it is a threat. And when under threat, we are all going to respond accordingly, by fighting or resisting,

fleeing or avoiding, or by freezing and shutting down. This is not conducive to anyone benefitting from mental health treatment.

The criteria used to identify those whom the AOT program proposed in SB 453 is meant to 'help' is incredibly pathologizing (one incident of harm or threat of harm to self or other, and/or 2 inpatient stays in the past 3 years) and victim blaming (failure to protect oneself from danger). First, this criteria is incredibly broad and would likely encompass a significant number of people in ongoing mental health treatment, making it susceptible to misuse by perpetrators of interpersonal or family violence. These criteria also punish people for struggling, especially those with complex needs who are not adequately served by existing resources made available in our public mental health system. Furthermore, the use of the phrasing 'lacking insight or awareness' is also being used out of context[1] and is a dehumanizing way of justifying forced treatment for anyone that declines treatment or disagrees with treatment recommendations. Court ordering individuals into treatment is also a set up for mental health treatment to be adversarial and gives power to the provider over the client. This is especially concerning in light of overwhelming evidence that the strength of the therapeutic relationship is the most influential outcome in determining the likelihood of treatment success.

How can anyone be open and receptive to help under the conditions identified in SB 453? Aren't we just swapping out mental health provider for parole officer? Is AOT the new prison minus the locked door? AOT is effectively criminalizing the struggles of individuals in their most vulnerable states when what they most need is compassion, understanding and to be included in conversation about what they need.

Mental illness is a disability just like any other and warrants the same approach we give to any other disability. People with mental illness deserve to be treated with the same respect, dignity, and given the same autonomy and inclusion in treatment decisions as any other type of disability and illness. Is Maryland claiming to be a safe state for individuals seeking abortions and gender affirming care but not a safe state for THOSE people, the mentally ill ones who by the language of this bill seem to be presumed to be other, rather than members of our communities? And who do you really think AOT is targeting? It's the most marginalized and vulnerable groups-Black and Brown people, transgender and gender non-conforming people, and disabled people. The same people who are already targeted in other systems for mistreatment, abuse and misunderstanding. THOSE people, who are members of our communities, deserve access to choice-based mental health supports, and to be included in decisions about what care they need and receive, and with whom they receive it.

If we put financial and systemic resources into mental health programming that values self-determination, informed consent, cultural competence, and trauma-informed care, we are much

[1] Anosognosia is a concept that arises out of stroke research to mean a "profound lack of awareness of an obvious deficit." There is little to no evidence to suggest the same phenomenon is at play in serious and persistent mental illness, as there are case group differences on neuroimaging in studies of anosognosia in mental illness. However, unlike the stroke research there is no consistent brain damage between these studies that leads to a discernable neuroimaging finding that can be translated to making a diagnosis of anosognosia with any certainty. Sandra Steingard, MD, (2019) Critical Psychiatry: Controversies and Clinical Implications.

more likely to sustainably engage people in mental health treatment long term. And that is the approach our ethical obligations require. Therefore, I respectfully request you to issue an unfavorable report on SB 453.

If you have any questions, please don't hesitate to contact me at (443) 377-6440 or KimberlyBrenninkmeyerPhD@gmail.com.

Sincerely,

Kimberly Brenninkmeyer, Ph.D.

OpposeSB453.pdf
Uploaded by: Laura Ziegler
Position: UNF

Joint Testimony in Opposition to SB 453 — Disapprove

"We all have our lists of casualties"
Judy Grahn, *A Woman is Talking to Death*

After reading testimony submitted to the House Health and Government Operations Committee in support of the companion to this bill, e.g.:

"Medications can allow people to be their true selves, and even more importantly it can allow people to live the lives they want to live and avoid the horrific repercussions of untreated mental illness."
"It will restore their competency, and their independence."
"It was not from innate stubbornness, but one of the most diabolical symptoms of the brain disorder. Some can be persuaded, and enough trust established to participate in treatment, but others would not accept treatment if it came with a cash prize and was provided at a 5-star resort… The sad irony is that we have treatments that work."

I feel compelled to submit my own, and to endorse that of Disability Rights Maryland. Without dismissing the experience — or suffering — behind the testimonies, I believe they present only a partial truth, and that what the bills offer is a false and destructive solution. I know I and others have sustained irreparable physical and psychological harm from forced psychiatric intervention.
Background: I've worked as a paralegal at a law clinic that served as a regional Protection and Advocacy office. As a minor I was detained in a psychiatric facility, given major psychiatric diagnoses (paranoid schizophrenia and manic depression) and forcibly drugged with neuroleptics until a court enjoined it and denied the hospital's petition for retention. Later I was active in Project Release, one of the earliest mutual support and advocacy organizations run for and by people with "lived experience" of the mental health system.
I moved from New York over 30 years ago and Project Release is long defunct, but I've maintained contact with some of the people I met through it. It's given me a long perspective on the impact of psychiatric intervention — including community commitment orders — on their lives. So when I read proponents' arguments, especially the many speculations about how compelled community treatment would have saved or salvaged particular lives, I think of them.
One has been under an "Assisted Outpatient Treatment" [AOT] order for years. It's required her to take psychiatric drugs. When I've been in NYC I've visited her in an assortment of locked hospital units — because drugging has not prevented her severe episodes from recurring, or kept her from being repeatedly, involuntarily hospitalized. She lives in what's technically the community — in actuality, a unit in a high rise building at one of the state hospitals in NYC. Chronic administration of neuroleptics gave her tardive dyskinesia (and obesity, and cardiac issues) so it's difficult for her to walk, and she's further isolated from the community by the layers of security protocols just to get in or out of the building. Before years of institutionalization and drugs she had an executive level job in the health care system, was athletic, hadn't lost most of her hair and teeth. I remember her criticism of the mental health system, describing her encounters with hospitals as "incarceration and brutalization." Lately she seems to have

given up on regaining a life outside the institution.
Another was on an AOT for years and technically living in the "community" — a congregate residence on the grounds of another state hospital in NYC. Thanks to her extended commitment to the state hospital she'd lost her subsidized apartment; another possible placement at a shared apartment with a supportive acquaintance was vetoed by the treatment team over concerns about overseeing her compelled drug regimen. She refused placement in an SRO. She recently suicided in her room at the residence. The day before she left me a voicemail saying "I'm in a modern day snake pit… it's the most horrible place on earth."
The primary focus of these AOT orders appeared to be containment and control. They did not prevent hospitalizations, trauma, homelessness or suicide. They were not remotely person-centered or supportive and they did not provide a less restrictive alternative. If anything, they **foreclosed** alternatives outside of congregate facilities and maintenance drugging. Nor was competency a basis for discontinuing an order. They were, in effect, open ended, despite the option of challenging them.
Another women who occasionally attended Project Release meetings was chronically homeless, with a long history of testing — and failing — people's limits of tolerance. She'd experienced involuntary hospitalizations and electroconvulsive shock treatment [ECT] and was highly critical of the mental health system. She got locked up in a psychiatric unit in a Manhattan hospital, where she died in surgery for fecal impaction — an adverse effect of the psychiatric drugs that were being forced on her.
Refusal can, and often is, based on knowledge and direct experience. The blanket characterizations of refusal as a symptom is inaccurate, profoundly discriminatory and offensive. It also begs the question of the dubious track record of many psychiatric treatments and the inadequate or indifferent response to adverse effects.
Testimony in support of the companion bill has repeatedly emphasized that AOT orders will only be applied to a small number of people. But the impact of this "tool" would be far wider than those directly subject to orders. The vague, attenuated and predictive nature of required dangerousness and the relative ease of targeting a person make it a possibility — or threat — to anyone with a significant psychiatric history.
Concerning advance directives, which would merely be considered rather than control: a 1998 Vermont enactment limited advance directives of people who were civilly committed to forty-five days after which they could be set aside. It was challenged, and the Second Circuit affirmed the District Court's finding that the provision violated the ADA and Section 504 of the Rehabilitation Act. See Hargrave v Vermont, 340 F.3d 27 (2d Cir. 2003) [https://casetext.com/case/hargrave-v-vermont].
Concerning electroconvulsive shock treatment [ECT], the bills are silent. Forced outpatient maintenance electroshock has been a practice elsewhere. There are apparently no protections or further due process to prevent this highly intrusive intervention from occurring under an AOT order. I hope this was an omission and that the committee will expressly exclude this modality.
Thank you for considering my testimony. Please see the accompanying/joint testimony of Judith Shalitt, below.

Laura Ziegler, POB 164, Plainfield VT 05667

Joint Testimony in Opposition to SB 453 — Disapprove

I am 85 years old and 25 years ago I was one of the early peer workers in New York State. As a participant in Project Release I advocated—and I continue to advocate—against any kind of forced treatment. I know the people described in Ms Ziegler's testimony, which is accurate, and I add my name to her testimony.

I myself have irreversible tardive dyskinesia, first detected by my dentist, from taking a prescribed antipsychotic drug for over 15 years. Neither the prescribing doctor nor the psychologist counseled me about the difficult, painful process of tapering off, which I did on my own over a period of two years, and I have taken no psych drugs for over 40 years, although doctors had told me I would have to take them for the rest of my life.

I have observed among friends, former clients and family members that long-term use of psychiatric drugs often leads to early diabetes, heart, lung, kidney, or digestive diseases, obesity, as well as dangerous, painful, and/or disfiguring neurological problems, and the warnings on these very medicines bear this out. No one should be forced to take these medicines against their will.

IS THERE A BETTER WAY? Look at what Promise Resource Network in North Carolina has accomplished with fully voluntary services. (promiseresourcenetwork.org) Promise Resource Network has created a community of peers who now provide a 24/7 warm line, a respite residence without locked doors, classes, support groups, including harm reduction groups, and continuing peer worker training. The decision on whether to take psych medicine, which, and for how long is left to the individual, based on their own experience.

Build a better mental health system and you won't have to force people to use it.

Judith Shalitt, 1122A Argyle Circle Lakewood NJ 08701

TENNEY CV 01302024.pdf
Uploaded by: Lauren Tenney, PhD, MPhil, MPA, BPS
Position: UNF

Lauren J. Tenney, PhD, MPhil, MPA, BPS
516-319-4295 LaurenTenney@aol.com www.LaurenTenney.us

HIGHER EDUCATION

PhD, Psychology, Environmental (2014)
Graduate School and University Center, City University of New York, New York, New York
Cumulative GPA 3.85
Dissertation: (de)VOICED: Human Rights Now. An Environmental Community-Based Participatory Action Research Project.

Master of Philosophy, Psychology (2010)
Graduate School and University Center, City University of New York, New York, New York
Second Doctoral Examination: Passed with Distinction (March 2009)
Topic One: "Mad Annals: Consistent Attempts at Reform and Abolition Throughout the History of Institutions"
Topic Two: "On the Road toward Liberation: Slavery, Oppression, Racism, and the Black Power Movement"

Master of Arts, Psychology (en route) (2008)
Graduate School and University Center, City University of New York, New York, New York
Fieldwork: "Can You Dig It?" A participatory action research project based on The Opal, an inmate edited Journal published at the Utica State Lunatic Asylum from 1850 through 1860 exploring the similarities and differences of the 19th Century Lunatics Liberation Movement and the modern-day Mental Patients Liberation Movement.

Master of Public Administration (2003)
Metropolitan College of New York, New York, New York
Thesis: The Choice thru Voice Project. A participatory action project edited by the Statewide Youth Advisory Council to the New York State Office of Mental Health. The evolution of the Prime Directive Initiative (based on the Prime Directive Journal, Draft Copy written by Laura Cisco and Lauren J. Tenney (1999 – 2000). The Prime Directive Initiative is a recognized strategy to eliminate restraint and seclusion in the U.S Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services (2005) Roadmap to Seclusion and Restraint Free Mental Health Services.

Bachelor in the Professional Studies of Human Services (1998)
Audrey Cohen College, The College for Human Services, New York, New York

BOARDS & COMMITTEES

Academic Advisory Board Member
(2022 – 2023)
The Lancet Psychiatry Commission on Psychoses in Global Context
Academic Advisory Board

Advisory Council Member
2020 – 2023
Protection and Advocacy for Individuals with Mental Illness Advisory Council Disability Rights Florida

Committee Member
(2018 – 2023)
Mental Health Subcommittee
National Council on Independent Living

Vice-President, Board of Directors
(2020 - September 01, 2021)
Picture Social Justice, Inc.

Facebook Administrator, General Support
(2016 – 2023)
Surviving Race: The Intersection of Injustice, Disability, and Human Rights

CERTIFICATION

CITI Certification, Social-Behavioral-Educational Research – Refresher Course
November 14, 2022 – November 14, 2023
Record ID: **52737048**

SKILLS

Work Style

Conscientious. Reliable. Flexible. Eager. Approachable. Open. Responsive. Creative. Agile. Interpersonal. Curious. Collaborative. Empathetic. Self-Direction, Team Player. Organized. Person-first, person-centered, multicultural approach.

Overarching Skills:
Advocate, Activist, Community Organizer, Facilitator, Trainer, Mediator, Motivational Speaker, Change Agent, Community Liaison, Public Speaker, Social Media Management, Public Affairs, Public Relations, College Professor, Grant Writer, and Fundraiser.

Basic Skills
Microsoft Office Suite, Google Suite, Adobe Suite, Video Production (shoot, edit, distribution). Podcast Production (record, edit, distribution). Written and Oral Communication. Classroom Management. Website Design and Development. Transcription. Interview. Branding. SEO. Information Architecture.

Research Skills:
Institutional Review Board Applications. Organizational Needs Assessments. Mixed Methods Research Design. Focus Groups. Interview. Participant Observation. Naturalistic Observation. Behavior Mapping. Mental Mapping. Life-Space Mapping. Archival and Historical Research. Biography. Environmental Inventory. Environmental Autobiographies and Workographies. Qualitative Analysis. Atmosphere Assessment, Literature Review. Video Research. Academic Writing. Participatory Action Research. Instructional Design. SPSS. GIS. Tableau. Qualtrics. APA Style 7.

UX Research:
Participatory Design. Field Study. Interviews. Focus Groups. Surveys. Card Sorting. A/B Tests. Daily Diaries. Journey Maps. Heat Maps. Usability Testing. Empathetic Iterative Development.

UX Design:
Critical Thinking. Analysis. Synthesis. Evaluation. Behavior Analysis. Pain Point Identification. Information Architecture. User Flow. Flow Charts. Mental Models.
Wireframes. Low-Fidelity Prototypes. Equitable Design.

UX Writing:
Persona Development, User Story Development, and Scenario Development. Storyboards

UX Program Management:
Pitching. Presentations. Conference and Meeting Logistics.

Administration Skills:
Project Time Management. Conference Coordination. Environmental Inventory. Force Field Analysis. Form and Application Development. Grant Writing. Graphic Design. Mission and Values Development. Participatory Planning Processes. Program Design. Program Evaluation.

TEACHING EXPERIENCE

Keiser University Fort Lauderdale Campus, Florida
Assistant Professor (May 2021 – October 20, 2023)
Delivered a range of on ground and remote undergraduate Psychology courses.
Advisor, student organization, Psychology Club
Academic Advising
Chair, Research Committee, Systemwide Psychology Research Committee.
Member, Retention Committee

Adjunct Professor (March 2020 – April 2021)
Keiser University Port Saint Lucie Campus, Florida
Delivered a range of on ground and remote undergraduate courses including:
Introduction to Psychology; Life Span Development; Writing and Careers in Psychology; Experimental Psychology; Counseling and Clinical Psychology; Psychology of Coaching and Team Building; and Psychology Internship II Coordinator.

Keiser University Fort Lauderdale Campus, Florida (November 2020 – April 2021)
Writing and Careers in Psychology; Life Span Development; Social Psychology, Human Exceptionality, and Psychology of Personality.

City University of New York, New York
College of Staten Island, Staten Island, New York
Adjunct Assistant Professor (2014 – Fall 2019)
Adjunct Lecturer (2009 – 2014)
Provost Fellow (2005 – 2009)
Undergraduate courses designed and delivered include:

Introduction to Psychology; Introduction to Psychology Super Jumbo Section; Research Methods and Ethics; Psychopathology; Theories of Personality; History and Systems of Psychology; History and Systems of Psychology Summer Intensive; Experimental Lab in Social Psychology; Developmental Psychology; Social Psychology; Cross-Cultural Psychology.

Montclair State University, New Jersey

Adjunct Professor Fall 2014 – Spring 2019
Undergraduate courses designed and delivered on ground and online include:
Developmental Psychology; Psychology of Women; History and Systems of Psychology (online); Children's Rights and Child Advocacy; Psychological Aspects of Human Sexuality (online).
Graduate course designed and delivered on ground: Developmental Psychology.

Field School housed at Columbia University, New York
Nathan Kline Institute Center to Study Recovery in Social Contexts
Faculty (Summer/Fall 2010).

Team member for the development of the curriculum for the Field School.
Syllabus design. Teaching classes. Tutoring. External Supports.

RESEARCH

Archival Historical Research: 2004 – Present.
Currently working on a book contracted through Palgrave Macmillan/Springer Nature with the provisional title, "American Psychiatry: Except As A Punishment" due August 20, 2024. This work incorporates multiple research and historical projects as well as current archival research including a fresh perspective and yet-to-be revealed archival materials. Previous work is reorganized with new information in this volume that traces the establishment of the field of modern psychiatry, the roots of state-sponsored organized psychiatric industries, and the ways in which corporate institutions and trade organizations emerged in the 19th century as a competing system of slavery. Can You Dig It? (2005 – 2008) and (de)VOICED: Human Rights Now (2008 - 2014) are two participatory action research projects that gave insight into this historical work. The Sprawl of American Psychiatry (2017 – 2019) and other archival work was also piloted as a video project inspired by R. J. Hall called "Mental American Monster" (2020 – 2023).
http://www.radpsynet.org/journal/vol5/Tenney.html.
https://web.archive.org/web/20160306123728/http://www.radicalpsychology.org/vol7- 1/tenney2008.html
https://academicworks.cuny.edu/gc_etds/296
http://www.laurentenney.us/the-sprawl-of-american-psychiatry.html
www.MentalAmericanMonster.org
https://www.youtube.com/channel/UCLYrOc52jufDUlSoSE-SPgw
Active.

Study: Hair Care? A Qualitative Research Study: Early Childhood Experiences of Hair Care, Child-Parental/Guardian Relationships, Attachment and Conflicts Concerning Hygiene, and Control of Hair Expression in Identity Throughout the Lifespan. Human Participant Research, IRB-approved.
Concluded.

Study: Watched for Life: What Is It Like to Live Under Active Surveillance for Monoclonal Gammopathy of Undetermined Significance (MGUS) and/or Leukocytosis and/or Their Resulting Consequences? Human Participant Research, IRB-approved.
Concluded.

Study: (de)VOICED: An Environmental Community-Based Participatory Action Research Project. Human Participant Research, IRB approved.
Research Terminated: July 25, 2016
Final Report: July 31, 2016
Text of Final Report: http://laurentenney.us/files/117279917.pdf

Study: The Freedom Discussions. Human Participant Research, IRB-approved.

Nathan Kline Institute and Mental Health Empowerment Project, Inc. Collaboration.

https://hd-ca.org/wp-content/uploads/2014/03/Alexander-Mary-Jane-Recovery-in-Social-Contexts.4-30- 2013-MJ-Alexander.pdf=

Concluded.

GOVERNMENT

New York State Office of Mental Health, Albany, NY (1998 – 2010)

Center to Study Recovery in Social Context, Nathan Kline Institute.
Field School housed at Columbia University. (Summer/Fall 2010).
Faculty/Tutor.
Syllabus development, teaching, and external supports.

Bureau of Children and Families. (2000-2003)
Statewide Projects Director
Local Youth Involvement Initiative; Coordinator of the Statewide Youth Advisory Council; and Coordinator of the Choice thru Voice Project.

Bureau of Recipient Affairs. (1999 – 2000)
Recipient Affairs Specialist
Co-chair, Children's Restraint and Seclusion Committee; Chair, Children's Trauma Committee; and Co-author (with Laura Cisco), Prime Directive Initiative.

Training Bureau. (October 1998 - December 1998).
Consultant
Child Visiting Policy in state-operated psychiatric facilities; GLBT research (now LGBTQI2SA); and the New York State Office of Mental Health's Trauma Initiative.
Recipient Advisory Committee (1993 –1999).
Member

NON-PROFIT

Mental Health Empowerment Project, Inc. Albany, NY. (2008 – 2020)
Consultant
Creating an Approachable Approach to the Capabilities Approach: The Freedom Discussions. Consultant (2009) Project Based.

Environmental Design and Staff Development. Consultant. (2008). Project based.
"Rethinking the NASHMPD Morbidity/Mortality Report" Focus Groups and Analysis with Isaac Brown. Project Based

Howie T. Harp Advocacy Training Center, Harlem, NY (2008 - 2010)
Consultant
Training on the history of the consumer and survivor movements; 5-week Weekly Educational Series on Family Education. Training: The current state of activism in human rights at the local, national, and international levels of legislation and government policy and regulation.

Sky Light Center, Staten Island, NY (1998-1998)
Unit Coordinator, Generalist
Responsibility for care coordination of 35 people; Coordinated, with members of this psychosocial clubhouse model program, lunch and dinner for more than fifty people a day.

Stage 2! Youth Empowerment, NYC, NY (1995 - 1997)
Co-Founder, Director
Contracted by New York State Office of Mental Health to create advocacy, self-help, and peer support activities for young people in state-operated psychiatric facilities in New York City and a plethora of other activities including program management, supervision, and contract negotiations.

Youth Empowerment Association! YEA! NYC, NY (1992 - 1995)
Director, Peer Counselor (1993 – 1995)
Coordinated activities of the organization. Participated in many meetings to give input into policy and regulation of the New York City Department of Mental Hygiene and the New York State Office of Mental Health.

Director of Public Relations; Peer Counselor. (1992 – 1993)
Coordinated media opportunities for the organization including work with MTV; press conferences; demonstrations; and panels.

ACADEMIC AND PROFESSIONAL HONORS

December 2022. Howie the Harp Award. Alternatives Conference 2022.
May 2006, Youth Pioneer and Leader, Families Together in New York State.
October 2002, Support of Consumer Initiatives, Mental Health Empowerment Project, N.Y.
June 1999, Stigma Eraser Award, Families Together in New York State.

FELLOWSHIPS AND GRANTS

Provost Fellow, 2004- 2009. Psychology Department. Graduate School and University Center, City University of New York.

Creating a User-Friendly Version of the Capabilities Framework. Nathan Kline Institute, New York State Office of Mental Health. Awarded May 2008 to the Mental Health Empowerment Project, Inc.

SELECTED PUBLICATIONS

Tenney, L. J. [Forthcoming]. *American psychiatry: Except as a punishment*. [Manuscript in preparation]. Palgrave Macmillan/Springer Nature.

Tenney, L. J. (2022). Spirituality, psychiatry, and mad studies. In Beresford, P. and Russo, J. (Eds.) (2022). *Routledge International Handbook of Mad Studie*s. Routledge. https://www.routledge.com/The-Routledge-International-Handbook-of-Mad-Studies/Beresford-Russo/p/book/9781138611108.

Tenney, L. J. (April 29, 2021). Racism and the rights movement. https://www.taylorfrancis.com/chapters/edit/10.4324/9781003119401-7/racism-rights-movement-lauren-tenney. In Newnes, C. (Ed.). (2021). *Racism in psychology: Challenging theory, practice and institutions*. Routledge. https://www.routledge.com/Racism-in-Psychology-Challenging-Theory-Practice-and-Institutions/Newnes/p/book/9780367635022.

Tenney, L. J. (2020). Rights, Psy and forms of Slavery. *Journal of critical psychology, counselling, and psychotherapy, 20*(3), 27-30. https://www.egalitarianpublishing.com/JCPCP/2020/jcpcp2003_Tenney.html.

Tenney, L. J. (September 11, 2019). Trump and Cuomo: Red flags are red herrings. Mad in America: Science, psychiatry and social justice. https://www.madinamerica.com/2019/09/trump-cuomo-red-flags-red-herrings/.

Burstow B. (2019) Dialogue with Survivor and Academic Lauren Tenney. In: The Revolt Against Psychiatry. Palgrave Macmillan, Cham. https://doi.org/10.1007/978-3-030-23331-0_5. https://link.springer.com/chapter/10.1007/978-3-030-23331-0_5.

Tenney, L. J. (July 1 2016). End Kendra's Law: Racist, classist practices in involuntary psychiatry persist. Mad in America: Science, psychiatry and social justice. https://madinamerica.com/2019/07/kendras-law-racist-classist-involuntary/

Tenney, L. J. (November 29, 2016). Warning: A psychiatric tsuNAMI is upon U.S.. *Mad in America: Science, psychiatry and social justice*. https://www.madinamerica.com/2016/11/warning-psychiatric-tsunami-upon-u-s/.

Tenney L.J., Brown C., Cascio K., Cerio A., Grundfest-Frigeri, B. (2016) Spirituality Psychiatrized: A Participatory Planning Process. In: Burstow B. (eds) Psychiatry Interrogated. Palgrave Macmillan, Cham. https://doi.org/10.1007/978-3-319-41174-3_4. In Burstow, B. (Ed.). (2016). *Psychiatry interrogated: An institutional ethnography anthology*. Palgrave Macmillan. https://link.springer.com/chapter/10.1007/978-3-319-41174-3_4#citeas.

Tenney, L. (July 31, 2016). Final report of (de)VOICED (An environmental community- based participatory action research project. Research Terminated: July 25, 2016. Report Electronically submitted July 31, 2016. http://laurentenney.us/files/117279917.pdf.

Member-Initiated Task Force of Division 35, Psychology of Women, American Psychological Association. (2016). Report on Division 35 involvement with PENS and its aftermath. https://div35mitf.wixsite.com/report.

Tenney, L. J. (March 25, 2016). Only 72 hours left to say #FDAStopTheShockDevice. Mad in America: Science, psychiatry and social justice. https://www.madinamerica.com/2016/02/40-days-to-tell-the-fdastoptheshockdevice/.

Maisel, E. R. and Tenney, L. J. (March 13, 2016). Lauren Tenney on mad activism. On the future of mental health interview series with Eric Maisel, PhD. Psychology today. https://www.psychologytoday.com/us/blog/rethinking-mental-health/201603/lauren-tenney-mad-activism.

Tenney, L. J. (February 17, 2016). 40 days to tell the #FDAStopTheShockDevice. Mad in America: Science, psychiatry and social justice. https://www.madinamerica.com/2016/02/40-days-to-tell-the-fdastoptheshockdevice/.

Tenney, L J. (December 30, 2015). Shock device as safe as eyeglasses? 89 days to say no. Mad in America: Science, psychiatry and social justice. https://www.madinamerica.com/2015/12/shock-device-safe-as-eyeglasses-89-days-to-say-no/.

Tenney, L. J. (November 24, 2015). Electroshocking Veterans and their fetuses. Mad in America: Science, psychiatry and social justice. https://www.madinamerica.com/2015/11/electroshocking-us-veterans-and-their-fetuses/.

Tenney, L. J. (August 11, 2015). Senate bill 1945: The new fraud – getting into the "Mental Health Reform Act of 2015. Mad in America: Science, psychiatry and social justice. https://www.madinamerica.com/2015/08/s-1945-the-new-fraud-getting-into-the-mental-health-reform-act-of-2015/.

Tenney, L. J. (2015). PSY 352 History and Systems of Psychology Summer Intensive Syllabus. Published as an Undergraduate Teaching Resource. Society for the History of Psychology, Division 26 of the American Psychological Association. https://historyofpsych.org/wp-content/uploads/2022/08/Updated_Tenney_PSY_352_Summer_2015_Syllabus_Final.pdf.

Tenney, L. J. (June 24, 2015). A witness to fraud. Mad in America: Science, psychiatry and social justice. https://www.madinamerica.com/2015/06/a-witness-to-fraud/.

Tenney, L. J. (June 7, 2015). With the public defrauded, the illegitimacy of forced psychiatry crystalizes. Mad in America: Science, psychiatry and social justice. https://www.madinamerica.com/2015/06/with-a-public-defrauded-illegitimacy-of-forced-psychiatry-crystalizes/.

Tenney, Lauren J. (2014). *(de)VOICED: Human Rights Now. (An Environmental Community-Based Participatory Action Research Project).* Proquest. UMI. *CUNY Academic Works.* https://academicworks.cuny.edu/gc_etds/296.

Tenney, L. J. (April 23, 2014). An open letter to the Colorado House Health, Insurance and Environment Committee RE: HB1386. Mad in America: Science, psychiatry and social justice. https://www.madinamerica.com/2014/04/open-letter-colorado-house-health-insurance-environment-committee-re-hb1386/.

Tenney, L. J. (April 20, 2014). I'm going, are you? How to get involved in the annual protest of the American Psychiatric Association. Mad in America: Science, psychiatry and social justice. https://www.madinamerica.com/2014/04/im-going-get-involved-annual-protest-american-psychiatric-association/.

Tenney, L. J. (2010). The Freedom Discussions. (Unpublished Manuscript)

Tenney, L. J. (2009). Opal, The. In Burch, S. *Encyclopedia of American disability history.* Facts on File. pp. 676-677. https://www.handicapcenter.com/wp-content/uploads/2014/05/Encyclopedia-of-American-Disability-History.pdf.

Tenney, L. J. and Hopper, K. (2009). Freedom discussions: Values clarification in Capabilities Framework.

Downing, M. and Tenney, L. J. (Eds.). (2008). Video Vision: Changing the culture of social science research. UK: Cambridge Scholars Publishing. https://www.cambridgescholars.com/product/978-1-4438-0001-3.

Tenney, L. J. & MacCubbin, P. (2008). When no one was watching: Human subject protections and videotaping, Take 1. In Downing, M. & Tenney, L. (Eds.). (2008). Video Vision: Changing the culture of social science research. UK: Cambridge Scholars Publishing. (pp. 14-79). https://www.cambridgescholars.com/product/978-1-4438-0001-3.

Tenney, L. J. (2008). Psychiatric Slave No More: Parallels to a Black Liberation Psychology, Journal of radical psychology, 7. https://web.archive.org/web/20160306123728/http://www.radicalpsychology.org/vol7-1/tenney2008.html.

Tenney, L. J. (2006). Who fancies to have a Revolution here? The Opal Revisited (1851- 1860). Journal of radical psychology, 5. http://www.radpsynet.org/journal/vol5/Tenney.html.

Libman, K. Tenney, L. J. & Saegert, S. (2005). Good design alone can't change society. Progressive planning, 164, Summer, 12-14. http://www.plannersnetwork.org/2005/07/good-design-alone-cant-change-society-marcus-garvey-village-brownsville-brooklyn-after-thirty-years/,

Tenney, L., J. with the New York State Office of Mental Health Statewide Youth Advisory Council. (2001). Nothing About Them Without Them: Youth Empowerment Programs. OMH quarterly, New York State Office of Mental Health. June.

Tenney, L. J. (2000). It has to be about Choice. Journal of clinical psychology, 56(11), 1433-1445. Wiley and Sons. https://pubmed.ncbi.nlm.nih.gov/11098867/.

Cisco, L. & Tenney, L, J. edited by the Statewide Youth Advisory Council. (1999, 2000, 2003). My Prime Directive Journal Draft Copy. (Choice thru Voice Project, My Voice & My Private Voice). New York State Office of Mental Health.

OTHER PROFESSIONAL ACTIVITIES LECTURES AND PAPERS PRESENTED

Tenney, L. J. (November 2-4, 2022). Artists in Action. Featured. Alternatives Conference, 2022.

Tenney, L. J. (September 17 – October 8, 2022). Hallucinations and medications. House of Shadows. Tampa, Florida.

Tenney, L. J. (August 31, 2022). Except as a punishment: 19th century psychiatric design. Keynote presentation. Surviving Race: The Intersection of Injustice, Disability, and Human Rights National Dialogues. Savannah, Georgia.

Tenney, L. J. & Hall, R. J. (May 27, 2022). Mental American monster: The sprawl of American psychiatry. 24th Annual Family Café. Orlando, Florida.

Belyea, Z. A., Bussell, C., Grant, T. A., and Tenney, L. J. (February 11, 2022). The Power of Writing. Present tense. Future perfect. SCCA 2022 Conference: Shaping purposeful writing center practices. Southeastern Writing Center Association. Nova Southeastern University. Florida.

Adam, S. and Tenney, L. (December 23, 2021). The monster of psychiatry with Dr. Lauren Tenney. Crazy Making Podcast with Dr. Simon Adam. The monster of psychiatry with Dr. Lauren Tenney by Crazy Making (anchor.fm).

Belyea, Z. and Tenney, L. J. (December 1, 2021). The Multiple Intelligences Project. Edited Video. KES II. Keiser University.

Tenney, L. J. (November 17, 2021). Facilitator: Brainstorming Session on Professional Development and Scholarly Activities. Psychology Department Convocation. Keiser University.

Tenney, L. J. (September 28, 2021). Panelist and video. Artists for Change: Politically, Personally, and Socially. Part 2. (Schedule was changed to accommodate my teaching schedule, published as Part 3). New York Association of Rehabilitation Services. 39th Annual Conference. United in Hope. Together for Justice. Wellness for All.

Tenney, L. J. (September 2021). Art Exhibit. Two paintings included in a statewide exhibit. New York Association of Psychosocial Rehabilitation Services. 39th Annual Conference. United in Hope. Together for Justice. Wellness for All.

Tenney, L. J. (July 14, 2021). Debut of Tribute to George Ebert. Video.

Tenney, L. J. (April 2021). A.M.A. (1854) Pills vs. Bleeding. Video. Drop the Disorder Poetry and Music Evening. Zoom event. https://www.youtube.com/watch?v=V1nJXSCmFyk.

Tenney, L. J. (July, 2021). Art Exhibit. Two paintings included in a national exhibit. National Alternatives Conference.

Caplan, P., Brown, C., Smith, A., Stone, S., and Tenney, L. J. (September, 2018). Modern myths of "mental illness". National Association of Rights, Protection, and Advocacy (NARPA) Annual Conference, Baltimore, MD. https://www.narpa.org/conferences/2018/modern-myths.

Farber, S., Giffen, T., and Tenney, L. J. (2016). Neoliberalism and the "Mental Health" System: The Failure of The Left. LeftForum 2016. New York City: John Jay College of Criminal Law, City University of New York.

Tenney, L. J. (August 26, 2015). Unlocking individual passions as a means to student engagement, retention, and success. GSTA Teaching of Psychology, Division 2 of the American Psychological Association Mentorship Program, Workshop I: Total Student

Tenney, L. J. and Dech, E. (August 22, 2015). Aspirational Arguments from (de)VOICED: Survivors of deadly force with deadly weapons. National Association of Rights, Protection, and Advocacy Annual Conference: Washington, D.C..

Farber, S., Tenney, L. J., and Dubral, S. (2015). New mad pride movement: "Schizophrenics" and "Bipolars" as the new spiritual vanguard? Left Forum: 2015, May 30, 2015, John Jay College, CUNY: New York.

Tenney, L. J., Dech, E., Liebert, R. (2015). This is not justice. There ought not be peace: Psychiatry, capitalism, and state power. Left Forum: 2015. May 30, 2015. John Jay College, CUNY: New York

Tenney, L. J., Cook, L, Calkins, D., Cascio, K., & Shomo, A. (2013). (de)VOICED: Implications for People who Work in Peer Roles: Our Findings Affect Your Work. Seventh Annual Peer Specialist Conference: Crossroads: Creating New Paths to Whole Health: Health Care Reform and the Role of Peer Specialists. A Conference of the New York State Office of Mental Health. New York University. New York City.

Tenney, L. J., Cook, L., Calkins, D. (2013). (de)VOICED: Environmental Workographies Reveal Multiple Human Rights Violations Committed in Psychiatric Places. Presented to the PhD Program in Environmental Psychology, Graduate School and University Center. New York.

Tenney, L. J., Dech, E., Merlino, M., Brown, C., Sanchez, D., & Cascio, K. (2010). How the Murder of Our Sister Gave Us Life and What We are Doing with It. PsychOUT. A Conference for Organizing Resistance Against Psychiatry. A Conference of the Ontario Institute for Studies in Education of the University of Toronto (Department of Adult Education and Counseling Psychology). Toronto, Canada.

Tenney, L. J., Dech, E., Brown, C., Sanchez, D., & Cascio, K. (2010). (de)VOICED: An Environmental Community Based Participatory Action Research (ECBPAR) Project. PsychOUT: A Conference for Organizing Resistance Against Psychiatry. A Conference of the Ontario Institute for Studies in Education of the University of Toronto (Department of Adult Education and Counseling Psychology) Toronto, Canada.

Alexander, M.J., Hopper, K., McKinney, J., Brown, I., Koerner, J., & Tenney, L. J. (September 17, 2009). Capabilities: Research about Real Opportunities to Do and Be What You Value. NYAPRS Annual Conference, Kerhonkson, NY.

Tenney, L. J. (July 30, 2009). Mad Pride: Demystifying Psychiatric Labels. Options for Independence "Adventures through Advocacy" Conference, Auburn, NY.

Tenney, L. J. (March 26, 2009). Exclusion outlawed, contested access practiced: Negotiating public spaces with a psychiatric service dog. American Association of Geographers Annual Conference, Las Vegas, NV. (accepted).

Tenney, L. J. (March 13, 2009). The Transformative Effects of Audrey Cohen on Education and Human Services: Celebrating her life and legacy. American Women of Psychology Annual Conference, Rhode Island.

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Tenney Testimony UNFAVORABLE HB576 and SB453 02122

Uploaded by: Lauren Tenney, PhD, MPhil, MPA, BPS

Position: UNF

Lauren J. Tenney, PhD, MPhil, MPA, BPS, Psychiatric Survivor

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TO: An Open Letter to the Maryland Legislature Memorandum of Opposition UNF HB576 and SB453

FROM: Lauren J. Tenney, PhD, MPhil, MPA, BPS, Psychiatric Survivor

DATE: February 12, 2024

RE: Letter Informing Legislature of Submitted **Memorandum of Opposition UNFAVORABLE UNF HB576 and SB453** and any subsequent laws court ordering or compelling psychiatric treatment or oversight over expressed objection of any individual.

I am writing as a new resident of the State of Maryland. One of the things that made Maryland attractive to me was that it was one of the few States in the US that did not have an involuntary outpatient commitment law. I have a PhD in Psychology with a specialization in Environmental Psychology, a Master's Degree in the Philosophy of Psychology, a Master's degree in Public Administration, and a Bachelor's degree in the Professional Studies of Human Services. I have more than thirty years of experience working in the field of public mental health policy, regulation, and rights protection and advocacy. I worked as a professor of psychology at the undergraduate level for nearly two decades. I am also a psychiatric survivor who was first institutionalized at fifteen years old in 1988. I have been working to end these types of laws since 1995, when at the time, I qualified to be subject to them.

I am personally concerned about the effects of this law on my own life as well as the live of people in Maryland.

Please find attached my written testimony concerning HB576.

In short, this bill or any one like it supporting any type of court ordered psychiatry, in the community or in an institution ought not be passed legislation in Maryland.

1. Involuntary Outpatient Commitment laws cannot exist without human rights violations.
2. Forced psychiatric treatment is futile.
3. Psychiatric treatment can often leave one voluntarily or involuntary complying with treatment with liver and kidney damage, tardive dyskinesia, aphasia, metabolic syndrome and diabetes, and early death.

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4. In short, any proposed law that would support forced treatment by court order or compulsion or coerced or uninformed compliance presents serious ethical, legal, and practical challenges.
5. There is a need for independent external advocates. People in peer positions ought not be involved in the support of forced treatment in any way.

Key Points:

Human Rights Concerns: This bill presents human rights violations and concerns risking people to potential iatrogenic consequences of psychiatric treatment and torture.

Deceptive Psychiatry Narrative: . Misinformation and the harmful nature of psychiatric treatments raise serious questions about the effectiveness of forced psychiatric treatment.

Racial Disparities: There is a great potential for creating further racial disparities in a system that already shows racialized trends.

Financial Burden: The proposed bills allocate significant taxpayer resources to state-sponsored inpatient services, creating an institutionalized community.

Iatrogenic Effects: Unintended adverse effects or complications caused by a medical intervention. Psychiatric treatments consistently cause iatrogenic effects as well as intentional damage, such as in the situation of intentional brain damage by coursing electricity through the brain.

The following are specific concerns presented in the bills:

Definition of "Peace Officer": Clarification on the roles, powers, and rules surrounding peace officers involved.

Certified Peers Involvement: In no law in Maryland ought there be any involvement of people who are certified peers in any service that is provided with force or compulsion. There should be clear guidelines and Memorandums of Understanding for independent external advocacy.

Minors Inclusion: Minors ought to be completely excluded from the language in these bills.

Medical Evaluation: Only medical doctors without financial stakes should be allowed to evaluate individuals for involuntary commitment, and even then, the practice is questionable and problematic.

Petition Parameters: The petition parameters must be much tighter and have built in safeguards from being misused as a form of control. This includes both who can petition and for what

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reason as well as how long one will be in the role of respondent, and what happens to the respondent if they do not meet requirements set out in a petition that has been granted.

Advanced Directives: Advance Directives ought to always be followed.

Data Collection: There needs to be stricter ongoing independent external data collection on respondents, and petitioners, including demographics, psychiatric history, and outcomes of investigations. I

Additionally, you will notice that several people have signed their support as "*Others in Opposition to Any Legislation Supporting Involuntary Outpatient Commitment (Developing).*

Thank you for your time and consideration. I am available to discuss any of the information for which I provided as written testimony below.

Kind regards,

Lauren J. Tenney, PhD, MPhil, MPA, BPS, Psychiatric Survivor

As of February 12, 2024:

Others in Opposition to Any Legislation Supporting Involuntary Outpatient Commitment (Developing).

Iden D Campbell McCollum

Erick Fabris, Author of *Tranquil Prisons: Chemical Incarceration under Community Treatment Orders*

Dr. Craig Newnes Dip.Clin Psych, PhD (History) Multiple universities

Amy

Kathryn Cascio, Advocate and Activist for No force. Force doesn't work. I am a New Yorker fighting involuntary outpatient commitment since 1997.

Daniel B. Fisher, MD, PhD

Lauren J. Tenney, PhD, MPhil, MPA, BPS, Psychiatric Survivor

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UNFAVORABLE UNF HB576 and SB453

MEMORANDUM OF OPPOSITION

TO: Maryland Legislature

FROM: Lauren J. Tenney, PhD, MPhil, MPA, BPS, Psychiatric Survivor

DATE: February 9, 2024

RE: Testimony of Lauren J. Tenney, PhD, MPhil, MPA, BPS, Psychiatric Survivor to the Maryland Legislature and Memorandum of Opposition to Maryland Involuntary Outpatient Commitment Bills; UNFAVORABLE HB 576 and SB 453 and any subsequent laws court-ordering or compelling psychiatric treatment or oversight over objection.

I am writing to express my strong opposition to Maryland's Involuntary Outpatient Commitment bill: UNF HB 576 and SB 453These bills, any subsequent laws court-ordering or compelling psychiatric treatment or oversight over objection, raise significant concerns related to human rights violations and potential disparities in their application.

Involuntary Outpatient Commitment laws cannot exist without human rights[1], [2] violations [3], [4]. [5] Involuntary Outpatient Commitment laws and are often implemented by States with gross disparities with respect to race, ethnicity, gender, sex, sexuality, disability, age, religion, and spiritual practice. Individual autonomy and the right to refuse treatment are paramount in protecting the rights and safety of people involved with psychiatry [6], [7], [8]. There is not one biological test for any psychiatric diagnosis[9], [10] and tremendous biological evidence for the damages caused by those psychiatric drugs[11],[12], [13], [14], [15], [16], [17], [18], electric shock[19], [20], [21], [22], [23], [24], [25], [26] insulin shock[27], [28] lobotomy and psychosurgery[29], [30] and aversive and behavior modification such as skin shocks[31].

Society has been sold a false bill of goods when it comes to psychiatry[32], [33]. People are often misinformed about the lack of efficacy the field has even though they are presented with the long lists of adverse effects every commercial airs. Direct-To-Consumer Marketing, via the field of advertising, uses psychology to allow mass manipulation to occur. The amount of damage and risk of damage people experience from treatments they have received, whether they receive those treatments voluntarily or by force is the same. Psychiatric treatment can often leave one with liver and kidney damage, tardive dyskinesia[34], aphasia, metabolic syndrome and diabetes[35], and early death, just to name a few of the iatrogenic effects of psychiatric drugs[36].

Why without biological evidence for supposed disease are biological responses allowed to be court ordered over the expressed objection of the respondent? Even if there was biological evidence for psychiatric diagnoses, why would the court ordered treatment over objection be an acceptable course? Certainly, people have the right to refuse all types of medical treatments.

Forced psychiatric treatment is futile. Supporting forced treatment as doing the right thing for people who are presented as being unable to make good choices for themselves is nothing more than a veil of paternalistic beneficence.

Psychiatric treatment in general is ineffective and often causes other health issues. The morbidity and mortality rate of those with psychiatric histories shows a loss of life of twenty-five years or more over people who do not have a psychiatric history. (NASHMPD, 2006)[37]

Many psychiatric survivors and people who are struggling under psychiatric court orders experience forced, compelled, coerced, and court ordered psychiatry as a form of torture and a violation of basic human rights[38], [39], [40], [41], [42]. Many more people who have been subjected to forced psychiatry argue that the experience had a negative impact on their lives and does not lead to therapeutic outcomes. Forced treatment leads to mistreatment and abuse.

I am writing as a new resident of the State of Maryland. One of the things that made Maryland attractive to me was that it was one of the few States in the US that did not have an involuntary outpatient commitment law. I have a PhD in Psychology with a specialization in Environmental Psychology, a Master's Degree in the Philosophy of Psychology, a Master's degree in Public Administration, and a Bachelor's degree in the Professional Studies of Human Services. I have more than thirty years of experience working in the field of public mental health policy, regulation, and rights protection and advocacy. I worked as a professor of psychology at the undergraduate level for nearly two decades. I am a psychiatric survivor who is personally concerned about the effects of this law on my own life.

My work opposing involuntary outpatient commitment laws officially began circa 1993, In 1995 when the involuntary outpatient commitment program was being piloted at Bellevue Hospital in New York City. As a New Yorker, having been born in Brooklyn in 1972, and institutionalized in a psychiatric facility on Staten Island in 1988, that was likely part of the response to the Willowbrook State School being shut down only a decade before, I railed against the Orwellian plan that New York presented to mandate treatment over objection. As someone who was institutionalized as a minor, the idea of someday maybe reaching "adult" status and making a choice about compliance with a psychiatric regimen that was causing me harm had always been dangled over my head, 'When you're an adult you will have the right to refuse . . .' so the idea that adults were losing their rights struck a chord with me. Of course, the other thing that struck

a chord with me was that I qualified for the law if someone chose to use it against me – either as a form of social control or weaponized for compliance with daily activities of living.

The New York Movement of people with psychiatric histories was strong in the mid-1990s. We successfully eliminated the Bellevue Pilot Project of Involuntary Outpatient Commitment in New York State with the help of legislators, lawyers, progressive psychiatrists and psychologists, advocates, and everyday people who saw the blatant problems with court ordered treatment via taxpayer resources.

And then someone who had a psychiatric history pushed someone else in front of a train in 1999 and the law was knee-jerk rammed through the legislature, even though the person who the law was set to control would not have qualified for the law because the person had sought out treatment dozens of times and dozens of times was refused services by providers.

I was at the tables, as the Children's Recipient Affairs Specialist, when the New York State Office of Mental Health made the decision to name the program that "Kendra's Law" required the State to develop, implement, and evaluate. They modeled the name "Assisted Outpatient Treatment" after the Department of Health's Tuberculosis Treatment Program, "Delivered Observable Treatment" to make it sound kinder and gentler than what they were doing, involuntary outpatient commitment, forcing people to comply with treatment that they do not want and that likely is causing iatrogenic effects – causing harm.

Recently, I was a resident of Florida from February 2020 – November 2023. Atrocious human rights violations were conducted through Florida's involuntary outpatient commitment law, the "Baker Act" which was aimed at all people and had horrendous rates of use on children in the State of Florida. During my residency, I was an appointed member of the Protection and Advocacy for Individuals with Mental Illness Advisory Council. I had on-the-ground understanding of how the disability rights movement, lawyers, advocates, and progressive professionals protected people who had psychiatric involvement from court order. There were many people who were in opposition to the ways the law was implemented. Many people were entirely opposed to the law existing at all.

Involuntary Outpatient Commitment laws consistently are implemented in ways which smack of classist and racist practices[43],[44], [45], [46], [47], [48], [49].

In the 2022 Uniformed Reporting System[50] data submitted by the State of Maryland to the Center for Mental Health Services (URS/CMHS) 27% of people receiving psychiatric services are employed and the type of employment or earnings for employment is not specified. However, with just under three-quarters of the population of people we are concerned with most affected by the proposed laws, economic struggles and poverty and/or abject poverty is part of the discussion. Evaluation of whether one can meet financial needs is part of the psychiatric

diagnostic process. With barely one-fourth of people in the psychiatric system employed, being petitioned under potential involuntary outpatient commitment laws via class, or lack of resources, is of concern. In New York, for example, a geospatial analysis based on economic health of neighborhoods shows the locations of involuntary outpatient commitment programs in neighborhoods that experience economic hardship.

In New York, those practices are clear and that racialized implementation of the law is consistently a reason why it ought to be eliminated. Part of what was presented by Swartz et al. (2009)[51] was that the population of people who meet the requirements for the New York law included people who were institutionalized, and in services. Swartz et al. noted that there was a clear disparity in institutions with people who are Black over-represented in institutional settings stating, "Candidates for AOT are largely drawn from a population where blacks are overrepresented: psychiatric patients with multiple involuntary hospitalizations in public facilities" (p. 13).

There are clear racial disparities in the current system of Maryland. In the 2022 Uniformed Reporting System data submitted by the State of Maryland to the Center for Mental Health Services (CMHS) the total population served included American Indian of Alaska Native (0.8%), Asian (3.0%), Black (39.6%), Native Hawaiian or Other Pacific Islander (0.2%) White (33.5%), More than One Race (0.0%), and Not Available (23%).

In Maryland 2022 data reported in the Uniformed Reporting System[52] data submitted by the State of Maryland to the Center for Mental Health Services (URS/CMHS) 39% of people receiving services are Black and 33.5% of people receiving services are White. With no data on the race of 23% of people receiving services in Maryland, a formal independent study ought to begin to ensure that race is not playing a role in those who are subjected to services that compromise International Human Rights, and US Constitutional Rights and Civil Rights.

US Census Data[53] on Race and Ethnicity shows in Maryland indicates that people who are "White Alone or in Combination" make up 55.40% of the state of Maryland's population and people who are "Black or African American Alone or in Combination" make up 32% of the state of Maryland's population. When these data are compared to the URS/CMHS data, there is a grave concern that race is playing a role in diagnosis, treatment, and institutionalization. Additionally, demographics reflected in the current system sets the stage for an overrepresentation of People of Color, particularly people who are Black or African American, in a court ordered treatment over objection, as was found in New York's system by Swartz et al. (2009)[54]. We must always learn from history and the long road we still travel to repair current and past transgressions[55], [56]

In Maryland 2022 data reported in the Uniformed Reporting System[57] data submitted by the State of Maryland to the Center for Mental Health Services (CMHS) that 4.4% of people served reported Hispanic or Latino Ethnicity and 55.3% of people served report Not Hispanic or Latino Ethnicity. For 40.3% of the population served were in the category, "Ethnicity Not Available"[58]. An accurate accounting people receiving psychiatric services in the State of Maryland is required to rule out any types of disparities in services, particularly when services are conducted with state power over the expressed objections of people receiving those services.

In the Executive Summary of the report on race and involuntary outpatient commitment commissioned by the New York State Legislature, Swartz et al. (2009) acknowledged there was a question posed as to whether AOT was discriminatory in its practice and that whether you saw the program as beneficial or detrimental was determined by how you viewed psychiatry. supported a group that did not have access to resources.

Swartz et al. were clear on how the perception of each person contemplating court-ordered psychiatry as rooted in discrimination would have to answer this for themselves:

> Whether this overrepresentation is discriminatory rests, in part, on whether AOT is generally seen as beneficial or detrimental to recipients and whether AOT is viewed as a positive mechanism to reduce involuntary hospitalization and improve access to community treatment for an under-served population, or as a program that merely subjects an already-disadvantaged group to a further loss of civil liberties" (p. vii).

Swartz et al. (2009) continue:

> We find that the overrepresentation of African Americans in the AOT Program is a function of African Americans' higher likelihood of being poor, higher likelihood of being uninsured, higher likelihood of being treated by the public mental health system (rather than by private mental health professionals), and higher likelihood of having a history of psychiatric hospitalization. The underlying reasons for these differences in the status of African Americans are beyond the scope of this report. (Swatz et al., 2009, p. vii)

These issues must be explored and the scope of investigation must be extended. The State of Maryland must safeguard against the possibilities of race-based diagnosis and court-ordered, coerced, compelled, and/or uninformed psychiatric treatment.

State Inpatient Services take up sixty percent of Maryland's allocated expenditures – over three hundred fifty-five million dollars is allocated to state-sponsored inpatient services[59].

While some may try to argue that involuntary outpatient commitment laws will help shorten the length of stay, this is not true. What the involuntary outpatient commitment laws do is create an institutionalized community, where one is constantly living under surveillance and threat of institutionalization, while often being forced to ingest brain and body damaging drugs or other treatments over their objection and participate in social and psychiatric programming they may not want to participate in, particularly without choice and full informed consent. Court ordered programs of forced psychiatry are bottomless pits. The money allocated for this proposed law will never be enough and its budget will forevermore need to be expanded.

There are many better uses for these taxpayer resources than what is found in these proposed bills.

What is needed cannot be found in these proposed bills and includes holding psychiatry accountable to the truth of its science.

There is a need for external advocates. People in peer positions ought not be involved in the support of forced treatment in any way. Memorandums of Understanding between Peer Run Organizations and Institutions ought to be created to allow for independent external advocacy for any person who is investigated or subjected to court ordered or compelled treatment over objection. This safeguard is crucial to protect the rights and interests of those subjected to involuntary treatment.

There is a need for full protection and compliance with the Americans with Disabilities Act. Involuntary outpatient commitment takes away the individual decision-making power of people with psychiatric labels. The selective targeting of this group for forced treatment raises ethical and legal concerns surrounding discrimination based on a perceived disability.

There is a need for trauma-informed practices. A trauma informed approach does not align with services that are inherently grounded in force and removal of autonomous decision making of individuals. Trauma informed approaches also would not have at their root practices that promote prejudice and strip away civil rights from historically marginalized groups. The perpetuation of discriminatory practices against those psychiatrically labeled, as well as the potential of how People of Color and people who are struggling economically will be disproportionality effected is counterproductive and unacceptable. The economic consequences are not only during the period of forced treatment but long persisting with deleterious consequences on future economic well being due to discrimination people face when subjected to compulsory psychiatry[60]

In short, any proposed law that would support forced treatment by court order or compulsion or coerced or uninformed compliance presents serious ethical, legal, and practical challenges.

In addition to the bill existing at all, there are specific concerns that I have concerning the language and spirit of the bill, and they are as follows:

- The bill should not set law for the process for both involuntary admission/emergency admission procedures to confinement in a psychiatric institution and the process of being involuntarily committed to outpatient treatment. I do not believe either action is a legitimate action and both processes constitute human rights violations and constitutional and civil rights violations. However, minimally, these should not be in the same bill.
- What is the definition of a "peace officer?" Do they carry guns, tazers, and/or restraint devices? If so, what are the rules around these devices? This is particularly concerning since one out of four people killed by the police are killed during "wellness/mental health" checks[61].
- The bill seems to potentially include people who are certified peers in the process of force and coercion. Any involvement of people working in peer roles ought to be with a memorandum of understanding for independent external advocacy and support. People in peer roles ought not have any role in implementing any type of forced treatment.
- At points minors are mentioned. It should be made clear that minors are excluded from any type of involuntary outpatient commitment laws.
- The bill allows for Psychiatric Nurse Practitioners to evaluate people for involuntary admissions and commitment proceedings. This ide that psychiatric nurses can make an evaluation to suspend the freedom of a person to make their own voluntary medical decisions must be eliminated. Only medical doctors, and it ought to be only medical doctors who have no financial stake in the process or its outcome, should be able to evaluate someone for involuntary commitment to an institution or to involuntary outpatient commitment, and even then acknowledge how weak such an evaluation is with any actual evidence for any supposed diagnostic tools, which most often are interview and observations.
- The parameters for who can petition a respondent to be evaluated ought to be lessened and tighter, and more limited. It is a very broad net to have no parameters or minimal parameters for filing petitions. Very often the threat of filing a petition is used by family, significant others, roommates, sometimes friends, and others as a type of control over the person that they are threatening with an investigation. This sentiment of having a potential investigation of the person at any moment hovers above someone under threat much like the threat that, once you go to court you cannot get out of the court system, is used to dissuade people from asserting their rights for a court hearing and instead, being compelled to comply with treatment.
- The length of the petition and the consequences of not abiding by the results of a petition (in terms of institutionalization) must be limited.

- The process of investigations, from how the report will be taken and by who to what happens every step of the investigation, by whom, using what procedures must be detailed and communicated to the public.
- An acknowledgement of the lack of efficacy of the field of psychiatry by the court and an acknowledgement of the tremendous biological damage the treatments of psychiatry cause to the human body must be made at each phase of the involuntary outpatient commitment process.
- Treatment without informed consent when data is being collected is experimentation. When treatment occurs without informed consent over expressed objection of the person receiving the treatment, it is forced experimentation.
- Psychiatric Advanced Directives should always be followed.
- Stricter data collection on respondents, including race, ethnicity, gender, sex, sexuality, religion, spiritual practice, age, employment, veteran status, and disability.
- Data ought to be collected on petitions, petitioners, investigations, and outcomes of investigations including race, ethnicity, gender, sex, sexuality, religion, spiritual practice, age, employment, veteran status, and disability.

I urge you to oppose the passage of any involuntary outpatient commitment bill that has been shown in other places where similar actions were taken to have demonstrated ineffectiveness, discriminatory practices, and negative impact on individual rights and participation in voluntary mental health services. Involuntary Outpatient Commitment is not a panacea to social ills rooted in economics, that quite frankly the budget allotted will never suffice.

Involuntary Outpatient Commitment is not a program that will help a struggling population instead, Involuntary Outpatient Commitment is an extraordinarily costly program that will further marginalize a group of people who already experience oppression and loss of life, liberty, and fortune who ought not be under the control of state-sponsored psychiatric overseers.

I am available for clarification on any of this information.

Thank you for considering my opposition and concerns.

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Others in Opposition to Any Legislation Supporting Involuntary Outpatient Commitment (Developing)

Iden D Campbell McCollum

Erick Fabris, Author of *Tranquil Prisons: Chemical Incarceration under Community Treatment Orders*

Dr. Craig Newnes Dip.Clin Psych, PhD (History) Multiple universities

Amy

Kathryn Cascio, Advocate and Activist for No force. Force doesn't work. I am a New Yorker fighting involuntary outpatient commitment since 1997.

Daniel B. Fisher, MD, PhD

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sb453.pdf
Uploaded by: Linda Miller
Position: UNF

MARYLAND JUDICIAL CONFERENCE
GOVERNMENT RELATIONS AND PUBLIC AFFAIRS

Hon. Matthew J. Fader
Chief Justice

187 Harry S. Truman Parkway
Annapolis, MD 21401

MEMORANDUM

TO:	Senate Finance Committee
FROM:	Legislative Committee Suzanne D. Pelz, Esq. 410-260-1523
RE:	Senate Bill 453 Mental Health – Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment Programs
DATE:	February 7, 2024 (2/20)
POSITION:	Oppose, as drafted

The Maryland Judiciary opposes Senate Bill 453, as drafted. The Judiciary supports the intent of this legislation and its goal in establishing assisted outpatient treatment programs. The Judiciary's only objection is to the amendment to Health General Article § 10-625(b)(2). This amendment significantly alters the Maryland Department of Health's (Department) responsibility to admit an emergency evaluee to an appropriate facility. The current statutory language states that "the Department **shall provide** for admission of the evaluee to an appropriate facility." The proposed amendment states "The Department **may require** admission of the emergency evaluee to an appropriate facility." This proposed amendment significantly changes the Maryland Department of Health's obligation to admit persons who have been found to be suffering from a mental disorder and present a danger to themselves or others. Instead, it allows the Department to choose whether to admit such a person despite the earlier findings of danger. There is no indication in the legislation how the Department would make such a decision nor is there a requirement that the Department address the needs for which the evaluation was granted. This change presents significant safety concerns for the individual evaluee and for the public at large. Additionally, it renders the Court's earlier findings, for which an evaluation was sought and obtained, meaningless. It also further attenuates the responsibility of the State to provide clinically appropriate treatment to mentally ill and dangerous individuals, consistent with due process.

cc. Hon. Bill Ferguson
Judicial Council
Legislative Committee
Kelley O'Connor

2024-SB0453- Oppose AOT.pdf
Uploaded by: Melinda Morgan
Position: UNF

Written Testimony in Opposition to Senate Bill 453:
Mental Health - Emergency Evaluation and Involuntary Admission Procedures
and Assisted Outpatient Treatment Programs

Thank you to Chair Beidle, Vice Chair Klausmeier, and to the committee members for your time.

My name is Mindy Morgan, here to state my opposition to Senate Bill 453. I am a mother of three, a taxpayer, and a clinical social worker with over 20 years in the mental health field.

I am 44 years old and was diagnosed with bipolar disorder at age 21. I have been hospitalized three times. As I fought for stability back then, I maintained a full-time job as the sole provider for my family of five.

In my last hospital stay I was held against my will. I was not assessed to be a risk, but I was not allowed to discharge because I was told I needed help. As a result of this forced treatment, I didn't realize I needed help. I just did what it took to get out… and now I fear hospitals. Forced treatment traumatized me to the extent that I no longer will access any hospital for mental health care. This may put my life at risk one day if I am ill again.

In the end, the people I trusted helped me find my way to effective treatment. In all my experiences personally and professionally, people don't change because their hand is forced. They change because they trust.

From a provider's perspective, people struggle to engage with care because treatment systems are broken. Evidence based practices like ACT teams, WRAP providers, peer programs, First Episode Psychosis and respite are on long waits because of severe underfunding and availability issues despite their success rates. AOT is not an evidence-based practice, yet we are proposing to fund that instead. Why aren't we funding what already exists, is backed by strong evidence, and has people waiting in long lines to get in?

Last year was discussed by a fellow speaker that in other states, less than 1/3 to 1/4 of AOT petitions filed against individuals were found to be legitimate. If this is the case, 750 out of 1,000 individuals would be pulled into court to defend themselves against accusations of being "too ill to care for themselves" without justification. Where is the evidence showing the extraordinary results making it so worth traumatizing so many and wasting so much money on the judges, lawyers and psychiatrists for the 66-75% whose petitions were not legitimate?

Please let's stop focusing on those with mental health issues as though we are the problem. We aren't. Let's instead fund effective programs that already exist… the ones patients cannot access due to availability. ACT teams. Peer programming. WRAP providers. First Episode Psychosis. Respite. Please use our taxpayer dollars wisely. Please use resources on what works. Thank you for your time.

Mindy Morgan, LCSW-C
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SWASC SB 453 UNFAV Testimony .pdf
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Position: UNF

SWASC Social Work Advocates for Social Change

For more information, please contact
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TESTIMONY IN OPPOSITION OF SENATE BILL 453

Mental Health - Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment Programs

Finance

February 20, 2024

Social Work Advocates for Social Change strongly opposes SB 453, which will significantly impact the procedures for emergency evaluation and involuntary admission, as well as establish so-called Assisted Outpatient Treatment (AOT) programs. This legislation seeks to respond to real challenges causes by an inadequate behavioral health care infrastructure, but it does so in a way that raises concerns regarding the welfare and rights of individuals undergoing emergency evaluation. If enacted, the bill would mandate peace officers to transport individuals experiencing mental health symptoms to nearby emergency facilities, grant psychiatric nurse practitioners the authority to assess individuals for involuntary admission, and empower the Maryland Department of Health to require individuals be admitted immediately. Additionally, each county would be compelled to establish AOT programs, with the Maryland Office of the Public Defender (MOPD) tasked with providing representation in related proceedings. Some of these provisions will cause considerable harm by causing increased involuntary treatment, overburdening the already strained mental health system, and negatively impact the relationships between mental health care providers and clients.

SB 453 will result in coerced mental health care. AOT requires patients to adhere to court-ordered mental health care or face incarceration. Indeed, individuals in AOT report feeling more forced into treatment than individuals receiving care as part of a mental health court ruling.[1] A core aspect of successful psychiatric treatment is the therapeutic alliance between providers and patients.[2] Coercion undermines the therapeutic alliance, making it harder for individuals to engage meaningfully in their treatment and recover. The resulting trauma of forced mental health treatment lingers for years, causing individuals to avoid and delay seeking help.[3]

SB 453 does not address the mental health provider shortage. Two-thirds of Maryland counties are classified as mental health professional shortage areas.[4] Establishing AOT programs would refer more individuals to Maryland's already strained mental health

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For more information, please contact
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system. This will result in individuals who are voluntarily seeking help being turned away due to the influx of court ordered patients. In May of 2022, over 30% of individuals experiencing symptoms of anxiety and/or depressive disorders reported being unable to receive the counseling they needed.[5] Before we can even consider implementing AOT programs in Maryland, the significant shortages in the mental health care system must be addressed.

SB 453 will damage the provider-client relationship. A key part of the social work code of ethics is promoting the right of clients to self-determination.[6] AOT goes against this principle by requiring providers to either enforce treatment or report a client's non-compliance to the court system. This coercive approach undermines trust and collaboration between providers and clients, hindering the effectiveness of mental health interventions and potentially leading to disengagement from care.

SB 453 is likely to target racial minorities disproportionately. Only 12% of Maryland's population is Black,[7] yet they have the highest rate of receiving emergency petitions. Recent data collected by MOPD found that 51% of special emergency petitions for court ordered involuntary hospitalizations were for Black individuals.[8] The implementation of AOT will magnify this disparity, perpetuating systemic racism within the mental health care system and exacerbating existing disparities in access to care and outcomes.

SB 453 fails to address the underlying issues contributing to involuntary admissions and instead exacerbates harm to vulnerable populations while undermining fundamental principles of ethical and effective mental health care. We need to create a more robust and responsive behavioral health infrastructure that includes outreach and wraparound supportive services that meets people where they are. AOT is a top-down shortcut that values the comfort of our communities at the expense of the health and safety of the community members with mental health issues. **Social Work Advocates for Social Change urges an unfavorable report on SB 453.**

Social Work Advocates for Social Change is a coalition of MSW students at the University of Maryland School of Social Work that seeks to promote equity and justice through public policy, and to engage the communities impacted by public policy in the policymaking process.

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[5] Mental Health and Substance Use State Fact Sheets | KFF. (2023, March 20). KFF. https://www.kff.org/statedata/mental-health-and-substance-use-state-fact-sheets/maryland/#:~:text=Unmet%20Need%20and%20Barriers%20to%20Care,-Unmet%20need%20refers&text=As%20shown%20in%20the%20figure%20below%2C%20in%20May%202022%2C%20among,the%20U.S.%20average%20of%2028.2%25.

[6] National Association of Social Workers. (n.d.). *Social workers' ethical responsibilities to clients*. Retrieved February 10, 2024, from https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English/Social-Workers-Ethical-Responsibilities-to-Clients

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AOT MOPD Info.pdf
Uploaded by: Elizabeth Hilliard
Position: INFO

MARYLAND OFFICE OF THE PUBLIC DEFENDER

NATASHA DARTIGUE
PUBLIC DEFENDER

KEITH LOTRIDGE
DEPUTY PUBLIC DEFENDER

MELISSA ROTHSTEIN
CHIEF OF EXTERNAL AFFAIRS

ELIZABETH HILLIARD
ACTING DIRECTOR OF
GOVERNMENT RELATIONS

POSITION ON PROPOSED LEGISLATION

BILL: SB 453 - Mental Health – Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment Programs

FROM: Maryland Office of the Public Defender

POSITION: Informational

DATE: February 20, 2024

The Maryland Office of the Public Defender offers this information for this committee's consideration when they issue a report on Senate Bill 453.

The Maryland Office of the Public Defender ("MOPD") recognizes that through the Assisted Outpatient Treatment ("AOT") workgroup last session and attention to the concerns for the individuals whose bodily autonomy and liberty are being infringed by the assisted outpatient treatment process. We understand that numerous amendments are coming, some of which will address concerns we have previously articulated, but it is our understanding that the remaining concerns and proposed changes we have outlined below will not be addressed by the amendments. Since we cannot offer a full opinion until we see the finalized amendments being discussed, we are weighing in informationally at this time.

Our number one concern is the absence of funding in the bill for the critical MOPD attorney, staff, and experts necessary to implement this bill. MOPD has submitted a separate testimony to further explain the budget and resource concerns for our agency.

Assisted Outpatient Treatment Provisions

First, it is MOPD's understanding that the committee will be including a voluntary option in the bill, which is not currently reflected but will match voluntary language added from the workgroup last year. We are extremely supportive of this amendment. Forced medication can undermine the therapeutic relationship between clients and providers causing individuals to distrust their providers and avoid treatment in the future. And, studies show that compulsory community treatment does not reduce readmission or length of inpatient hospital stays nor increase the likelihood of better service use, social functioning, mental state or quality of life.[1]

[1] Compulsory Community Treatment to Reduce Readmission to Hospital and Increase Engagement with Community Care in People with Mental Illness; Community Treatment Orders for Patients with Psychosis (OCTET): A Randomized Controlled Trial.

I. Senate Bill 453 does not currently require assessment of or provision for access to services.

Access to services is the most efficient and effective way to ensure individuals with mental health concerns have improved outcomes. Thus, MOPD would like to see provisions in the bill that start planning for rural or underserved areas to get access to necessary services. We know that vulnerable clients frequently struggle to get to appointments and afford get their medications. Lack of services is why people end up in the hospital, and a court order will not change that. Studies show that in communities with well-coordinated mental health services the imposition of compulsory supervision does not reduce the rate of readmission of psychotic patients.[2] Accordingly, if Maryland chooses to implement an AOT program, it should also ensure that there are congruent assessments of availability of community services.

Notably, the World Health Organization published a report in 2022 regarding guidelines for mental health treatment that includes a discussion of the harms associated with forced mental health treatment.[3] The report expressly promotes supported decision-making over substitute decision-making (*i.e.*, forced treatment) as an evidence-based practice that allows the individual to receive mental health support without employing coercive practices. Marylanders would undoubtedly benefit from this progressive approach to mental health care.

II. Senate Bill 453 has a too narrow definition of "treatment plan."

We know that crisis services, licensed professional services, and peer support are critical for the success of individuals managing their mental illness in the community. Johns Hopkins Medicine has seen improvement in compliance with treatment for individuals diagnosed with Schizophrenia and related conditions through their text message program.[4] MOPD has also seen improved outcomes through our own grant-funded peer support services for justice involved clients with a substance use disorder and parents at risk of losing their children. Since AOT is focused on long-term mental health management for individuals in the community, we believe the specific articulation of crisis support and licensed professional services, along with peer support should be ensured in the bill.

To ensure such services, MOPD suggests numerous additions to and one subtraction from the definition of a "Treatment Plan" outlined in Senate Bill on pages 6-7. Suggested language for including in definition of "Treatment plan" is bolded and underlined:

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[2] https://pubmed.ncbi.nlm.nih.gov/23537605/; https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(15)00231-X/fulltext; https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(18)30382-1/fulltext; https://pubmed.ncbi.nlm.nih.gov/28303578/

[3] World mental health report: Transforming mental health for all. Geneva: World Health Organization; 2022. https://www.who.int/publications/i/item/9789240049338

[4] https://clinicalconnection.hopkinsmedicine.org/news/text-message-intervention-may-prevent-relapse-in-patients-with-schizophrenia

(2) Includes, at a minimum:

(I) Services of a treating psychiatrist;

(II) Services of a licensed social worker or licensed professional counselor;

(III) Community-based 24/7 crisis support services;

(V) Case management or Assertive Community Treatment services; and

(IV~~) [If resources permit]~~ Services of a certified peer recovery specialist;

(VI) **Services of a substance use disorder specialist as needed.**

III. Senate Bill 453 does not sufficiently protect respondent's rights.

Civil jury trial rights and enumerated rules of civil procedure to protect the respondent are not adequately protected in the bill. The right to refuse mental health treatment is well-established in the U.S. Constitution and by both the Supreme Court of the United States and the Supreme Court of Maryland.[5] Currently, the only exception to this fundamental right is extremely limited and narrowly tailored to preserve an individual's right to bodily integrity: psychiatric treatment may be involuntarily administered only if an individual with a mental illness presents a danger to themselves or others.

Senate Bill 453 and the Assisted Outpatient Treatment program introduces a far broader exception to this fundamental right by authorizing any individual living in the community with a history of a "lack of compliance with treatment" to be required to appear in court to determine if the individual should be forced into mental health treatment. Health General Article § 10-6A-03 allows for any adult "who has a legitimate interest in the welfare of the respondent" to submit such a petition for forced treatment. That petition begins the AOT legal process at the end of which the respondent may be ordered into forced outpatient care, potentially including an order to take medication that the individual does not want to take. Allowing *any interested party* to file such a petition may open the process to opportunities for malicious filings, a practice that is regular under the current context of involuntary inpatient commitment and most common in situations involving domestic violence, divorce and custody proceedings, and control over familial assets. Thus, we must ensure that all the protections available in a civil proceeding apply to individuals being petitioned.

Even among well-meaning individuals, there is a grave possibility that forced treatment will be sought due to the petitioner's discomfort with the respondent's lawful choices rather than for a legitimate safety need. The law requires that such an intrusion on fundamental rights happen only with counsel and due process protections.[6] Effective assistance of counsel in

[5] See, e.g., U.S. Const. Amends. 5, 14; O'Connor v. Donaldson, 422 U.S. 563 (1975); Addington v. Texas, 441 U.S. 418 (1979); Vitek v. Jones, 445 U.S. 480 (1985); Mercer v. Thomas Finan Center, 476 Md. 652 (2021).

[6] See e.g., Cirincione v. State, 119 Md.App. 471(1998) "We have long recognized that the right to counsel entitles individuals to more than the mere presence of someone who happens to possess a law degree. The right to counsel is the right to effective assistance of counsel, the benchmark of which is whether counsel's advocacy was sufficient to maintain confidence that the adversarial process was capable of producing a just result." Coles v Peyton, 389 F.2d 224 (1968) The Fourth Circuit Court of Appeals held that "Counsel for an indigent defendant should be appointed promptly. Counsel should be afforded a reasonable opportunity to prepare to defend an accused. Counsel must confer with his client without undue delay and as often as necessary, to advise him of his rights and to elicit matters of defense or to ascertain that potential defenses are unavailable. Counsel must conduct appropriate investigations,

hearings pursuant to Senate Bill 453 demands that the attorney obtain and review years of medical and psychiatric treatment records (including criminal records), locate/interview collateral witnesses, and retain expert psychiatrists to evaluate respondents, review said records, and provide expert testimony. Any procedure that may erode the rights of the respondent, whether it be the timeline of the case or the absence of independent experts, would be at odds with the effective representation that must go into the preparation of an AOT case.

It is also important to note that forced outpatient treatment would have the same collateral consequences as involuntary inpatient treatment. Civil commitment statutorily limits individuals from engaging in certain occupations, places restrictions on one's immigration status, potentially impacts driving privileges, can have implications in child custody disputes, restricts an individual's right to own a firearm, and prohibits individuals from serving on a federal jury. In addition to these consequences, individuals must also live with the social stigmatization of mental illness, which can deter individuals from voluntarily seeking out subsequent treatment. Again, when such fundamental liberties and important rights are at risk, the proceedings must clearly afford due process to the respondent.

a) Expediency requirements in Senate Bill 453 erase critical protections.

On page 11, there is a provision applying the rules of civil procedure, yet this articulation of rights is immediately undermined by an exception for "procedures or timeliness." Right now the bill has expediency requirements that may be read to override the civil jury trial rights of the respondent. On page 11 there are expediency requirements that would significantly hinder an individual's ability to prepare a case and demand a jury trial. The expediency requirements on page 11 should be struck. To further protect civil jury rights, the references to the court decision making should be revised to "fact finder."

MOPD understands that there may be circumstances in which a person may need immediate, emergency medical care. Maryland already has the emergency petition process that can be pursued by a court, mental health professional, or law enforcement if a person decompensates to the point that they are a danger to themselves or others. Thus, there does not need to be an expediency requirement that could override the respondent's critical civil discovery and jury trial rights. The expediency provision may create a disparity in the amount of due process a person is afforded. If a respondent is just a little sick and the court accordingly determines that the case does not need to be rushed, they get all of their rights, but if a respondent is very ill, the court may decide to expedite the process, potentially eroding critical procedural protections.

There are numerous ways to ensure a clear codification of a jury trial right for the individuals who face deprivation of their bodily autonomy. One suggestion is modify the references to court decision making to "fact finder." This ensures that judges will not interpret the law to mean that a respondent is not entitled to a jury trial upon request merely because of the reference to the "court" making findings. Respondents in AOT proceedings must be allowed a jury of their peers to adequately evaluate the allegations that infringements on their fundamental right to bodily autonomy.

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both factual and legal, to determine if matters of defense can be developed, and to allow himself enough time for reflection and preparation for trial."

b) Every respondent needs to be entitled to an expert in every case.

Individuals being petitioned for forced outpatient treatment should have access to their own independent experts.

Suggested language:

> **(D) The respondent shall be permitted to have an examination conducted by an independent expert who may testify at trial and shall be provided for by the State if the respondent is indigent**.

AOT cases must be centered around long-term care and sustainable mental illness management. The rights of the respondent to fully investigate, call witnesses, and have their own expert are important due process protections that require an attorney and state funding if the respondent is indigent. Those who are not represented by MOPD are unlikely to be able to hire their own expert, their financial circumstances should not impact their ability to have an adequate, independent evaluation. Respondents in an AOT case must be able to fully evaluate the validity of the petitioner's psychiatrist's opinions and this cannot occur without the ability to retain their own expert. To ensure this right is not compromised by someone's financial status, MOPD suggests the above language.

IV. Senate Bill 453 definition of "serious mental illness" needs additional protections.

It is the understanding of MOPD that there is a forthcoming amendment to ensure the "serious mental illness" definition matches the language that the workgroup included for "serious **and persistent** mental illness" in the last iteration of 2023's House Bill 823. We appreciate that amendment and agree that it is critical for the inclusion of the language from the workgroup last year. However, we further encourage the committee to ensure that substance use is explicitly excluded from the consideration of whether a respondent has a "serious and persistent mental illness." This is necessary for psychiatric care to be effective, and this is consistent with how substance use is addressed in cases of certification for involuntary admission to inpatient units. Ensuring that substance use is not part of the consideration would not exclude individuals with co-occurring mental illness and substance use disorders from being found to have a serious and persistent mental illness. Instead, excluding substance use as a factor in deciding "serious and persistent mental illness" would merely ensure that for individuals to be petitioned for AOT, the primary diagnosis must be a mental illness and not their substance use. Maryland has made great strides in acknowledging the need to destigmatize and effectively treat substance use as a health condition, failing to explicitly exclude substance use in the evaluation for AOT qualifications could result in a conflation of mental health disorders and addiction that may harm patients long term outcomes.

V. Failed compliance with AOT should not be considered for emergency petitions.

Senate Bill 453 on page 14, lines 23-29 should be removed. Currently, the bill language states that an individual's failed compliance may be used as a factor for consideration in involuntary admission. Last year, pursuant to the workgroup's recommendation, the language was changed so that an individual's failure to comply with an AOT order was not permitted to be

subsequently considered when determining whether an emergency petition is warranted.

VI. Senate Bill 453 currently allows for indefinite applications of AOT orders.

MOPD would request that the language in Senate Bill 453 be altered to match the language in House Bill 823 last year that was amended per suggestion by the workgroup:

10–6A–10.

~~(A)~~ **WITHIN 30 DAYS BEFORE THE EXPIRATION OF AN ORDER OF ASSISTED OUTPATIENT TREATMENT,** ~~**A PETITIONER MAY PETITION THE COURT TO ORDER CONTINUED ASSISTED OUTPATIENT TREATMENT FOR A PERIOD NOT TO EXCEED 1 YEAR FROM THE DATE OF THE EXPIRATION OF THE CURRENT ORDER**~~ **THE RESPONDENT'S CARE COORDINATION TEAM SHALL PROVIDE THE RESPONDENT WITH A PLAN FOR CONTINUED TREATMENT, IF CONSIDERED NECESSARY.**

~~(B) IF THE COURT'S DISPOSITION OF THE PETITION FILED UNDER SUBSECTION (A) OF THIS SECTION DOES NOT OCCUR BEFORE THE DATE OF THE EXPIRATION OF THE CURRENT ORDER, THE CURRENT ORDER SHALL REMAIN IN EFFECT UNTIL THE DISPOSITION.~~

~~(C) THE PROCEDURES FOR OBTAINING ANY ORDER UNDER THIS SECTION SHALL BE IN ACCORDANCE WITH THE PROVISIONS OF THIS SUBTITLE.~~

The above language ensures that any plan for continued treatment will only be issued if it is considered necessary.

VII. Senate Bill 453 must include data collection and reporting requirements to ensure transparency, accountability, and equity.

Senate Bill 453 should require reporting of the outcomes of the AOT cases. This data should not only track cases and an individual's subsequent involuntary hospitalizations and readmissions, but also racial disparity data. It has been well-established that Black Marylanders are not only more likely to be subjected to Petitions for Emergency Evaluation, but they are also more likely to be retained at involuntary commitment hearings as compared to their white peers. Senate Bill 453 has the potential to exacerbate this racial disparity among Marylanders. Evidence shows that similar legislation ("Kendra's Law") in New York State has resulted in exactly this – 77% of those who have been forced into outpatient treatment since the introduction of this legislation in New York City are Black and Brown individuals.; This disparate impact has been observed in other states as well.[7] Black individuals are up to four times more likely than whites to receive a schizophrenia diagnosis – even after controlling for all other demographic variables[8]

[7] https://www.nyclu.org/sites/default/files/field_documents/2022-nyclu-onepager-kendraslaw.pdf; https://static.prisonpolicy.org/scans/Kendras_Law_04-07-05.pdf.

[8] Barnes, A., Race, schizophrenia, and admission to state psychiatric hospitals (2004), Administration and Policy in Mental Health, Vol.31, No.3; Barnes, A., Race and Hospital Diagnosis of schizophrenia and mood disorders (2008), Social Work, Volume 53, Num 1.

– and more than twice as likely to be involuntarily committed to state psychiatric hospitals.[9]

Provisions in Senate Bill 453 not related to Assisted Outpatient Treatment

VIII. We must continue to require physician evaluation for Emergency Petitions.

Senate Bill 453 permits Psychiatric Nurse Practitioners to be the first person to evaluate a patient who is confined against their will by Emergency Petitioner. MOPD has serious concerns about the removal of the requirement that a physician be the first to evaluate an individual being confined involuntarily. It is critical that all individuals brought to a hospital for involuntary confinement, under an emergency petition need to be brought to an Emergency Room and seen by a physician that can rule out serious medical conditions like brain tumors, encephalitis, UTI, delirium, and others which can all be deadly if left untreated. Many of these serious conditions may have side effects that can be conflated with serious mental illnesses. The evaluation in the Emergency Room is the first time a respondent is evaluated by a medical professional, so for the individual's safety, it must be a physician who is qualified to rule out other potential illnesses. It is critical that these emergency medical evaluations are conducted by the most highly trained medical personnel to because they are making decisions about a person's health, safety, and liberty. For these reasons, we ask the committee to reject this portion of Senate Bill 453.

VI. Senate Bill 453 removes critical time limits on placement for individuals subject to involuntary admission.

Senate Bill 453 removes the 6-hour rule for admission to an appropriate facility. The 6-hour rule is necessary to ensure that individuals who are being involuntarily admitted will continue to be entitled to an evaluation within 6 hours of their arrival at the emergency facility. Maryland already has the longest wait times in the country. Violation of this rule will not result in an individual in need of treatment being released, in other words an individual cannot be released based solely on the department's failure to provide an evaluation within six hours.

The Maryland Office of the Public Defender thanks the Committee for considering the above information as they work to improve the bill and before they issue a report on Senate Bill 453.

Submitted by: Maryland Office of the Public Defender, Government Relations Division.

[9] Lewis, A., Davis, K., Zhang, N., Admissions of African Americans to state psychiatric hospitals, International Journal of Public Policy (2010). Volume 6, Number 3-4, pp. 219-236; Lawson, W.B., Heplar, H., Holladay,J., Cuffel, B. (1994) Race as a factor in inpatient and outpatient admissions and diagnosis. Hospital and community psychiatricy, 45, 72-74.

HB 576 AOT costs MOPD Informational.docx.pdf
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POSITION ON PROPOSED LEGISLATION

BILL: SB 453 Mental Health - Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment Programs

FROM: Maryland Office of the Public Defender

POSITION: Informational

DATE: 2/20/2024

The Maryland Office of the Public Defender provides this informational testimony to address the significant cost issues related to Senate Bill 453.

SB 453 would authorize involuntary outpatient treatment statewide and require OPD to provide representation. We anticipate that thousands of individuals would require representation. In 2023, our Mental Health Division represented over 9,600 clients in involuntary admission cases. Thousands of those clients, as well as an unknown number of people who are not initially subject to involuntary hospital admission, could be subject to involuntary outpatient treatment under this bill.

As an initial matter, OPD must receive direct appropriations for its role. Whether in a hospital or outpatient, forced treatment is a significant liberty issue that requires resources dedicated to ensuring that this process is not abused, that individual rights remain intact to the greatest extent possible, and that due process is fully afforded to anyone who may be subject to forced medication or other treatment. The General Assembly must invest in protecting the rights of those who may be subject to involuntary services as much as it seeks to invest in providing involuntary services.

A direct appropriation to OPD is also important for both practical and ethical considerations. The Maryland Department of Health (MDH) will be our adversary in resulting litigation. Requiring us to seek funding from MDH and potentially be audited for the use of those funds, will create immediate conflict issues. Moreover, grant funding is not a sustainable way to fund a legislative mandate. Grant funding cannot create permanent positions in our agency and therefore does not allow for the stability and support needed for this initiative to succeed.

Providing effective assistance of counsel will require a substantial effort. Each case requires obtaining years worth of inpatient and outpatient medical records, treatment records, criminal records, jail medical/treatment records, housing provider records, depositions of the opposing expert mental health treatment professionals and fact witnesses, etc. We would also need to interview collateral sources, hire expert psychiatrists and pharmacologists, and engage additional support staff, investigators, social workers, and peer specialists.

As detailed in our submission for the fiscal note, we anticipate that our costs would include 20 attorneys, 7 secretaries, 10 social workers, 10 peer specialists, 5 paralegals, and a mental health treatment professional to train these new staff positions on substantive mental health issues. Each of these positions is necessary to provide the legal representation, administrative support, and expertise to encourage compliance with services and to address the surrounding issues (housing needs, food security, etc.) that may impede success. Beyond these staffing costs, OPD will also incur significant expenses in securing experts needed for resulting litigation. Experts in hospitalization cases are paid $200/hour and are generally retained for a minimum of 10 hours. While we do not know exactly how much time would be needed for experts in outpatient cases, given that there would be voluminous records, we anticipate the expert fees to be comparable. Assuming that there are 300 cases, with 10 hours of labor per case, would result in $600,000 in expert costs. There is the potential for thousands of people to be subject to AOT proceedings, so our 300-case estimate is incredibly low. Ensuring sufficient resources for AOT respondent representation is a key component of ensuring the protection of individual liberty and bodily integrity.

The Department of Legislative Services Fiscal note assumes that OPD attorneys can carry the same number of forced outpatient treatment cases as involuntary civil commitment cases. That assumption is incorrect because the two types of cases are procedurally different. Involuntary civil commitment cases are administrative proceedings and are controlled by the State Administrative Procedure Act. Discovery is limited, pretrial motions are sporadic and there is only one hearing that must be held within 17 days of a client's admission into an inpatient psychiatric unit. There will be significant discovery, motions practice, preparation for trial, and time spent determining the effect of an AOT order on each client's life.

Submitted by: Maryland Office of the Public Defender, Government Relations Division.

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