February 12, 2024

Joseline A. Pena-Melnyk, Chair
Health and Government Operations Committee
Room 241
House Office Building
Annapolis, Maryland 21401

Re: **HB 576 – Mental Health - Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment Programs – OPPOSE**

Dear Chairman Pena-Melnyk 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 HB 576 – 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 a question like, "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** HB 576 – Mental Health - Emergency Evaluation and Involuntary Admission Procedures and Assisted Outpatient Treatment Programs.

Sincerely,

Kelsey McClain