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POSITION ON PROPOSED LEGISLATION

**BILL: House Bill 279 - Correctional Services - Medication Review Committee -
Administration of Psychotropic Medication to an Incarcerated Individual**

FROM: Maryland Office of the Public Defender

POSITION: Unfavorable

DATE: Feb 4, 2026

The Maryland Office of the Public Defender respectfully requests that the Committee issue an unfavorable report on House Bill 279 for the following reasons. We want to first thank the Department of Public Safety and Correctional Services (DPSCS) for working with the Office of the Public Defender to attempt to address our concerns. We want individuals who are seriously mentally ill to receive the care that they need and we understand that DPSCS seeks to achieve that goal. We believe, however, that the level of care necessary for this population can only be appropriately met in hospital settings. Although there are ongoing conversations about potential changes to the bill, OPD asks the committee to consider the following testimony in its deliberation and respectfully asks for an unfavorable report.

House Bill 279 seeks to allow the Department of Public Safety and Correctional Services (DPSCS) to forcibly administer psychotropic medications to incarcerated individuals who are housed in a Licensed Mental Health Infirmiry ("LMHI"). One of the primary concerns with this bill is that Licensed Mental Health Infirmaries are not equivalent to hospitals within a correctional institution. Of critical importance are the differences in staffing and regulatory requirements. Licensed hospitals, including mental hospitals, have a licensed physician, such as a psychiatrist, *physically present or on call at all times*. A Licensed Mental Health Infirmiry within a prison has no such requirement. Rather they are required to have a psychiatrist *on call* around the clock. COMAR 10.7.12.09.

House Bill 279 seeks to allow forcible administration of psychotropic medication in Licensed Mental Health Infirmaries in two circumstances:

First, in "emergency situations," defined as situations when the incarcerated individual presents an imminent danger to the life or safety of self or others by order of a "practitioner."

Second, House Bill 279 permits forcible administration of psychotropic medications in "non-emergency situations" if the following seven conditions are met:

1. The person has a mental disorder

2. Is housed on the Licensed Mental Health Infirmiry because their mental disorder makes them unable to be housed within the general population
3. The person is a danger to the life and safety of themselves or others.
4. The person is either unwilling to consent to taking psychotropic medication or unable to consent because of their mental disorder
5. There are no less restrictive treatment interventions, consistent with the welfare and safety of the individual
6. The use of psychotropic medication is the most appropriate treatment for the person's condition.
7. A review committee has determined the medications should be administered over the person's objection.

House Bill 279 creates a process whereby a "medication review committee" shall review the practitioner's recommendation for forcible medication and determine whether administration is appropriate. Currently, the review committee shall consist of the chief psychiatrist for the region where the LMHI is located, another psychiatrist, and a mental health professional who is not a psychiatrist or physician. Recommendations for medications should only be made by medical personnel.

Additionally, the bill provides for the assignment of a lay advisor to assist the incarcerated person with the review committee process, and lays out the processes to be utilized by a review committee.

As to the committee process, House Bill 279 requires the committee to review a report generated by the treating psychiatrist, and to conduct a meeting for the purpose of clinically assessing the person's need for medication. At that meeting the committee is required to consult with the person about their reason for refusing the psychotropic medication and their willingness to accept alternative treatments, including other medications. The committee is also required to consult with treating clinicians responsible for initiating and implementing the proposed treatment plan. The committee is required to allow the incarcerated person to present information and the opportunity to ask questions of the people presenting the information. Lastly, the committee is required to review the consequences of administering the psychotropic medication and the consequences of the incarcerated person's continued refusal.

The committee may approve the forcible administration psychotropic medication if the following criteria are met:

- 1) The medication is prescribed by a "psychiatric provider" for the purpose of treating the person's mental disorder.
"Psychiatric provider" is not defined and therefore is likely not limited to licensed psychiatrists, or even licensed professionals who are otherwise permitted to prescribe medication.

- 2) The administration of medication is a reasonable exercise of professional judgment, and
- 3) Without medication the incarcerated person is at substantial risk of continued self-harm and dangerous behaviors caused by remaining seriously mentally ill with no significant relief in the symptoms that require them to be housed in the Mental Health Infirmery; or would cause the person to be a danger to themselves or others if sent back to the general population; or to relapse into a condition where they are unable to provide for their own essential needs.

The committee must base its decision on the clinical information presented and it must meet privately when rendering its decision. The committee is required to document its consideration of the issues and basis for its decision. That written decision must be provided to the incarcerated person, the lay advisor, and the person's treatment team. If the committee approves forcible administration of medication they must also notify the incarcerated person of the right to request an administrative hearing within 72 hours of receiving the decision, and an appeal of that hearing to the Circuit Court. The committee's authorization to forcibly medicate a person is stayed during that 72 hours; and if a hearing is requested the order is stayed until an ALJ renders a decision. House Bill 279 further lays out a procedure for requesting and conducting administrative hearings before an Administrative Law Judge regarding the committee's decision. The preponderance of evidence standard applies at these de novo hearings. The bill does not provide the right to an attorney. Additionally, an appeal on the record of the ALJ's decision may be heard by a Circuit Court Judge in accordance with the Administrative Procedures Act. It does not provide the right to an attorney.

Finally, House Bill 279 requires the treating practitioner to document any known benefits of taking the medication and the side effects of that medication on the incarcerated person at least once every two weeks.

The Office of the Public Defender has numerous concerns with the bill:

First and foremost, forcibly administering medications is an extreme violation of an individual's body, mind, and humanity. Current constitutional law dictates that in rare and imminently dangerous circumstances an incarcerated individual can only be subject to forcible medication if there is a finding that it is in the best interest of the incarcerated individual. Second, administering medications against a person's will is dangerous, and there is a significant risk of harm and this bill does not sufficiently mitigate those risks. Third, DPSCS has a history of failing to safely or adequately administer basic somatic health care, which often involves less severe side effects than the psychotropic medications discussed in this bill. Fourth, this bill does not adequately protect the constitutional rights of the people being forcibly medicated, and does not comport with existing Maryland Law regarding forcibly medicating hospital patients. Fifth, House Bill 279 permits forcible medication in emergency situations without defining what constitutes an emergency or a requirement that a licensed physician prescribe the medication and in non-emergency situations, which is completely inappropriate. Sixth, other more appropriate, and less dangerous measures could be taken to accomplish the same goals.

Forcibly administering medication is an extreme violation of an individual's body, mind, and humanity.

The act of forcibly medicating a person, even in a hospital setting, requires several people to hold the individual down while a clinician injects the medication, typically in the buttocks or hip. One individual who was forcibly medicated in a hospital described the experience in a YouTube video "My Experience with Forced Medication"¹ as follows:

I was brought to the hospital by police... I was very agitated, being brought by the police, and very scared of being kept in the cinderblock room with the metal bedframe. It was all very jarring and was getting agitated and I upset. I was suicidal at the time and trying to hurt myself. Instead of trying to talk to me and de-escalate, a flood of people came rushing into the room, lifted me up by my limbs, strapped my arms, strapped my legs to the bed so that I couldn't move. I was in a starfish position and I couldn't move. They administered meds by a shot into my buttocks or the side of my thigh. It was horrifically traumatizing. I remember screaming at the top of my lungs to please stop and please untie me and to please not medicate me. I did not want the medication, I did not want to be held against my will. I did not want any of this... What happened was an authoritarian approach to just sedating and medicating someone who is posing a bit of a problem. It happened again when I was in a solitary confinement room. I was getting agitated, I was very scared. What happened next was that 6 huge men slammed the door open, security guards and nurses rushed in and pinned me to the ground, stripped me of all my clothes so that I was completely naked, and again injected me with medication to sedate me. And I think an antipsychotic was administered as well. It was just so dehumanizing and awful."

Forcibly medicating people is dangerous and carries with it significant risk of harm.

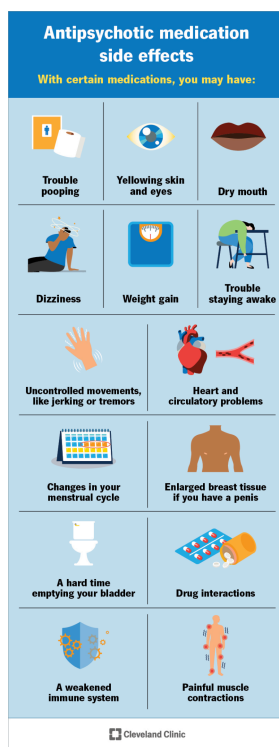
As described above, the very process of forcibly medicating people causes harm. In a prison setting, administering forced medication to incarcerated individuals will require Corrections Officers to physically extract people from cells (likely cells in which the individual is already being held with no bedsheets and no clothing), and restrain them so that medical staff can forcibly inject them. The bill does not specify any guidance on the use of restraints before, during, or after the administration of the refused medication. Notably, House Bill 279 does not prevent use of four point restraints, meaning the individual could be strapped down at each wrist and ankle in a spread eagle position on a gurney. This process itself is inherently dangerous to both the incarcerated individuals and staff. Despite these serious safety concerns, House Bill 279 makes no provision for training requirements for corrections officers in assisting with forcible medication, in fact, the bill does not provide for any safety protocols for the forcible administration of psychotropic medication.

¹ YouTube Video: My Experience with Forced Medication, Lauren Kennedy West: <https://www.youtube.com/watch?v=vejAlrkRue8>

House Bill 279 does not define “licensed practitioner”, or specify who must administer the medication. Further, the bill does mandate the administration take place with a psychiatrist and physician present, which should be required given the severity of the side effects risked by the administration of psychotropic medication. And, to potentially compound this harm, House Bill 279 requires only that the “treating practitioner” document any known benefits and side effects to the incarcerated individual every two weeks.²

The physical administration of the medication is not the only safety concern presented by forced medication. Many psychotropic medications have dangerous side effects that require monitoring by physicians and nurses. A 2024 study found that nearly all of the participants, individuals living with severe and persistent mental illness, experienced at least one side effect of medication and many experienced more than one.³ For example, the Cleveland Clinic lists potential side effects⁴ including: tardive dyskinesia (involuntary movements such as lip smacking, grimacing, frowning, and thrusting or rocking of the pelvis), painful muscle contractions, dizziness and sedation, heart and circulatory problems, high blood sugar, high blood pressure, high cholesterol, immune

disruption, constipation, urinary retention, and weight gain. Some side effects, like tardive dyskinesia may not be reversible only treatable with the use of yet another medication.



For all of these reasons, forcibly administering psychotropic medications, especially to severely unwell individuals, requires oversight and monitoring that can only truly be achieved in hospital settings in order to ensure the safety and well being of all involved. Notably, the Office of Health Care Quality and Disability Rights Maryland conducts on site inspections of hospitals, this bill makes no provision for the oversight needed when forcibly administering medications.

DPSCS historically has a poor track record of administering health care.

There is no indication that DPSCS will be able to provide adequate oversight to ensure the safety and well being of patients being forcibly medicated as contemplated in House Bill 279. The Department of Legislative Audits released a report on its fiscal audit of DPSCS healthcare contracts in November 2024,⁵ and gave a presentation to the Joint Audit and Evaluation Committee regarding this audit as well as the audit of

² A review of other states policies regarding forced psychotropic medication can be found at <https://link.springer.com/article/10.1186/s40352-023-00204-1>.

³ Collins JC, Wheeler AJ, McMillan SS, Hu J, El-Den S, Roennfeldt H, O'Reilly CL. Side Effects of Psychotropic Medications Experienced by a Community Sample of People Living With Severe and Persistent Mental Illness. Health Expect. 2024 Dec. <https://pmc.ncbi.nlm.nih.gov/articles/PMC11632627/pdf/HEX-27-e70122.pdf>.

⁴ <https://my.clevelandclinic.org/health/treatments/24692-antipsychotic-medications>.

⁵ Audit Report. Department of Public Safety and Correctional Services Incarcerated Individual Healthcare Contracts. November 2024. <https://dls.maryland.gov/pubs/prod/NoPblTabPDF/DPSCS-HealthCont24.pdf>.

DPSCS Central Operations in December 2024.⁶ The audit found that DPSCS could not support that staffing levels were sufficient to provide all required services.⁷ What's more, DPSCS expressed concern with the contractors ability to recruit and retain the necessary levels of staff prior to awarding the contracts.⁸ Currently, DPSCS has two LMHI. But there is nothing to prevent or regulate the creation of an LMHI in most DPSCS facilities if not all of its facilities. There is no evidence to suggest that DPSCS either already has medical staff required to do this, or that they will be able to have sufficient staff by July 1, 2026—the bill's effective date. As the Legislative Audit concludes, DPSCS has routinely failed to provide for critical physical and mental health examinations. DPSCS “did not follow up with the mental health contractor to ensure that missing screenings and incomplete physical exams were completed.”⁹ The Audit found that in just three months, DPSCS's mental health contractor failed to evaluate an incarcerated individual for suicide risk 548 times. In the same three months, the contractor failed to examine an incarcerated individual's mental health 682 times.¹⁰ Accordingly, the Audit concluded that DPSCS consistently failed to provide adequate oversight for the evaluation of clients' physical and mental health. The Department's failure to ensure routine evaluations and examinations indicates that the Department cannot adequately provide treatment as complex and precarious as managing and forcibly administering psychotropic medication.

DPSCS has taken remedial measures in light of the problems described in the November 2024 Audit by negotiating a new contract with a different provider. But there has been a new audit conducted of this contract. The relatively new Office of the Correctional Ombudsman is also tasked with ensuring safety and accountability in Correctional Facilities. However as a relatively new office they have filed relatively few reports and none address the facilities with Mental Health Infirmaries.

In short, DPSCS has an insufficient ability to monitor patients' side effects, adverse reactions, or the risk of long term and permanent damage from psychotropic medications.

House Bill 279 does not adequately protect the constitutional rights of the people being forcibly medicated, and does not comport with existing Maryland Law regarding forcibly medicating hospital patients.

Contradictions with other Maryland Law

In the analogous Health General statute (HG § 10-708), which provides the process for administering involuntary medication in hospitals, the panel must “[a]ssist the individual and the treating physician to arrive at a mutually agreeable treatment plan” before determining whether

⁶ Department of Legislative Services, Office of Legislative Audits. Presentation to Joint Audit and Evaluation Committee. December 10, 2024. All reports and a pdf of the presentation and meeting video can be found : <https://www.ola.state.md.us/Search/Report?keyword=&agencyId=&dateFrom=&dateTo=>

⁷ *Id.*

⁸ *Id.* at page 11.

⁹ *Id.* at 12;16.

¹⁰ *Id.* at 17.

to approve the forcible administration of medication. House Bill 279, under subsection (J), includes no such requirement to support a collaborative relationship between the incarcerated individual and their doctor; this intimates a preference for compelled medication. House Bill 279 fails to provide the level of transparency seen in HG § 10-708. For instance, House Bill 279 requires the committee to make a decision in private; per HG 10-708, the decision *may* be made privately, but could also be made in the presence of the patient. Critically, House Bill 279 allows a committee to compel medication where alternative treatments are available and acceptable to both parties, where HG §10-708(h)(3) would not.

Right to Counsel

All people, including those who are incarcerated, have a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs under the Due Process Clause of the Fourteenth amendment, and Maryland Declaration of Rights.¹¹ This includes the right to meaningful hearings, an appeal and the right to counsel. For hospital patients being involuntarily medicated, Health General Article §10-708 details the legal standards appellate procedures for involuntary administration of medication. Regarding the right to counsel, House Bill 279 acknowledges that an incarcerated individual has the right to request assistance from a lay advisor and to be advised of their identity. This lay advisor appears to owe no fiduciary duty to the individual facing forced medication. Further, there are no guidelines on the lay advisor's connection with DPSCS or the incarcerated individual. In contrast, Health General §10-708(v)(1) not only acknowledges this right but also requires the hospital to inform the patient of the name and contact information for the lay advisor. Incarcerated people have limited access to contact with people outside of the prison to ask for help. Being given a name without a means of contacting the advisor is tantamount to blocking that assistance. Further, while House Bill 279 does require that individuals be advised of their right to request an administrative hearing to appeal a committee decision, it makes no provision for supplying people with counsel at administrative hearings. By contrast Health General §10-708(i)(4)(2) requires notice of the right to an appeal to be given, and also requires them to be advised of the right to an attorney and given the contact information of the designated State protection and advocacy agency and the Lawyer Referral Service.

In similar hospital situations Legal Aid and private attorneys have contracts to provide counsel at these hearings. The Office of the Public Defender has no information about the cost of these contracts. Currently, given that forced medication hearings could apply to incarcerated individuals in three different facilities with LMHI, if OPD were required to represent people in these hearings, this would require OPD to have two attorneys assigned to these hearings, depending on the number and frequency. In addition to attorneys, OPD would need support staff and potentially to consult with experienced psychiatrists regarding the medical necessity of the proposed medication.

¹¹ Washington v. Harper, 494 U.S. 210 (1990); Williams v. Wilzack, 319 Md. 485 (1990).

House Bill 279 permits forcible medication in emergency situations without defining what constitutes an emergency or a requirement that a licensed physician prescribe the medication.

As noted above, this bill seeks to enable LMHI within DPSCS to forcibly administer psychotropic medication without “in an emergency, on order of a practitioner, when the incarcerated individual presents an imminent danger to the life or safety of self or others.” House Bill 279, page 2, Lines 14-20. Notably the bill fails to define “practitioner.” This is inconsistent with other Maryland laws that require emergency medication to be ordered by a physician. It is unclear whether the term “practitioner” includes only medical professionals permitted to prescribe medications (physicians, nurse practitioners, and some physician assistants) or whether the term encompasses people who are not authorized to prescribe medications.

Further, the term emergency is not clearly defined by the statute. In correctional facilities a wider array of behaviors are considered infractions and could be considered “safety” issues when they would not be considered as such in either the community or in hospital settings. For example, in a DPSCS facility it is conceivable that someone disagreeing with or talking back to guards would be considered an emergency that presents an imminent danger to the safety of others.

The goals of this bill can and should be effectuated more safely and appropriately by other means.

Incarcerated individuals with serious mental illness would be much better served by receiving the treatment they need in order to become psychiatrically stable in hospitals rather than in prisons. Health General § 10-614(b) specifically contemplates involuntary admission to facilities from the Division of Corrections but limits involuntary admission to apply to situations where the Behavioral Health Administration agrees to pay the expenses.

It provides:

(a) Except as provided in subsection (b) of this section, application for involuntary admission of an individual to a facility or Veterans' Administration hospital may be made under this part by any person who has a legitimate interest in the welfare of the individual.

(b) If the Administration agrees to pay the appropriate expenses, application for involuntary admission to a facility of an incarcerated individual in an institution under the Division of Correction or the Patuxent Institution may be made under this part by the Division or the Patuxent Institution.

By striking “if the Administration agrees to pay the appropriate expenses” from subsection (b) it would be clear DPSCS can make an application for involuntary admission to a hospital with or without BHA’s agreement to pay the expenses for hospitalization. Budgetary concerns over the difference in costs to house individuals in prisons as compared to state hospitals could be allayed by allowing BHA to request reimbursement for those costs at a set per diem rate.

Regulations facilitating this already exist. COMAR 12.02.09.03 details how inmates are to be transported to and from psychiatric hospitals, and Correctional Services 11-509 addresses the application of diminution credits for periods of time when people are hospitalized.

For serious medical issues such as those contemplated by the bill, a hospital setting must be the only place that administration of psychotropic medications can safely and justly occur.

For these reasons, the Maryland Office of the Public Defender urges this Committee to issue an unfavorable report on House Bill 279.

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