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

Erik 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.

Lauren J. Tenney, PhD, MPhil, MPA, BPS, Psychiatric Survivor[62]
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Others in Opposition to Any Legislation Supporting Involuntary Outpatient Commitment (Developing)

Iden D Campbell McCollum

Erik 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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