Commission to Study Mental & Behavioral Health

Written Testimony – November 9th, 2021

Testimony Before the Commission to Study Mental & Behavioral Health
Submitted by: Donald Reed
Representing: Self
Tuesday, November 9, 2021

My name is Donald Reed. I am here to state my support for the three recommendations proposed by the Involuntary Commitment Stakeholder Workgroup, to suggest that additions be made to these recommendations, and to encourage the Commission to Study Mental and Behavioral Health to define a commitment process that ensures the full participation of family members who are caregivers for persons living with mental illness.

I am a resident of Montgomery County and the parent of an adult son living with mental illness. I have been a volunteer with the National Alliance on Mental Illness (NAMI) for the past 15 years. As a NAMI volunteer, I have taught a 12-week course called Family to Family, which has provided me an opportunity to spend 40 hours with approximately 400 family members who were and are caring for a loved one living with serious mental illness. My testimony is informed by the experiences those 400 class members.

During my son's first psychotic episode, under the guidance of inner "voices," he attempted to take his life. He had no prior history of violence. He provided us no warning of what he planned to do. My wife and I certainly did not receive the 24 or 48 hours notice that would have allowed us to fill out a Petition for Emergency Evaluation and to submit it for the Court's approval.

When, a few years later, he became psychotic once more, this history compelled our vigilance. But, upon contact with authority figures, our son always "pulled himself together." After several failed attempts to have him hospitalized, we completed a Petition for Emergency Evaluation, submitted it to the District Court, and spent a full day waiting for our case to be heard.

Our family was lucky that day. An experienced and sympathetic judge led me through a litany of questions. At first, I was puzzled. Later, I realized that he sought to elicit some response that would allow him to grant our petition under the language of the law. At some point, he said "That's it. That's all I need." I wept with relief.

But, after having our petition certified by the Court, other hurdles remained. We sat for hours in the ER and begged to have someone listen to and consider our son's recent history. Eventually, a part-time staff psychologist gave us a hearing, verified our assertions, and authorized an emergency evaluation. When our son was admitted to the only psychiatric hospital in the county that accepted involuntary admissions, we fought to have him retained there long enough to find effective treatment.

That final step is often the most dispiriting. Many of my Family to Family class members report that their hospitalized family members are released after 48 or 72 hours, when hospital staff report that they are no longer psychotic - despite having received no treatment or having received treatment of insufficient duration to allow medications to take effect. While, in limited circumstances, Maryland permits "medication over objection," it has been my experience and the experience of many class members that this almost never occurs in Montgomery County and surrounding jurisdictions. This points to a piece that seems to be missing from the considerations of the Involuntary Commitment Working Group: Why provide access to involuntary commitment if the patient will receive no treatment?

Over the past 15 years, my wife and I have heard our own experiences echoed and amplified in the stories told by 50 or more Family to Family class members.

Family caregivers need: (1) involuntary commitment regulations that allow our ill family members to be hospitalized *before* they become a danger to themselves and others; (2) a process that ensures they are not released without having received effective treatment; and (3) to be offered a place at the table, at every step in the process, which can occur within current HIPAA regulations, in order to share our unique and highly-relevant knowledge of our family member's mental health history and current situation.

The three streps proposed by the Workgroup - (1) refine the definition of dangerousness in regulations, (2) provide comprehensive training around the dangerousness standard, and (3) gather additional data about civil commitment - are a small step in the right direction. They offer some hope to family members who need the State's help to obtain treatment for their loved ones living with mental illness. But each needs to be taken a little further.

Concerning the revisions to dangerousness regulations: The third element of the Workgroup's revised definition of dangerousness, item (3)(iii), will be the most helpful to families. Any language that makes it possible for our ill family members to receive treatment *before* they become a danger to themselves and others is a welcome revision to the current regulations. Family members are the draft regulation's unnamed "others" who must - often without being able to obtain treatment for their loved ones - meet their needs for "nourishment, medical care, shelter or self-protection and safety." I suggest that subpoint (iii) be slightly modified to read "a substantial risk for **homelessness**, bodily harm, serious illness, or death." Families would also welcome a fourth element, such as that proposed by NAMI Maryland, that addresses the deterioration in judgment that attends psychosis. Persons in psychosis may experience serious consequences beyond physical harm. The Commission to Study Mental and Behavioral Health heard oral testimony at their November 9, 2021, meeting that made this very concrete. A witness living with mental illness spoke of what was lost when she was unable to be hospitalized during psychosis. Freedom, in her case, was the freedom to lose her job, life savings, and custody of her child.

Concerning data collection and monitoring activities: The proposed augmentation of current data collection practices is needed. Lacking the necessary data, it is not possible to determine the efficacy of the current regulations. Some earlier commenters on the Workgroup's proposed regulations asserted that the current regulations are largely effective. I assure you that this is **not** what my Family to Family class members report. The proposed new data collection categories - for example, the counts of emergency petitions granted and resulting in hospitalization - will begin to provide the data needed to assess the efficacy of the regulations. It is essential to track additional outcomes. For example: How many people, certified for hospitalization, are released at the hospital's discretion prior to a hearing with an administrative law judge? How many refuse treatment? How many are released without treatment? Ultimate outcomes are more difficult/costly to measure but would be helpful to know: How often do individuals, especially those who do not receive treatment, return to be re-hospitalized, enter the criminal justice system, suffer serious health impairment, or die?

Concerning training: The proposed training expansions should prove valuable. I suggest that family caregivers - along with persons living with mental illness - need to play a role in the training of those whose technical skills make them part of the commitment process but who lack experience living daily with the effects of mental illness. How can public defenders and administrative law judges and even health care professionals assess the "proper balance between the patient's rights and public safety considerations" when they have no experience in living with and assuming responsibility for persons diagnosed with serious mental illness? When they have no knowledge of the patient's history? Legal and health care professionals need to walk a mile in the family's shoes in order to make better-informed decisions and to fully comprehend the effects of those decisions.

The Workgroup's report states that it is the role of Administrative Law Judges and defense counsel "to ensure that there is a proper balance between the patient's rights and public safety considerations." But the patient's rights and public safety are, in fact, balanced on the backs of family caregivers. We remain responsible for our ill family members until they are able to be responsible for themselves. We expend our time, our financial resources, and our health in negotiating this balance each and every day. We could use a little help.

Thank you for taking a small step in the right direction. Thank you for the opportunity to offer my personal testimony.

Comments on the Involuntary Commitment Stakeholders' Workgroup Report of Aug. 11, 2021

My name is Mary Ellen Moran. My son has schizophrenia and I have bipolar disorder. I strongly support inclusion of a psychiatric deterioration standard which would clearly include psychosis in the Maryland "danger standard" for evaluation and involuntary hospital admission. I also support clarifying that the "danger" need not be "current", but that there is "a substantial likelihood of danger in the near future."

The Behavioral Health Administration's (BHA) proposed standard rejects psychiatric deterioration and psychosis as an "element of danger." It also requires an individual to have deteriorated to the point of already being unable to care for themselves.

I am greatly concerned that according to BHA's definition of the "danger standard" I would not be considered in need of involuntary evaluation and hospital commitment and receive the prompt lifesaving involuntary treatment that I received when I started exhibiting the symptoms of psychosis while visiting my sister in Virginia.

The statutory danger standard in Virginia includes the following:
"there exists a *substantial likelihood* that, as a result of mental illness, the **person *will, in the near future,*** ...(b) suffer serious harm due to his *lack of capacity* to protect himself from harm or to provide for his basic human needs." (Emphasis added).

Maryland's proposed standard, on the other hand, requires behavior that already shows the person is "unable" to care for themselves, not "in the near future" based on "lack of capacity". In other words, I would be allowed to deteriorate until the psychosis worsened to the point where I was already unable to care for myself.

If I were to again start exhibiting signs of psychosis, I want treatment as soon as possible, even involuntary treatment, if at the time I am unable to understand my need for treatment. Having psychosis can be an extremely traumatizing experience, causes brain deterioration, and often terrible social repercussions. **For me this would include the inability to care for my son. Like a stroke or heart attack psychosis needs immediate treatment.**

For these reasons, I strongly support inclusion of a psychiatric deterioration standard which clearly include psychosis in the Maryland "danger standard" for evaluation and involuntary hospital admission. I also support clarifying that the "danger" need not be "current", but that there is "a reasonable expectation of danger in the near future."

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Testimony to the Commission on Mental and Behavioral Health in Maryland 11/9/21

The Final Involuntary Commitment Stakeholders' Workgroup Report dated Sept. 11, 2021, does **not** propose a definition to the danger standard for involuntary hospital treatment that removes the barrier to care for many of those with severe mental illness who as a result of their illness lack insight into their need for treatment.

1. **IMMINENT DANAGER**: The Commission identified the common interpretation of the present danger standard as requiring immediacy as a barrier to care for those with serious mental illness. Unfortunately, the definition of the danger standard proposed by the Behavioral Health Administration (BHA) does not make clear that the danger need not be immediate or imminent. Their language, if anything, on Page 9, makes the interpretation more restrictive by requiring "current" danger: "must be *recent* and relevant to the danger which the individual may *currently* present" (emphasis added). Recently at a meeting of about 10 Maryland psychiatrists, when asked if this definition made clear that the danger need not be imminent, the only answer was NO.

Contrary to what BHA claims on Page 11 of the Report, the BHA proposed danger definition is NOT at all well aligned with SAMHSA's Best Practice Elements. The specific SAMHSA guideline which addresses a definition of the danger standard was presented to the stakeholders at the first meeting, was never referenced again, and is completely omitted from BHA's final report. If SAMHSA's danger standard guideline had been included in the report, it would be clear that the proposed Maryland definition does NOT meet the SAMAHSA Best Practice Elements. The SAMHSA danger definition makes perfectly clear that the danger need not be "imminent" or "current" by using the following words: "the individual *will* be at significant risk *in the foreseeable future*". (Emphasis added).

The SAMHSA Best Practice Elements relating to the Danger Standard definition is as follows:
"*Without commitment*, and as a result of the serious mental illness diagnosed, the individual *will be at significant risk, in the foreseeable future,* of behaving in a way actively or passively (i.e., by acts or omissions) *that brings harm* to the person or others; harm to the person may include injury, illness, death, or other major loss due to an inability to exercise self-control, judgment, and discretion in the conduct of his or her daily activities, or to satisfy his or her need for nourishment, personal or medical care, shelter, or self-protection and safety." (Emphasis added).

It is clear from the comment on Page 10 of the BHA report that any training BHA designs, would not support SAMHSA's best practice elements. BHA states: "The issue of whether the criteria for involuntary commitment have been met, in order to detain someone against their will, should be based on *current and acute issues* present for a specific individual, *not as SAMHSA suggests that the lack of immediate treatment may lead to future harm or treatment resistance. SAMHSA guidelines say just the opposite: "Without commitment...the individual will be at significant risk in the foreseeable future of behaving in a way...that brings harm...". (Emphasis added)*

BHA clearly still accepts that imminent or immediate danger should still be a requirement, and we fear that will be in any training they promote unless the proposed standard clearly indicates otherwise. On page 10, they repeatedly make the case that a psychiatric deterioration standard should not be included partly because they say psychosis does not have "an element of ***immediate*** danger." (Emphasis added) (Note: the advocates of psychiatric deterioration actually claimed that untreated psychosis causes current and ongoing brain damage, but BHA still did not consider that "immediate" danger.)

2. ***PSYCHIATRIC DETERIORATION*** *(also known as Need for Treatment).* **Clarification needed that harm to self includes psychiatric deterioration.**

SAMHSA recommends a definition that states "harm to the person may include…other major loss due to an inability to exercise self-control, judgment, and discretion in the conduct of his or her daily activities…" This recommendation recognizes psychiatric deterioration and psychosis.

The BHA Proposed Definition in section (C)(iii) still totally ignores this SAMHSA recommendation. It states: (iii) The individual has behaved in a manner that indicates he or she is unable, without supervision and the assistance of others, to meet his or her need for nourishment, medical care, shelter or self-protection and safety such as to create a substantial risk for bodily harm, serious illness, or death.

Normally, one might assume that medical care includes psychiatric care, that bodily harm includes harm to the brain and illness includes psychiatric illness. However, it is clear from BHA's comment on Page 10 of their report that BHA interprets "medical care" as only somatic medical care. They state: "Somatic medical care was specifically spelled out, because even though the refusal of somatic care can create a danger to self, it can still be overlooked because danger to self is usually narrowly viewed only in the context of suicide." They also state on Page 10: "As such, psychiatric deterioration language … are not recommended for inclusion in the revision of the dangerousness standard." One can only assume that they will design training accordingly.

SAMHSA also recognizes, as Joanne Connors testified, that besides physical harm, significant losses can occur when one becomes psychotic, including loss of one's job, insurance, life-time savings, child custody. Therefore, SAMHSA recommends that harms include "other major loss". BHA does not include this in its danger standard definition.

By rejecting inclusion of a psychiatric deterioration standard, BHA is choosing to ignore current scientific knowledge. Extensive research has shown and SAMSHA has acknowledged that psychosis itself causes ongoing damage to the brain.[1] It results in loss of gray and white matter.[2] In addition, the length of time of untreated psychosis is correlated with poorer treatment response and worse social, emotional, and occupational outcomes.[3] Also, as Dr. Buchanan, Director of the Maryland Psychiatric Research Center and the Maryland Early Intervention Program testified to the Commission, "increased DUP [Duration of untreated psychosis] is also associated with increased risk of suicide and violence".

Psychosis needs to be treated like the medical emergency that it is. and treatment provided promptly. Inclusion of psychiatric deterioration language is essential if we want to be able to provide treatment early enough to prevent the tragedies of brain damage, violence, suicide, homelessness, and incarceration. Not just scores of families but individuals with serious mental illness have testified that they want early treatment when they are unable to recognize the need, in order to prevent the tragic consequences of non-treatment.

By ignoring scientific knowledge, BHA is in effect denying treatment to many whose only symptom is psychosis, thereby callously ignoring the consequences of non-treatment: brain damage, diminished chance of recovery, homelessness, increased risk or suicide and violence in the community and incarceration, which is the ultimate depravation of liberty. BHA is ignoring their legal obligation to make treatment available to all of those with mental illness, not just those with insight who agree to voluntary treatment. They are not willing to make decisions based on the science and take the political heat from opposition groups. Therefore, after saying the danger standard should be defined in Regulation and having almost a year to solicit opinions from all interested groups, they are now saying that the psychiatric deterioration standard part of the standard should be decided by the legislature. It makes no sense to have part of the definition in Regulation and part in Statute, so if they want the legislature involved, they should let the legislature decide the entire danger standard definition, without the Department opposing inclusion of a psychiatric deterioration standard.

3. **Comments on BHA's other reasons for not including psychiatric deterioration in the danger standard. None are valid concerns.**

A. Supreme Court's Olmstead ruling. Right to live in the least restrictive setting this is appropriate. This is totally irrelevant to the issue of a psychiatric deterioration standard as part of the danger definition. As BHA pointed out on Page 9, under Health Gen. 10-617, an individual must meet ALL 5 criteria for involuntary commitment with the danger standard being one of the five. Two of the other criteria prohibit involuntary commitment if there is a less restrictive setting that is appropriate. They are (2) The individual need inpatient care or treatment, and (5) There is no available less restrictive form of intervention that is consistent with the welfare and safety of the individual. These two criteria assure that there is no constitutional issue regarding Olmstead.

B. Supreme Court's O'Connor vs Donaldson. "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" The report points out on Page 10, that the Court declined to address what "more" would be required to render confinement constitution, however this ignores what Mr. Brian Stettin, an attorney from the Treatment Advocacy Center, pointed out in his previous comments "Justice Stewart's explicit clarification in the O'Connor opinion that **"[T]here is no reason now to decide ... whether the State may compulsorily confine a non-dangerous, mentally ill individual for the purpose of treatment."** This statement and the whole context of the case clarify that "more" refers to treatment. Thus, the O'Connor vs Donaldson case has nothing to do with confining a mentally ill individual for the purpose of treatment and should not be of any constitutional concern.

C. Other concerns raised include that involuntary commitment may not be the most effective method to work with this population. This statement is vague, makes little sense and is totally unsupported. One of the five hospital commitment criteria is that the individual needs inpatient care or treatment. As far as I know there are only two forms of inpatient admission: voluntary and involuntary. One of the other five requirements for involuntary admission is "The individual is unable or unwilling to be admitted voluntarily". If that requirement is also met, no other method remains except involuntary hospital admission.

D. "Other concerns raised include that involuntary admission of non-dangerous individuals would put significant strain on the psychiatric hospital system. " First of all, no one suggests that non-dangerous individuals be admitted involuntarily. The psychiatric deterioration standard would admit only those who are dangerous to self, such as those with psychosis, which is a danger to self because it destroys brain cells, worsens functioning, and greatly increases the risk of suicide. Furthermore, BHA has shown no evidence to support this concern from the 24 states that have a psychiatric deterioration standard. However extensive research has shown that early intervention increases the chance of stabilization with shorter hospital stays, which should decrease hospital admissions, and reduce the strain on hospitals and jails and prisons as well.

4. **Consideration of individual's current condition and if available, personal, medical, and psychiatric history".** It is vitally important that the danger standard clearly indicate that those making danger determinations not be limited in the information they can consider. Both violence to others and self and non-adherence to medication are high risk factors and should not be ignored. According to Dr. Thomas Insel, past NIMH Director, "There is an association between untreated psychosis and violence, especially…towards family and friends. [There is] a fifteen-fold reduction in the risk of homicide…with treatment". Currently families and clinicians are sometimes told by judges that personal and medical history (including psychiatric history) cannot be considered when determining if an individual meets the danger standard. The result is that individuals with the illness suffer the consequences of non-treatment and families must wait in fear of a recurrence of violence or other harm before treatment can be accessed.

5. **Individual & System Consequences of Barrier to Care caused by the Danger Standard**

A. **Individual and Community effects** from denial of Emergency Evaluation or involuntary hospital admission due to the Danger Standard. Please see chart below for detailed consequences described in testimonies of 22 individuals. 40% reported incarceration, 36% reported homelessness, 27% reported violence to others, including 2 sheriffs that were killed, and 12 others that were harmed, 31% reported ill

individual remained psychotic and untreated, 40% reported job loss, 40% reported injury or debilitation of the ill individual. A total of 9 children no longer had 1 parent home due to death or incarceration, 1 individual died of suicide and 2 others attempted suicide.

B. **Consequences to the State Systems**:

1. **Criminalization of those with mental illness**: Partly because of high criminalization and incarceration rate of individuals denied involuntary services (see A above), Maryland local jails and state prisons have about 30-50% of inmates with mental illness. This is often for crimes directly related to their inability to conform to the law because of the symptoms of their illness, such as delusional beliefs. State hospitals are at capacity with court ordered inmates for whom the Health Department is fined if they are not admitted promptly. Therefore, the lowest admission priority goes to convicted inmates in local jails even if their medical acuity is extremely high because there is no fine for their delayed admission. Also, some who become psychotic do not qualify for state hospital admission because the danger standard is not defined to include psychiatric deterioration. Therefore, some with mental illness must be held in restrictive housing for safety reasons. Then they may be released in a more dangerous state to themselves and others than when they entered, making recidivism even more likely. Care of those with mental illness greatly increases jail and prison costs and puts tremendous stress on jail and prison employees who do not have extensive training on dealing with those with mental illness.

2. **Our state hospitals are generally filled to capacity almost entirely with forensic patients**, most of whom are there for longer than they would need to be if treated as a civil patient because of legal and court procedures. Many are there for competency evaluation taking up a bed needed by others for treatment. State hospitals no longer have the capacity to accept involuntary civil patients from emergency departments who cannot be placed in a community hospital within 30 hours as the law requires. They complete ignore the law. State hospitals almost never accept civil patients from community hospitals, who need intermediate or long-term treatment, as they as they formerly did.

3. **Hospital Emergency Departments.** ED's need to board patients because the state hospitals no longer have the capacity to accept involuntary civil patients that are hard to place. (see 2 above.) Especially patients that have a history of violence or complex needs may wait many days or even weeks in the ER, since few community hospitals are willing to take them. These patients are often discharged prematurely without sufficient stabilization and cycle in and out of hospitals, and homelessness or jail and are at high risk of suicide and violence if they remain psychotic.

4. **Community Hospitals**. The current danger standard, according to testimony to the Commission, not infrequently prevents the ability of the hospital to appropriately treat those with psychosis who lack insight into their need for medication. One doctor at Washington Behavioral Health for example recently told a family who had received death threats over the phone from their hospitalized family member that it was not "worth his time to ask for a commitment hearing because the administrative law judges ,would not commit a patient unless the patient had been violent on the unit. Instead, the patient was being discharged while still in a psychotic state on a non-therapeutic dose of medication because he would not voluntarily agree to a therapeutic dose. The family was advised to seek a protective order if they were concerned for their safety. The hospital medical director agreed with the doctor's comments and decision. Statements by the ALJ's like "the patient has a right to be psychotic" would understandably discourage doctors from "wasting their time" with commitment hearings. **This could be corrected by including a psychiatric deterioration standard as part of the danger standard definition.** Because insurance companies are unwilling to pay for non-compliant patients after several days, and they cannot be committed, such patients are released while still psychotic and unstable and often cycle in and out of hospitals. Psychotic individuals often become homeless because housing providers and even shelters are unwilling to accept them because they are not staffed to deal with that level of acuity. Once homeless they frequently break the law and end in the criminal justice system .

5 **Peace Officers**. Because the danger standard is a barrier to care, the police have to spend a large percent of their time dealing with individuals who remain ill for extended periods because the danger standard is a barrier to the hospital care needed to stabilize them. This leads to an increase in arrests, some of which are "mercy arrests" to protect the ill individual who may be unable to conform to societies laws and is at risk of future harm even though the harm may not be "imminent." Individuals with psychosis who are denied involuntary hospital treatment also present a greater risk of harm to the peace officer as well as a greater risk of suicide by cop.

6. **Medicaid. As was described in testimony to this Commission, when individuals with psychosis are not given** appropriate hospital treatment, they may remain psychotic for years, cycling in and out of hospitals, emergency departments, housing providers, crisis centers, and shelters with ACT team or intensive case management, at tremendous cost to Medicaid and little benefit to the individual. For example, one family reported 13 hospitalizations, 18 ED visits, and 7 Crisis Center evaluations over a period of 12 months with much more time in hospitals that out of them. This psychosis lasted so long mainly because the patient refused a therapeutic dose of medication and although psychotic, did not meet the current danger standard because it does not include psychiatric deterioration, so no hospital was successful in getting a commitment to enable medication over objection so that the individual could be stabilized.

In conclusion, all of the above problems would be positively affected, lives would be improved and saved, state costs would reduce if the SAMHSA guidelines were followed and the proposed BHA danger standard were improved by clearly specifying that the danger need not be imminent, by clearly including a psychiatric deterioration standard, and including of a requirement to consider the individual's current condition and person, medical and psychiatric history if available.

NOTES

[1] Gerald Martone. Is psychosis toxic to the brain? Current Psychiatry April 2020 p12-13 https://cdn.mdedge.com/files/s3fs-public/CP01904012.PDF

[2]Andreasen, N. C., Liu, D., Ziebell, S., Vora, A., & Ho, B. C. (2013). Relapse duration, treatment intensity, and brain tissue loss in schizophrenia: A prospective longitudinal MRI study. American Journal of Psychiatry, 170(6), 609–615.

[3]Rubio, J. M., & Correll, C. U. (2017). Duration and relevance of untreated psychiatric disorders, 1: Psychotic disorders. Journal of Clinical Psychiatry, 78(3), 358–359.

Research Weekly Post Aug. 18, 2017. https://www.treatmentadvocacycenter.org/fixing-the-system/features-and-news/3903-first-episode-psychosis-response-to-be-more-aggressive

Amador Z. I Am Not Sick I Don't Need Help. Vida Press. 2012 p32-51

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EMERGENCY PETITION OR HOSPITAL ADMISSION DENIALS FROM DANGER STNADARD

TESTIFIER	LOCATION	WHO DENIED	OUTCOMES of Denial due to Danger Standard
Jennay G	Baltimore City	Judge, MCT	Remains psychotic, Unable to Work
Karen L	Prince Georges	ER-Dr.	**2 sheriffs killed, 30 yr prison sentence**
Barbara B	Montgomery	police	homeless
Bethesda Cares	Montgomery	Police, MCT	2 homeless, hypothermia, aggression
Swaroop R	Montgomery	Police, OP-Dr, MCT, ER-Dr	**Many incarcerations**
Paulette S	Howard	Police, OP-Dr	homeless, Criminalization-IST, reduced med response
Dan B	Anne Arundel	Police, ER-Dr	eye injured
June H	Charles	ER-Dr	**Attempted suicide-cut throat, stabbed heart & lungs, ICU for weeks**
Marilyn M	Montgomery	OP-D, Police, Judge	Attached father, criminal record
Katy S	Charles	Police	Prison
Joanne C	Montgomery	OP-Dr	**Suicide attempts, Jail, lost job, savings, insurance, child custody**
Joe A	St. Mary's	Inpatient Dr.	homeless, wandering in streets
Claire W	Montgomery	Er-Dr	**Suicide**
Janet H	Calvert	ER & inpat Drs	**homeless, Attacked 3 -caused Traumatic Brain Inj, prison**
Edward K	Howard	Police	homeless, poisoned his mother, jail
Amy H	St. Mary's	police	Harmed self, lost job, family, homeless, Jail
Jeanette F	Montgomery	OP-Dr	Catatonic coma, brain damage
Shantelle S	Montgomery	OP-Dr	Untreated diabetes, risk of diabetic coma
Giles K	Montgomery	MCT, Police	Homeless, threatens gov employees
Karen M	Montgomery	OP-Dr	Criminal record, jail-solitary confinement
Susan K	Montgomery	OP-Dr	Injury to others, police involvement
Janet B	Montgomery	OP-Dr	Attacked several people, criminal charges

KEY: OP-Dr. = Outpatient doctor. MCT=Mobile Crisis Team

8 Homeless
9 Jail/Prison
1 Suicide

2 Suicide attempts
6 individuals were violent to others
12 Others harmed
2 Others killed
9 Children without parent (killed or jailed)
9 Multiple Hospitalizations
11 Criminal record
1 Catatonic coma/brain damage
7 Remain psychotic & untreated
9 Lost Job
9 ill individuals injured or debilitated

9 OP-Dr.
6 ER doc
2 Inpatient Dr.
10 Police
2 Judge
3 MCT

HELP in the HOME

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Testimony for Nov. 9, 2021, meeting of the Commission to Study Mental and Behavioral Health in Maryland by Cornelius Kuteesa.on behalf of Help in the Home. LLC.

I am a Care Coordinator for Help in the Home, LLC. Our agency provides support to people with severe and persistent mental illness. Services range from coordinating the care outlined by various treatment providers to daily support with med monitoring, meal prep, household chores etc. We provide support to people who need treatment in order to live a meaningful life that is filled with purpose and dignity.

Because the current danger standard for Involuntary psychiatric evaluation and involuntary hospitalization is often interpreted by police and mental health professionals to mean that a person must present an imminent danger, and psychosis is not considered a danger to self, it allows many to refuse treatment and live a marginal life often in reprehensible conditions defined by isolation, fear, and inability to comprehend that they are ill and in great need of treatment. We have seen people with mental illness suffer tremendously as their families stand by helpless, waiting until their loved one is "dangerous enough" to be hospitalized and praying that irreparable health consequences, violence, death and incarceration can be avoided.

I'd like to share with you the story of one client we had, whom I will call Cassy. She thrived in our supported living community; working and taking college courses. However, after deciding she no longer needed to take her medication, she developed paranoid delusions . However, this did not meet the standard for involuntary hospitalization. She disappeared in the night, without her belongings. Her mother called us to say Cassie was recently found by a trucker on a highway. She was unsure of the month and did not want to go home, or to the hospital. The trucker bought her needed clothes and food but could not convince her to seek help. Cassie's mom told us she felt so helpless. And there was nothing our agency could offer either, but empathy. Her parents said that each day, the best they could hope for was that their daughter was alive, having been sent to jail or a hospital. Cassie's mom said her daughter felt like she was "on a cliff". A cliff indeed, with no safety net.

The danger definition in the final the Mental Hygiene Administration stakeholder report is inadequate to eliminate the current barrier to needed hospital treatment and prevent someone like Cassy from becoming homeless. It still requires that a person decompensate to a point that is almost guaranteed to become a public safety or personal safety catastrophe.

1. The proposed definition specifies that the danger "must be recent" and "current" which could still be interpreted as "imminent". Rather it should indicate that danger is reasonably expected in the foreseeable future.
2. The proposed definition intentionally does not include psychosis as a danger to self, thus condemning those with psychosis to continued brain deterioration, a worsened prognosis and increased

risk of suicide, violence, homelessness, incarceration, and victimization. The definition needs to include substantial inability to meet his or her need for psychiatric care such as to create a substantial risk of serious psychiatric deterioration.

3. Finally, the definition needs to require that personal, medical, and psychiatric history by considered, if available. This will enable those involved to look at the entire experience of the individual, not just the current moment as is done now.

The above changes would allow providers like us to help those who are refusing treatment before there are tragic consequences. We urge the commission to recommend these changes to the Governor.

Comments to the Commission to Study Mental and Behavioral Health in Maryland 11-9-21
Subject: The final Involuntary Commitment Stakeholders Workgroup Report of 9-11-21 and the criminalization of those with Serious Mental Illness

My name is Patricia Sollock, and the purpose of this communication is to comment on the Final Involuntary Commitment Stakeholders Workgroup Report of 9-11-2021 that I understand will be reviewed by the Commission to Study Mental and Behavioral Health in Maryland. **Based on my experience, the proposed danger standard language is not adequate to prevent the barrier to hospital treatment that is a major driver of those with untreated mental illness into the criminal justice system.**

I have lived and worked in Maryland for 41 years and practiced as a licensed mental health provider and MH Director of two detention facilities, certified by the National Commission on Correctional Health Care, with an average daily population of approximately 700-750 inmates. Additionally, I have been a consultant and trainer nationwide for various Corrections facilities, as well as provided consultation and training for the National institute of Corrections, Federal Parole and Probation, and Federal Judicial Center. I have participated in Mental Health Commissions and presented on mental health topics at national conferences. I have numerous times testified on the irreversible negative impact that incarceration has on mentally ill persons, their families, and the community, and I have tirelessly advocated for humane treatment in professional settings, not jails. Throughout my years I have witnessed the pervasive criminalization of mental illness and use of jails as de-facto hospitals for this population. As an out-of-state consultant, I have learned about other mental health systems and became aware of Maryland's low ranking in facilitating commitment for individuals in the process of psychotic decompensation. Despite my experience and insights about the challenges that caretakers and providers face to prevent the incarceration of patients with mental illness, I submit these comments on my behalf and not on behalf of any institution or organization that I am or have been affiliated with.

Outpatient and correctional mental health providers, as well as community first responders, or caretakers, all relay frustration about their hands being tied when trying to access treatment and prevent negative outcome for persons psychiatrically decompensating in the community. The current "danger standard" is a barrier to needed hospital treatment and once incarcerated and sentenced, patients are no longer eligible for Court ordered evaluations. Those who refuse treatment continue to deteriorate and create major management problems for Administrators, Correctional Officers and providers and because jails are not hospitals, restrictive housing is oftentimes the only way to ensure their safety and that of others.

Even if two mental health providers file certifications for hospitalization, this is the population that MDH has categorized as last priority for admission regardless of degree of impairment. This is because there are fines attached to delayed Court ordered evaluations while there are no penalties for not honoring physicians' certifications. This creates a terrible situation where hospital admissions are prompted by avoidance of penalty fees, rather than by patient need. The result is that some patients are likely to be released much more ill, less likely to respond to medication, more dangerous than when they entered jail, and even more likely to commit another crime that could also be more serious than previous ones. Outpatient programs may reject patients due their chronic involvement with the criminal justice system and/or history of non-adherence to treatment. This is the perfect storm for creating a criminal justice revolving door for mentally ill persons while their options for treatment and self-sufficiency are further reduced.

Allowing a psychotic person to arrive at such point of decompensation that his behavior results in incarceration, is callously disregarding the downward course of untreated psychotic decompensation, especially when the symptoms and performance indicate a deterioration of functioning known or believed to be leading to critical levels by any reasonable person. Sadly, the feared negative incarceration outcome, may result from misdemeanor offenses, although in some cases from very regrettable and

tragic crimes such as murder of caretakers or innocent persons in the community that forever affect the patient, their families, and the community at large.

Not surprisingly, oftentimes the public is astonished to learn after a tragic event affecting more than just the patient, that the patient's caretakers had unsuccessfully exhausted all means to seek in-patient treatment but that the patient did not allegedly meet the current danger standard. The current 'danger' standard focuses on obvious (overt) danger to self or others yet disregards the documented dangers of 'covert' brain damage that progressively deteriorates due to chronic psychotic episodes, especially if untreated.

For years I have witnessed how we penalize patients for decompensating and for committing crimes while their judgment is impaired by delusions that torment them, but we do not admit responsibility for placing obstacles to treatment when they are in the process of decompensating at which time treatment is essential.

Recommendation:

I find it surprising and regrettable that there was no representative from local jails on the BHA Stakeholder workgroup to address the role of the danger standard in the criminalization of those with serious mental illness.
For all the reasons presented above and to try to halt the pervasive criminalization of persons with mental illness***, I recommend the following:***

1. ***The inclusion of "psychiatric deterioration" in the current danger standard.***
   Note: the current danger standard only focuses on physical/medical deterioration and dismisses documented progressive brain deterioration in untreated psychosis reducing the life expectancy of persons with mental illness by 10-20 years.

2. ***The standard must clearly be defined and include***
   a. ***individual's <u>personal and</u> psychiatric history, <u>if available</u>***
   b. ***individual's level of performance deemed by any reasonable person to be heading to a deteriorating and dangerous course***
   c. ***<u>specific clarification that danger is reasonably expected and need not be imminent.</u>***
   d. ***danger to self as evidenced by <u>deterioration of</u> brain <u>function</u> or <u>by</u> physical deterioration due to psychosis.***

I believe it is time for conscientious citizens to facilitate early access to treatment instead of facilitating incarceration which is truly the ultimate infringement on a person's freedom and perpetuating the criminalization of mental illness. Jails offer patients criminal records that have lasting, critical negative repercussions in their lives.

I will gladly make myself available for any questions or clarifications related to this matter.

Sincerely Yours,

Patricia Sollock, MA, LCPC
Pss28@hotmail.com

Testimony to Maryland Commission to Study Mental Illness and Behavioral Health
Nov. 9, 2021 by Janet Edelman

My name is Janet Edelman, I am the Chairperson of the Howard County Local Behavioral Health Advisory Board, a longtime member of NAMI and a family advocate for people living with a mental illness. I am speaking today as an individual.

There was a discussion about Assisted Outpatient Treatment and the Baltimore Outpatient Commitment program at the September meeting of the Commission. I would like to revisit that topic. I believe that Dr. Jones stated that the program received good reviews from the program participants, however, I think that overlooks a major point: those most in need of outpatient commitment are not in the program at all. Traditionally, outpatient commitment programs are designed to help those who are most difficult to treat, especially those who resist treatment. For the past three years the Baltimore program reported that it did not serve any involuntary individuals. It was strictly a voluntary program. Since the Baltimore program makes no effort to leverage the court order and has no enforcement mechanism, the program is not designed to serve those who resist treatment and who need to be committed to the outpatient program involuntarily or who do not comply once in the program. The enforcement in the AOT model includes specific protocols to respond if participant falters in maintaining treatment engagement such as a clinic visit to try to convince the participant to engage and evaluation to determine whether the participant needs to be treated in a hospital setting.

Earlier this year NAMI had a series of four webinars called "Help not handcuffs: A webinar series focused on addressing mental health crises with comprehensive community responses" which presented some best models. The fourth webinar on May 20, 2021 was on "Implementing a New System". The webinar panel consisted of people from St. Tammany Parish, Louisiana, who implemented Assisted Outpatient Treatment and an AOT Court in December 2020 with a grant from SAMHSA. This is in addition to developing a large array of services and a tradition of specialty courts. St. Tammany is a small community, population 258,000, which implemented services to replace their state hospital which closed in 2012. The local government purchased the hospital property and used it to house community services. The panel discussed the services offered and how they paid for them. Here is part of what the judge on the panel said about Assisted Outpatient Treatment from page 10 of the transcript of the webinar (highlights are mine):

Judge Alan Zaunbrecher:
"How are we doing? Well, I can tell you this, that it's too early to tell with AOT because we've only been doing it five months. But we do know now that the sickest person in behavioral health court is healthier than the healthiest person in AOT. These are severely ill individuals that require much more attention at every level of the court. In BHC, you measure success, are they in treatment? Are they taking their medication? Do they have suitable living conditions? Are they employed? Have they avoided any criminal activity? In AOT, the first level of success is, they're still alive, they're still alive. After that, are they compliant with their treatment? Are

they compliant with their meds? Are they stable in their home environment? Employment is really not considered unless it's sheltered employment."

I hope that you take the time to watch or read the transcript of this webinar. I found it very informative. Here's the link to the webinar, which is one hour and 26 minutes in length:

https://www.nami.org/Blogs/NAMI-s-Ask-the-Expert/2021/Help-Not-Handcuffs-Implementing-a-New-System

Here's the link to the transcript of the webinar:

https://www.nami.org/NAMI/media/NAMI-Media/Images/Ask%20the%20Expert/AtE-HNH-Part-4-Transcript.pdf

For additional information on Assisted Outpatient Treatment, please visit the Treatment Advocacy Center at https://www.treatmentadvocacycenter.org/aot/what-is-aot . TAC has a wealth of information on this subject.

I am hopeful that someday soon Maryland will choose to implement an outpatient commitment program that follows the AOT model in order to help those who are too sick to comply with treatment voluntarily.

Thank you for giving me a chance to comment.

Janet Edelman
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Comments to the Commission to study Mental and Behavioral Health in Maryland. 11-9-21

My name is Liz Montaner and I am the mother of a 36 year old son diagnosed with schizophrenia. The definition of the danger standard proposed by the Behavioral Health Administration (BHA) in the Final Report of the Involuntary Commitment Stakeholders' Workgroup would NOT have helped facilitate needed hospital treatment for my son after his first psychotic break. This is because it does not include criteria for psychiatric deterioration and does not clearly specify that the danger need not be imminent. It would NOT have eliminated the need for us to ask him to leave home and make him homeless in a vulnerable psychotic condition in the hope he would then meet the danger standard.

After graduating from college, my son began showing signs of psychosis. Unfortunately his illness included a neurological deficit called anosognosia which prevented him from understanding that many of his thoughts were not reality based. He was unable to see a reason for any psychiatric treatment and refused it.

Before we made him homeless, my son was clearly experiencing psychiatric deterioration with psychotic delusional thinking that anyone, with or without training could recognize This would NOT meet the criteria proposed by BHA for involuntary hospital treatment. BHA accepts that "refusal of somatic care can create a danger to self". However, they blatantly discriminate against those with psychosis by ignoring that, rejection of psychiatric care can also create a danger to self. They acknowledge the extensive research supporting this but then choose to put their head in the sand, ignore the science and reject a psychiatric deterioration standard. This continues forcing families to make the excruciating decision to make their loved ones homeless to prove they are unable to meet their <u>physical</u> needs.

BHA has also chosen to ignore the recommendation of this Commission that the definition should clarify that the "standard of immediacy" is insufficient". Instead, they are proposing an even more restrictive standard of "current" danger. They specify: "circumstances below, which must be recent and relevant to the danger which the individual may <u>currently</u> present," They further explain "the criteria for involuntary commitment ..., should be based on <u>current and acute</u> issues ..., not because of the possibility that the lack of immediate treatment may lead to future harm or treatment resistance." They give no valid legal reason for this or justification for denying treatment to those critically ill. Most all other states look at future, such as "reasonably expected danger in the foreseeable future".

Research shows that the earlier treatment starts the better the long-term outcome. That was true for my own psychiatric emergency almost 40 years ago. I was placed in a psychiatric hospital within days of my first psychotic break, treated for almost three months and have never had another mental health incident. My son has not been as fortunate and will likely spend the rest of his life battling this horrendous illness.

BHA has clearly shown they don't care about preventing tragedies for those with serious mental illness. This commission was established to eliminate barriers to care. Please listen to the families experiencing tragedies and recommend further clarifying that danger need not be imminent and include psychiatric deterioration in Maryland's danger standard. Will you break down this barrier? Will you follow the science? Can you offer us any hope?

ClearView
COMMUNITIES

November 8, 2021

Maryland Behavioral Health Administration
Via e-mail to: mbh.commission@maryland.gov

To Whom it May Concern:

I am a board-certified psychiatrist and I serve as Medical Director of Clearview Communities, which is a 36 bed, intensive, residential treatment center for young adults with severe mental illness. I have been a practicing psychiatrist since 1990 and most of my career has been spent in caring for people with disabling illnesses such as schizophrenia or bipolar disorder.

Clearview Communities has had impressive success in helping patients learn to live independently and to work despite their disabilities. Unfortunately, we often must turn patients away who are unable to recognize that they are ill due to *anosognosia*. Under current statutes that require imminent dangerousness, we must let these patients go, usually to homelessness, to prison, or to the care of their overwhelmed families. This is especially disheartening as we know that if we could engage these patients in treatment, they have a reasonable chance of living a satisfying and independent life.

I have also served on the District of Columbia Commission on Mental Health since 2007. This body is a division of the D.C. Superior Courts and is responsible for overseeing all cases of involuntary psychiatric treatment in the District of Columbia. I have been impressed with the due process and deliberation that occurs in this body, and the extent to which civil commitment of outpatients can help to prevent hospitalization, incarceration, and serious clinical deterioration.

I support a proposed revision of the dangerousness standard to include:

The individual presents a danger to the life or safety of the individual or of others, which includes but is not limited to the circumstances below, which must be recent and relevant to the danger which the individual may currently present, and arise as a result of the presence of a mental disorder:

(i) The individual has threatened or attempted suicide, or has behaved in a manner that indicates an intent to harm self, or has inflicted or attempted to inflict bodily harm on self or another; or

(ii) The individual, by threat or action, has placed others in reasonable fear of physical harm; or

(iii) The individual has behaved in a manner that indicates he or she is unable, without supervision and the assistance of others, to meet his or her need for nourishment, medical care, shelter or self-protection and safety such as to create a substantial risk for bodily harm, serious illness, or death.

I believe that the medical literature now quite clearly supports the ideas that untreated psychosis can lead to structural damage of the brain and to an increased likelihood that the affected person will become less likely to respond to treatment in the future.

Please contact me if I may answer any questions or provide further information.

Sincerely,

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11/4/2021

Dear Members of the Commission to Study Mental and Behavioral Health in Maryland,

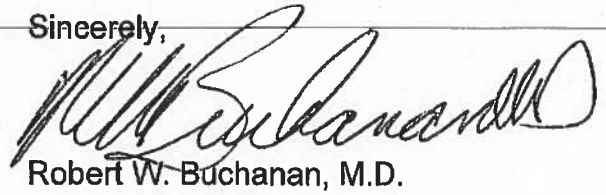
I am a Professor of Psychiatry in the Department of Psychiatry, University of Maryland School of Medicine; and Director of the Maryland Psychiatric Research Center (MPRC). I am also the Director of the Maryland Early Intervention Program (EIP), which is a collaborative for the early identification and treatment of mental illness with psychosis. The Maryland EIP is funded through the Maryland Department of Health/Behavioral Health Administration. The purpose of the Maryland EIP is to provide state-of-the-art clinical services for all citizens of the State of Maryland, who are at risk to develop or who have developed a mental illness with psychosis (e.g. schizophrenia). The Maryland EIP is a high-quality care, specialized program with expertise in the early identification, evaluation, and comprehensive psychiatric treatment of adolescents and young adults, who are at increased risk for developing psychosis or in the early stages of a psychotic disorder. The goal of the Maryland EIP is to address the unique developmental needs of adolescents and young adults with emerging psychotic symptoms with the priority of improving functioning and optimizing recovery and resilience, rather than simply reducing psychopathology. In order to achieve this goal, the Maryland EIP takes a broad public health perspective, in which we address comprehensively clinical issues in this population that contribute to safety concerns, especially aggression, violence, suicidality, and co-occurring substance abuse; high-cost services, such as physical health issues from poorly managed side effects; and academic/vocational underachievement.

A critical component to our ability to provide effective services to our patients is our focus on the early detection and intervention with people who are at risk to develop or who have developed a mental illness with psychosis. There is considerable empirical evidence to suggest that prolonged duration of untreated psychosis (DUP) is associated with poorer treatment response and worse social, emotional, and occupational outcomes. Increased DUP is also associated with increased risk of suicide and violence. Ten to 30% of suicide attempts occur prior to treatment; 15-20% of individuals with untreated psychosis have had some experience of violence prior to treatment; and a significant proportion of homicides committed by people with illnesses with psychoses occur prior to treatment. In addition, serious mental illnesses are associated with high rates of co-occurring alcohol and substance abuse, which increase risk of violence; co-occurring nicotine use; and co-occurring metabolic disorders, including obesity, hyperlipidemias, and Type 2 diabetes mellitus. Early intervention is critical to minimize morbidity and disability.

I have been Director of the Maryland EIP for over 8 years, which has provided me with extensive experience in the treatment of individuals with a first episode of a mental illness with psychosis. My experiences have only reinforced the importance of early detection and intervention. However, there are several important impediments to the delivery of early intervention; one of the most important is the failure of people with a mental illness with psychosis to sometimes understand the need for treatment, including hospitalization. The expansion of the standards for inpatient commitment along the lines recommended by SAMHSA, i.e., "Without commitment and as a result of the serious mental illness, the individual will be at significant risk in the foreseeable future of behaving in a way, actively or passively (i.e., by acts or omissions), that brings harm to the person or others; harm to the person may include injury, illness, death, or other major loss due to an inability to exercise self-control, judgement, and discretion in the conduct of his or her daily activities, or to satisfy his or her need for nourishment, personal or medical care, shelter or self-protection and safety" would greatly facilitate early intervention with individuals with a first episode of a mental illness with psychosis and improve their long-term outcomes. The expansion of the standards would also improve the treatment of people who are past their first episode, but continue to struggle with their illness.

Thank you for your consideration of my testimony.

Sincerely,



Robert W. Buchanan, M.D.