Maryland
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Behavioral Health Administration
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Involuntary Commitment Stakeholders' Workgroup Report

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Introduction

In behavioral health systems across the nation, people with severe behavioral illnesses have a greater propensity for repeated hospitalizations, are more likely to come into contact with the criminal justice system and may struggle to get the treatment they need. States use involuntary civil commitment as a safety net for when a person, due to their mental illness, exhibits a danger to self or others or is unable to maintain basic survival skills for self-care, but is unwilling to voluntarily comply with a recommendation for hospitalization. Even when there is a clear need for intervention, providing treatment to persons in such situations is not an easy task and community-based services such as crisis hotlines, mobile crisis teams, urgent care/walk-in appointment and hospitalization is often a critical first step in initiating psychiatric care. Over the last several years, states have become more specific on defining dangerousness in order to provide clarity for the legal process, clinicians, and first responders.

In Maryland, there is unclear language in the statutes and regulations, which has led to wide interpretation of the law on involuntary civil commitment with those meeting commitment criteria sometimes not being hospitalized, or not even being emergency petitioned in the community for an evaluation in an emergency department. It's important to note that mobile crisis teams, which are available in 16 jurisdictions across Maryland, offer an immediate response to a person in crisis potentially alleviating the need for an emergency petition. The dangerousness standard within Maryland's commitment law is brief and nonspecific, consisting of only one sentence, "The individual presents a danger to the life or safety of the individual or of others." In February 2021, the Behavioral Health Administration (BHA) was charged with reviewing current civil commitment laws, and examining the definition of dangerousness and grave disability. From March 3, 2021 to April 20, 2021, BHA led a diverse group of stakeholders, hosting four workgroup meetings, to better define the language of civil commitment. The purpose of the meetings was to review national best practices on civil commitment and develop recommendations to provide greater clarity to Maryland's civil commitment definition.

Throughout the Involuntary Commitment meetings, stakeholders had an opportunity to listen and dialogue with various participants, including people with lived behavioral health experiences, family members, local, state and national advocates, and the Maryland Department of Health and Department

of Disability (MDOD) staff. Participants from the Stakeholder Workgroup were invited to present to bring diverse opinions to the meetings. Presentations were provided by representatives from the Maryland Coalition for Families, Schizophrenia and Related Disorders Alliance of America, the Treatment Advocacy Center, Maryland Consumer Quality Team, Maryland Peer Advisory Council/Descendant of the Cherokee Nation Eastern Band, National Alliance on Mental Illness Maryland, Maryland Office of the Public Defender and the Outpatient Civil Commitment Program administered by Behavioral Health Systems of Baltimore.

Stakeholders dedicated time to actively participate in discussions, explore the many facets of this complex issue and develop recommendations as contained in this brief report. Stakeholders proposed three recommendations: (1) Refine the definition of the dangerousness standard in regulations; (2) Provide comprehensive training around the dangerousness standard; (3) Gather additional data elements about civil commitment. The implementation of these recommendations can address gaps in the Public Behavioral Health System and improve access to outpatient mental health services while decreasing the use of more restrictive levels of care.

The format of the report includes:

- The 2014 Involuntary Civil Commitment Historical Review
- National Best Practices and Advocacy Report Summaries
- Data from the State of Maryland Office of the Public Defender
- Clarifying the Definition of Dangerousness
- Draft Recommendations
- Stakeholder Testimony and Report Feedback

Involuntary Civil Commitment – 2014 Historical Review in Maryland

As background, in 2014, Senate Bill 882/House Bill 1267 legislative session required the *Secretary of Health and Mental Hygiene* (currently known as Secretary of Health) to convene a panel workgroup to examine the development of assisted outpatient treatment (also known as outpatient civil commitment) programs, assertive community treatment programs, and other outpatient services in the state; develop a proposal for a program in the State; and evaluate the dangerousness standard for involuntary admissions and emergency evaluations. The Department of Health was required to recommend draft legislation as necessary to implement the program included in the proposal, and required to evaluate the dangerousness standard for involuntary admissions and emergency evaluations of individuals with mental disorders. As part of this evaluation, the Department was required to discuss options for clarifying the dangerousness standard in statute or regulations and initiatives to promote the appropriate and consistent application of the standard.

In 2014, The *Department of Health and Mental Hygiene* (now the State of Maryland Department of Health), Behavioral Health Administration) convened a Panel workgroup of diverse stakeholders. The Panel reviewed the dangerousness standard, and found that in practice, there was variance in how the dangerousness standard is interpreted across the healthcare system. Specifically, there was an inconsistent application of the dangerousness standard in various settings, including emergency petition evaluations. Ultimately, the Panel developed a report with recommendations to promulgate regulations defining dangerousness to promote consistent application of the standard throughout the healthcare system[1].

Further recommendations included the development and implementation of a training program for healthcare professionals regarding the dangerousness standard as it relates to conducting emergency

evaluations and treatment of individuals in crisis. It was suggested that training should be extended beyond the emergency room to Administrative Law Judges, the Office of the Public Defender, consumers and family members to ensure consistent application of the standard statewide.

The Panel also recommended that the Department report annually on the Civil Commitment pilot program outcomes. In 2016, The Maryland Outpatient Civil Commitment proposal was accepted by the Substance Abuse Mental Health Services Administration (SAMHSA) and the program was launched in 2017. The program was subsequently funded by BHA when federal grant funds from SAMHSA was discontinued.

National Best Practices and Advocacy Reports

To help understand the issues and provide a framework, the Involuntary Commitment Stakeholder Workgroup used national best practices from the SAMHSA[2], and reviewed reports from the Treatment Advocacy Center[3] (TAC) and Mental Health America[4] (MHA).

According to SAMHSA, "Involuntary commitment, whether associated with hospitalization or a community treatment program, involves a significant limitation of liberty—the kind of limitation that is rare outside of the criminal justice system. For this reason, among others, commitment remains controversial, especially among recovery-oriented mental health stakeholders who place a high value on personal autonomy and self-determination (*Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice)*."

SAMHSA's Practical Tools to Assist Policy Makers in Evaluating, Reforming, and Implementing Involuntary Civil Commitment takes into account the competing interests in civil commitment, considers the inherent ethical concerns, and provides practical tools to assist policy makers and others responsible for reforming or implementing civil commitment laws or systems. Below is a checklist of specific model requirements for inpatient and outpatient commitment statutes. This checklist was presented to stakeholders as a reference and served as a guide in the suggested change in the dangerousness definition.

SAMHSA Best Practice Elements for Civil Commitment Checklist for Policy Makers and Practitioners
● The individual is reliably diagnosed with a serious mental illness.
● Treatment for the individual's mental illness is available.
● The treatment that is available is likely to be effective.
● A reasonable effort has been made to help the individual understand the nature of his or her mental illness and the treatment proposed, including the potential risks and benefits of such treatment and the expectable consequences if he or she is or is not committed.
Outpatient Commitments:
● Without the treatment and other supports that would be available as a consequence of an outpatient commitment order, it is reasonably predictable, given the individual's psychiatric history, that the individual, as a result of the serious mental illness diagnosed, will experience further deterioration to a degree that, in the foreseeable future, the individual will meet the requirements for inpatient commitment.
● The respondent is capable of surviving safely in the community with available supervision from family, friends, or others.
● The individual's understanding of the nature of his or her mental illness and the treatment proposed, including the potential risks and benefits of such treatment and the expectable consequences if he or she is or is not committed, is impeded to a significant degree by the symptoms of a serious mental illness or their mental disability, limiting or neglecting the individual's ability to make an informed decision whether to accept or comply with recommended treatment.

From different perspectives, TAC and MHA produce reports that rank mandatory treatment laws and behavioral health systems of care in the nation. The TAC report examines and compares laws from across the country on involuntary treatment. Ten states received an "A" and eight states received an "F." Maryland was one of the states to receive an "F" for its civil commitment laws. Maryland does not have outpatient civil commitment laws which contributed to the low grade.

MHA is an organization that advocates for policy, programming, and analysis. MHA's national report card examines 15 indicators for youth and adults to assess the comprehensiveness of a behavioral health treatment system. In the MHA national report card, Maryland received an A for the behavioral health system. This ranking was based on 7 factors which include the number of adults: With any mental illness, substance use disorder in the past year, serious thoughts of suicide, number of uninsured, number of people with any mental illness that did not receive treatment, reporting unmet needs and who could not see a doctor due to cost.

Summary of Stakeholder Meetings

BHA hosted four stakeholder workgroup meetings to discuss Civil Commitment in Maryland. Below is a summary of the four meetings with the full minutes included in the appendix[5].

● March 3, 2021: The Involuntary Commitment Workgroup was introduced to the work of two national advocacy organizations that highlight diverse viewpoints on behavioral health treatment and laws: Treatment Advocacy Center (TAC) and the Mental Health America (MHA). In the kickoff meeting, the workgroup began to review the current Maryland statute, regulations and definitions for civil commitment, and explored similarities/differences of the definition of dangerousness from Minnesota, and Michigan. It was noted that Maryland has a comprehensive, well developed behavioral health system in Maryland.

● March 17, 2021: A brief presentation was provided regarding the population and race by state. The workgroup discussed how to avoid racial bias and health disparities and promote parity/access across the state between urban and rural jurisdictions. Leadership from the Consumer Quality Team provided an overview of people with lived experiences regarding participation in the Outpatient Civil Commitment Program. This project is piloted in Baltimore City, administered by Behavioral Health Systems of Baltimore and includes both voluntary and involuntary participants. An overview of the Civil Commitment and Mental Health Continuum of Care: Historical Trends and Principles for Law and Practice by Substance Abuse Mental Health Services Administration was provided. As a comparison, the definition of dangerousness from West Virginia was discussed.

● April 7, 2021: This meeting included presentations from community members including the Maryland Peer Advisory Council-Cherokee Nation Eastern Band, Maryland Coalition for Families, and Maryland Chapter of Schizophrenia and Related Disorder Alliance of America[6]. Workgroup members continued to discuss proposed changes to Maryland's definition of dangerousness and the need for more data as well as training. It was suggested that workgroup members should also read the report by Dr. Paul Appelbaum, Almost a Revolution: An International Perspective on the Law of Involuntary Commitment. (Appelbaum, 1997)[6].

●April 20, 2021: This meeting began by reviewing Senate Bill 882/House Bill 1267 (2014)[7]. The 2014 Bill requires the Workgroup to determine how the standard should be clarified in regulations and statute and the Department supports further clarification of the current standard. The Chief Attorney from the Maryland Office of the Public Defender provided a review of data regarding mental health hearings. Stakeholders discussed and reviewed the data providing comments and insights reflecting that additional data is needed. A presentation from the National Alliance on Mental Illness Maryland from people with lived experiences and family members was provided. The Outpatient Civil Commitment Program, operated In Baltimore City through Behavioral Health Systems Baltimore, also provided an overview of the service delivery model and lessons learned from the project. The goals of OCC are to reduce inpatient hospitalizations, increase connections to outpatient behavioral health services, realize cost savings to the public behavioral health system and improve program participants' health outcomes and quality of life. Finally, workgroup members continued to discuss the revised definition of dangerousness and identify draft recommendations.

Presentation of Data

The State Maryland Office of the Public Defender, Mental Health Division provided an overview on Civil Commitment Data.

MENTAL HEALTH DIVISION
Office of the Public Defender
2020 INVOLUNTARY CIVIL COMMITMENT CASE STATISTICS

Month	Total Number of IVA Cases	Discharges	Voluntaries	Released By Admin. Law Judge	Retained By Admin. Law Judge	Voluntary or Discharge after Postponement	Represented Self at Involuntary Commitment Hearing	Retained Private Counsel	Never Appeared on Invol. Commit. Hearing Docket	No Disposition	Transfers
January	835	353	350	15	37	N/A this Month	3	0	60	11	6
February	713	285	304	15	43	N/A this Month	2	0	56	2	6
March	715	309	321	6	14	N/A this Month	3	0	37	15	10
April	718	303	272	13	50	N/A this Month	1	0	53	22	4
May	693	269	285	19	46	N/A this Month	2	0	61	8	3
June	865	331	333	23	52	N/A this Month	1	1	97	16	11
July	885	352	339	27	42	N/A this Month	2	0	103	10	10
August	854	301	263	18	44	115	1	0	97	8	7
September	904	328	281	21	61	70	6	0	111	13	13
October	901	334	301	27	58	43	1	0	113	19	5
November	735	297	312	14	31	14	7	0	46	4	10
December	794	299	388	21	35	14	3	0	19	10	5
TOTALS	**9,612**	**3,430**	**3,749**	**219**	**513**	**256**	**32**	**1**	**853**	**138**	**90**

Terms:

- Disposition: Resolution of a case
- Discharges: Person is admitted to the hospital, or released from hospital and is no longer on the docket.
- Never appears on Docket: Person was either admitted or released but information is not provided by the hospital.
- Administrative Law Judge: A judge who hear the involuntary commitment case and determines if the person meets the criteria for admission or release.

MENTAL HEALTH DIVISION
OFFICE OF THE PUBLIC DEFENDER
6 MONTHS –STATISTICS BY RACE

MONTH	TOTAL CASES	ASIAN	BLACK	HISPANIC	AMERICAN INDIAN	PACIFIC ISLANDER	WHITE	UNKNOWN
JULY	885	20	452	21	1	0	330	61
AUGUST	854	23	368	26	2	1	279	155
SEPTEMBER	904	18	469	32	0	0	312	73
OCTOBER	901	27	485	29	3	2	323	32
NOVEMBER	735	22	387	21	1	1	263	40
DECEMBER	794	18	423	36	0	1	277	39
TOTALS	**5,073**	**128**	**2,584**	**165**	**7**	**5**	**1,784**	**408**

Special Emergency Petitions by Race	
Asian	3%
Black	51%
Hispanic/Latino	3%
American Indian	.1%
White	35%
Other or unknown	8%

It was reported that of the clients who are self-represented during the Administrative Hearing for Involuntary Commitment, the vast majority come into the hospitals on emergency petitions. It was reported there have been situations where people have had difficulty getting an emergency petition for a family member but this is understood to be the minority of cases. The Office of Public Defenders had over 9,000 people come through the Office in 2020 and 219 were released by an Administrative Law Judge. According to The Office of Public Defenders, attorneys have begun to monitor emergency petitions by race. The data indicates that Black individuals are the largest racial group to experience an emergency petition (51% of the cases).

Statistics of individuals retained by race:

MENTAL HEALTH DIVISION
INVOLUNTARY CIVIL COMMITMENT AT HEARING BY RACE
RETAINED BY ADMINISTRATIVE LAW JUDGE
6 MONTH SNAPSHOT 2020

RACE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	TOTAL
Asian	2	0	2	3	2	0	**9**
Black	23	20	37	31	16	22	**149**
Hispanic	2	1	0	1	0	1	**5**
American Indian	0	0	0	0	0	0	**0**
Pacific Islander	0	0	0	0	0	0	**0**
White	15	11	18	22	13	11	**90**
Unknown	0	12	4	1	0	1	**18**

MENTAL HEALTH DIVISION
RELEASED BY ADMINISTRATIVE LAW JUDGE AT COMMITMENT HEARING
BY RACE
6 MONTH SNAPSHOT 2020

RACE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	TOTAL
Asian	1	0	1	0	0	1	**3**
Black	13	11	14	21	9	9	**77**
Hispanic	0	0	0	0	0	1	**1**
American Indian	0	0	0	0	0	0	**0**
Pacific Islander	0	0	0	0	0	0	**0**
White	11	4	6	5	5	10	**41**
Unknown	2	3	0	1	0	0	**6**

Statistics show that Black persons make up 51% of all emergency petitions in a recent six-month period, with the next largest group being White persons at 35%. Without county-specific population and emergency petition data, it is not possible to assess whether persons of any given racial identity are regularly emergency petitioned at a greater rate than persons of another racial identity or how these rates may vary across jurisdictional or periods of time. However, based on data provided for the total number of EPs per racial identity group and total number of persons ultimately retained (5.76% at a higher percentage than White persons (5.04%) during the time frame of data collection. Without data regarding the racial identity of persons who were discharged, chose voluntary admission, etc., it is not possible to calculate whether this differential persists, decreases or increases. The Office of Public Defenders is beginning to keep additional data such as the number of hours spent in the emergency room. While the data presented is important, additional data elements are needed to have a fuller understanding of the civil commitment process in Maryland.

In July, 2021, the Journal of Psychiatric Services published a study demonstrating that Black persons of Caribbean or African descent with first episode psychosis (FEP) were significantly more likely to be coercively treated than were non-Black individuals with FEP. The research found that age and violent/threatening behavior were predictors of coercive referral and intervention. The article identifies that more research is needed to explore the role of ethno-racial status, how it may influence hospital admissions, and how to reveal the role of racial prejudices in the assessment of danger (Knight, Sommer, 2021)[8].

Clarifying the Maryland Definition of Dangerousness

The Stakeholder workgroup reviewed, compared/contrasted the definition of dangerousness from Minnesota, Michigan and West Virginia Statutes.

Some stakeholders indicated that the dangerousness standard within the current statute, “danger to the life or safety of the individual or of others,” did not need to be further defined. More specifically, stakeholders contended that BHA should implement training around the current standard to address its

inconsistent application. The standard could then be further defined if training did not promote consistent application of the standard. Other stakeholders felt the standard was too vague and so inconsistently applied, and there was the issue of how to train with specific examples based on a brief dangerousness standard that was not specific.

The current statute for commitment states:

> *Health General 10-616 outlines the requirements for involuntary admission to a psychiatric or Veterans facility, which includes the requirements for what a certifying mental health professional puts on the form.*
> *"The rules and regulations shall require the form to include:*
> *(i) A diagnosis of a mental disorder of the individual;*
> *(ii) An opinion that the individual needs inpatient care or treatment; and*
> *(iii) An opinion that admission to a facility or Veterans' Administration hospital is needed for the protection of the individual or another."*

Health Gen. 10-617 states:

> *(a) A facility or Veterans' Administration hospital may not admit the individual under this part unless:*
> *(1) The individual has a mental disorder;*
> *(2) The individual needs inpatient care or treatment;*
> *(3) The individual presents a danger to the life or safety of the individual or of others;*
> *(4) The individual is unable or unwilling to be admitted voluntarily; and*
> *(5) There is no available, less restrictive form of intervention that is consistent with the welfare and safety of the individual.*

The Involuntary Commitment Workgroup proposes the following revision to (3) *The individual presents a danger to the life or safety of the individual or of others;* the dangerousness standard, to become the following:

> *(3) 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.*

Some workgroup members saw a brief and nonspecific dangerousness standard as a strength, and expressed concerns that adding specifics could limit appropriate involuntary commitments. Specifics are nonetheless recommended because the standard is not just for involuntary commitment hearings, which involves experienced participants well versed in the process, but also informs the emergency petition

process out in the community, where those involved may be inexperienced with emergency petitions. Without more specific guidance first responders, and sometimes even clinicians, do not always appropriately pursue emergency petitions, even when the dangerousness standard has been met.

The expanded language of "has behaved in a manner that indicates an intent to harm self," for the danger to self in (3) (i) adds additional criteria beyond only explicit statements of suicidal intent or a suicidal act. The expanded language on danger to others in (3) (ii) adds the reasonable perspective of the fear of a potential victim and includes the word action so the danger is not limited to only verbalized threats about harming someone. In (3) (iii) language was added about grave disability, the danger created because an individual cannot take care of their basic needs. 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.

There were strong views, but no consensus, for including criteria for commitment that did not require an element of danger based on psychosis and psychiatric deterioration, such as the below (iv).

It was discussed whether psychiatric deterioration without a current element of danger should be included, more specifically when psychosis is present, because it has been found that chronic psychosis is detrimental to the brain and worsens an individual's prognosis. In a 2014 article in the Canadian Journal of Psychiatry, cites that "from cancer to coronaries, early detection in the disease course offers better prognosis. The longer a pathological process is left unchecked the more damage is done; illnesses become more complex and thus they become more difficult to treat" (K. McKenzie, 2014)[9].

Additional articles were offered by the Treatment Advocacy Center to explore the deterioration of the brain. One article reported that first-episode psychosis (FEP) can result in a loss of up to 1% of total brain volume and up to 3% of cortical gray matter. The article highlights that repeated episodes of untreated psychosis could result in progressively lower levels of baseline functioning, and patients may require longer hospitalizations to achieve stabilization and higher doses of medications to achieve remission (Martone, 2020) [10].

It is clear that earlier treatment for many chronic illnesses, both medical and psychiatric, including those leading to psychosis, has in general a significant likelihood of preventing future harm or treatment resistance. 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 because of the possibility that the lack of immediate treatment may lead to future harm or treatment resistance. Another potential problem with not including a current element of danger is whether it is constitutional, since the Supreme Court in its Olmstead ruling indicated there is a right to living in the least restrictive setting that is appropriate. In the O'Connor vs Donaldson case, it indicated that a state should not be able to confine a non-dangerous individual who is capable of surviving safely in freedom. Other concerns raised include that involuntary commitment may not be the most effective method to work with this population, and that involuntary admission of non-dangerous individuals would put significant strain on the psychiatric hospital system.

As such, psychiatric deterioration language such as these two options are not recommended for inclusion in the revision of the dangerousness standard.

> *1. The individual has psychosis due to a mental disorder, and the psychosis and the deterioration it has caused severely impair an individual's judgment, reasoning, or ability to control behavior, to where this creates a substantial risk for the emergence in the near future of a danger to the life or safety of the individual or of others.*

2. Danger to self includes a substantial risk that as a result of the mental illness the individual will suffer substantial deterioration of the individual's judgement, reasoning or ability to control behavior, if unable to make a rational and informed decision as to whether to submit to treatment

Based on the SAMHSA Best Practice Elements for Civil Commitment, Maryland's proposed definition on civil commitment, is well aligned with SAMHSA recommendations.

SAMHSA Best Practice Elements for Civil Commitment Checklist for Policy Makers and Practitioners	Proposed Maryland Definition
• The individual is reliably diagnosed with a serious mental illness.	Meets
• Treatment for the individual's mental illness is available.	Meets
• The treatment that is available is likely to be effective.	Meets
• A reasonable effort has been made to help the individual understand the nature of his or her mental illness and the treatment proposed, including the potential risks and benefits of such treatment and the expectable consequences if he or she is or is not committed.	Meets
Outpatient Commitments:	
• Without the treatment and other supports that would be available as a consequence of an outpatient commitment order, it is reasonably predictable, given the individual's psychiatric history, that the individual, as a result of the serious mental illness diagnosed, will experience further deterioration to a degree that, in the foreseeable future, the individual will meet the requirements for inpatient commitment.	Meets
• The respondent is capable of surviving safely in the community with available supervision from family, friends, or others.	Meets
• The individual's understanding of the nature of his or her mental illness and the treatment proposed, including the potential risks and benefits of such treatment and the expectable consequences if he or she is or is not committed, is impeded to a significant degree by the symptoms of a serious mental illness or their mental disability, limiting or neglecting the individual's ability to make an informed decision whether to accept or comply with recommended treatment.	Meets

Stakeholder Discussions

Stakeholders had robust, varied, and thoughtful discussions about the issues surrounding the revision of the dangerousness definition. The meeting minutes, which are included in the appendix, contain the complete account of comments and electronic chats. Below is a snapshot of the broad opinions expressed and topics discussed.

"Minnesota's population is different from Maryland and some of the language may target people we don't need to target and looking at past incarceration can target vulnerable populations and people of color."
"The imminent danger part of the Maryland statute that was removed is still a barrier for families to get treatment for their loved ones. Unless the person is totally debilitated for several days the mobile crisis teams won't even come out. It's important to clarify that danger doesn't need to be imminent."
"The current dangerousness standard could be a driver to placing people into situations of homelessness and incarceration."
"We need to be careful that stigma, discrimination, ignorance and racism can come into play when it comes to one person making a snap assessment especially for young men with black or brown skin. There needs to be education and training to teach decision making."
'Choices should be included into our system."
"The clinical review process is cumbersome; we may have to look at that process as well. When someone is in a facility and refuses medication the appeal process can take 15-21 days. That is a barrier for getting people the help they need. It is a civil rights and due process issue."
"Most states have a definition of dangerousness that includes some form of neglect. The major concern is regarding population and bias. How much does racial bias and other biases impact involuntary commitment? There is some merit to having a timeline in the definition of danger to self and others. Prior violence for a person with mental health issues is the highest predictor for future violence."
"The dangerousness standard is for involuntary commitment and emergency petitions which means police and lay persons will have to interpret it. If clinicians struggle, law enforcement will not be able to determine based on psychiatric deterioration if someone is going to be a danger in the foreseeable future."
"The current standard results in a very narrow interpretation of imminent danger of suicidal or homicidal because they are not familiar with court precedent. The law needs to reflect the broader standard. Only those who meet the narrow standard even get to the commitment hearing. ER doctors interpret danger as imminent according to Delegate Morhaim, an ER doctor. Very serious consequences to denial of treatment: suicide, incarceration, homelessness, violence."
"I have concerns from a patient's right perspective. The language is entirely retrospective. There's nothing that says that we are trying to identify the danger that the person is likely to present in the foreseeable future. It's a terrible missed opportunity to not include language like psychiatric

deterioration as a basis for involuntary commitment. The likelihood that someone could cause harm to their mind is a danger in itself."
"The predictions on future danger are notoriously unreliable even for trained professionals. We have seen studies that show they are slightly more reliable than chance. This is not going to be interpreted by just mental health professionals. It will be interpreted by police officers and lay people. If mental health professionals struggle with determining dangerousness, I think it's reasonable to assume that people who aren't trained in mental health will struggle. Roman Numeral III doesn't do a good enough job tying the inability to care for oneself to mental illness regardless of the qualifier at the end. We strongly object to the inclusion of psychiatric deterioration consideration. Just because someone is at risk for worsening symptoms doesn't mean they will become a danger to themselves or to others. Including psychiatric deterioration could create a vastly over broad group of people that will be subjected to involuntary commitment."
"NAMI supports clear language to define danger appropriately and I think that the proposed expanded definition is a strong start."
"I participated in the meetings in 2013 and 2014 and there wasn't a unanimous agreement on what was reached for psychiatric deterioration in that proposal. In terms of predicting dangerousness, those studies primarily occur when referring to violent dangerousness and that may be difficult to predict but if someone stops eating, they will have serious repercussions. Future risk is something that doctors can assess."
"In this definition, where would Indigenous/Native People be included? *Response: Data for the Indigenous/Native population regarding involuntary commitment is not collected. "*
"Maryland does not have a definition of danger. The term is left undefined. The law talks about danger to self or others but it is not defined. Maryland is one of four states that doesn't provide a definition at all. So, while that is true that it leaves it open to compassionate progressive definition that encompasses all the areas it also leaves it open to a very narrow restrictive definition. It's the inconsistency and the lack of predictability across the state that leads to the need for us to have a definition. As useful as the data is, we must keep in mind that it does not tell the entire story as to the need for a definition of danger. When we are looking at the cases that make it to court that's downstream in the process. Most of us believe the problem is more upstream because law enforcement is making the determination that a person is not a danger to themselves or others. For determinations that are made in the emergency room, this indicates a case should not come to court because a person doesn't meet the definition as it is understood. You are not getting the total picture from the data that the Office of Public Defender presented as to why many of us believe there is a need for change."

Some stakeholders noted that dangerousness should be defined in regulation as opposed to statute. Proceeding through regulations, as opposed to legislation, is recommended because if concerns are identified in the implementation of this definition of "dangerousness," then the regulations can be amended without requiring the passage of new legislation. The Schizophrenia and Related Disorders Alliance of America provided a written response to the suggested changes in the definition. SARDAA specifically proposed language around imminence, psychiatric deterioration, and the consideration of potential for violence. There was no agreement on the inclusion of psychiatric deterioration standard [11].

Draft Recommendations

To strengthen the civil commitment process in Maryland, the Involuntary Commitment Stakeholder Workgroup proposed three recommendations: (1) Refine the definition of dangerousness in regulations; (2) Provide comprehensive training around the dangerousness standard; (3) Gather additional data elements about civil commitment. BHA believes that implementing these recommendations will safely support individuals in psychiatric crises while keeping a balanced, ethical approach for prescribing treatment against the person's will.

Proposed Revision of the Dangerousness Standard

It was recommended to promulgate regulations, rather than propose a statutory amendment, to define "danger" for purposes of emergency psychiatric evaluation and involuntary admission to a facility. As expected, there were areas where there was no consensus among stakeholders. This is particularly applicable to the revision of the dangerousness standard. The proposed definition is:

> *(3) 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.*

Data Collection and Monitoring

The collection of data (including demographics) and monitoring of data is key to understanding the full extent of the civil commitment process. The collection of racial and ethnic identity data is important to evaluate the potential issues of bias, disparity and discrimination. Stakeholders recommended collecting the following:

- Number of emergency petitions filed through the court system
- Number of emergency petitions granted and not granted through the court system
- Number of people who come to an emergency department via an emergency petition and the disposition (treated/released, admitted); number of emergency petitions differentiated by who completed/signed the emergency petition (clinician, law enforcement or court issued)
- Number of people certified for hospitalization
- Number of people who were certified who agreed to voluntary treatment
- Number of people who were certified and released by an Administrative Law Judge

Key stakeholders such as the Maryland Judiciary, Maryland Hospital Association, and CRISP are critical partners in implementing this recommendation.

Training

The Involuntary Commitment Stakeholder Workgroup recommends the development of a training initiative to promote the appropriate and consistent application of the dangerousness standard. The 2014 Report of the Outpatient Services Programs Stakeholder Workgroup identified training as a key recommendation. As such, it is advised that those recommendations, which have not yet been implemented, be carried forward. Once a new regulation standard is adopted, training curriculums should be developed and designed for specific audiences. The following audiences would benefit from training around the dangerousness standard:

- First responders,
- Emergency department staff and inpatient psychiatric clinicians,
- Judges, Administrative Law Judges, and
- Public defenders

Implementation of the new training program will require assistance from numerous stakeholders including: EMS and law enforcement agencies, the Maryland Hospital Association, the Office of Administrative Hearings, The Office of the Public Defender, the statewide academic health centers, and professional organizations, such as the Maryland Psychiatric Society. Training will be developed to target the needs of specific audiences. For example, the needs of clinicians working in emergency or crisis settings are quite different from the needs of Administrative Law Judges tasked with making decisions using civil commitment law — which includes a finding as to dangerousness.

First responders and emergency clinicians must make rapid decisions based on limited information, so their training will focus on how best to make good decisions in the context of their work. In contrast, inpatient mental health staff have time to gather information, talk with the patient and his/her significant others, and gather prior records, and can make a more considered decision regarding the need for continued acute involuntary treatment. It is recommended that statewide guidelines be developed to delineate the expectations of law enforcement in emergency departments. There is variability in this area across the state.

Administrative Law Judges and defense counsel are in a place to more strictly consider the legal standard as applied to the facts presented in evidence, and their role is to ensure that there is a proper balance between the patient's rights and public safety considerations. Through partnerships with the various stakeholders, training will be designed to meet each group's specific needs and ensure a full but targeted understanding of the standard as it is to be considered and/or applied by that group.

To ensure that the training has the widest possible distribution, they will be adapted as webinars suitable for distance learning. Webinars will be recorded to allow for later viewing by participants unable to join live training exercises. This will be especially important for workers on off shifts, as is commonly the case for first responders and emergency clinicians. The content of the training will include, as relevant to the specific audience, education regarding the dangerousness standard as it is to be applied during the "emergency petition" phase of a particular case and during the various civil commitment procedures and proceedings.

Stakeholder Testimony and Draft Report Feedback

In January 2019, Lt. Governor Rutherford announced Executive Order 01.01.2019.06[12], signed by Governor Hogan, establishing the Commission to Study Mental and Behavioral Health in Maryland. The commission, which will be chaired by Lt. Governor Rutherford, has been tasked with studying mental health in Maryland, including access to mental health services and the link between mental health issues and substance use disorders. The commission includes representatives from each branch of state government, representatives from the state departments of Health, Public Safety and Correctional Services, and Human Services, as well as the Maryland State Police, the Maryland Insurance Administration, the Opioid Operational Command Center, and six members of the public with experience related to mental health. Several Stakeholders took the opportunity to provide verbal and written testimony at the May 10, 2021 and July 12,2021 Lt. Governor's Commission to Study Mental and Behavioral Health. Recordings of the meeting can be found at: https://governor.maryland.gov/ltgovernor/mbhcommission/commission-to-study-mental-and-behavioral-health-in-maryland.

In addition to providing testimony, several organizations and one individual submitted written feedback regarding the draft Involuntary Commitment Report. Below is a synopsis of the information presented in the written feedback. It is important to read the letters included in the appendix to obtain the full scope of the comments received[13].

- Behavioral Health System Baltimore (BHSB): BHSB would like to offer the following feedback.
  - Clarifying the Dangerousness Standard: BHSB supports the recommendations to promulgate regulations, rather than propose statutory change, to define "danger" for purposes of detention for psychiatric evaluation and involuntary admission to a psychiatric facility. We also support the decision to exclude "psychiatric deterioration" in the proposed definition.
  - Training: BHSB supports the recommendation to develop a training to promote appropriate and consistent application of the dangerousness standard. A widespread training for multiple stakeholders may help to minimize inconsistencies.
  - Data Collection: BHSB supports the recommendation to gather additional data about civil commitment. BHSB believes it is important that the collection and analysis of this data happen prior to any substantive policy change.

- Ms. Evelyn Burton, Personal Opinion (7/16/21)
  - Psychiatric Deterioration standard. Statutes from West Virginia, Illinois, Minnesota, and Michigan as well as the SAMHSA Inpatient Commitments Checklist include psychiatric deterioration standards, however the workgroup never discussed whether the specific language in each was acceptable or not.
  - None of the 5 sources included language for a psychiatric deterioration standard.
  - The report should accurately reflect that there was no agreement on the inclusion of a psychiatric deterioration standard. Also, psych deterioration "without an element of danger" is inaccurate since the proponents consider psych deterioration to be a danger in itself.
  - Imminent Danger: All of the 4 states reviewed and the SAMHA guidelines include language to assure that "imminent" danger is not required.
  - Regulation vs Statute: Since Regulation was a recommendation, it should be so stated and a more thorough explanation of the pros and cons that were considered by the Department, especially given that the Commission recommended Statute in its 2020

Report. ("The commission recommends legislation that provides a clearer statutory definition of danger of harm to self or others.").
    - Some groups supported the inclusion of the psychiatric deterioration standard as well as language to clarify that the danger need not be imminent.

- Ms. Evelyn Burton, Personal Opinion (7/19/21)
    - In order to facilitate those with psychosis will not be denied hospital treatment is to add the word "mental" between "bodily" and "harm" in section (iii) of the proposed definition. This links psychiatric deterioration to the concept of harm.
    - As noted in Michigan, "An individual who has mental illness, whose judgment is so impaired by that mental illness that he or she is unable to understand his or her need for treatment and whose impaired judgment, on the basis of competent clinical opinion presents a substantial risk of significant physical or mental harm to the individual in the near future or presents a substantial risk of physical harm to others in the near future.
    - Thank you again for considering the treatment needs of those with anosognosia who are suffering from psychosis.

- Maryland Coalition for Families (MCF): We support the recommendations of the Workgroup Report and believe that the process that informed the Report was inclusive, thorough, well-informed and balanced.
    - Psychiatric Deterioration should not be included in the definition of dangerousness.
    - Comprehensive training around the dangerousness standard should be provided to a wide variety of professionals who might touch an emergency petition (this also was recommended in the Report of the 2014 Workgroup).
    - Data should be collected and continually analyzed, to get a clear idea about the ongoing practice of civil commitment in Maryland, and especially how it may be disproportionately impacting Black Marylanders.
    - Dangerousness should be defined in regulation as opposed to statute.
    - MCF's substance use staff vehemently oppose such a change.

- Maryland Psychiatric Society:
    - The Maryland Psychiatric Society supports the recommendation to provide more information and training around the current dangerousness standard, which readily accommodates a range of gray area situations involving serious risk to the individuals or others.
    - We also support the recommendation to gather more data about how the current system is working.
    - We disagree with the recommendation to refine the dangerousness standard in regulations. This gives the appearance of addressing the conflict between civil liberty and public safety but would not provide a comprehensive solution in our view.
    - This report does not address another serious concern, which is inadequate resources for people suffering acute mental health crises. Maryland needs more inpatient beds at both private and state hospitals.

- Mental Health Association of Maryland (MHAMD):
    - We support the recommendation to promulgate regulations, rather than propose statutory amendments, to define "danger" for purposes of detention for psychiatric

evaluation and involuntary admission to a psychiatric facility. We also support the decision to exclude "psychiatric deterioration" in the proposed definition.
    - Training: Regardless of the actual statutory or regulatory language, there will always be inconsistencies in how "dangerousness" is interpreted and applied in practice across multiple systems and actors. MHAMD supports the recommendation for widespread training on the dangerousness standard for a variety of audiences.
    - MHAMD supports the recommendation to gather additional data elements about civil commitment. We encourage the collection and analysis of this data prior to any substantive policy change.

- National Alliance on Mental Illness (NAMI) Maryland
    - NAMI Maryland strongly supports clear language to define danger appropriately…Overall the proposed definition is an improvement and brings a measure of flexibility needed to ensure individuals with severe mental illness are not prevented from accessing treatment.
    - We applaud BHA's commitment to widespread training to ensure proper implementation of the danger standard.
    - The recent data efforts are also critically important.
    - NAMI proposed the inclusion to the definition;
      (iv) The individual has psychosis due to a mental disorder, and the psychosis and the deterioration it has caused severely impair an individuals' judgement, reasoning or ability to control behavior, to where this creates a substantial risk for the emergence in the near future of a danger to the life or safety of the individual or of others.
    - Psychiatric Deterioration: NAMI Maryland believes that the sooner an individual has access to medical care, the better off their outcomes are. Specifically including language about psychosis and psychiatric deterioration is important.
    - Physical harm should not be the exclusive standard for danger- new language gets this right.
    - Reasonable fear of physical harm to self or others. When it comes to violence associated with psychosis, the signs of an individual in crisis are unmistakable. Physical harm should be a consideration but not the basis for the definition of danger.
    - Racial Injustice in health care: NAMI Maryland supports the additional training proposed by BHA to ensure that changes to the danger standard are fairly applied. All changes regarding involuntary commitment need to be systematically implemented and resourced.

- National Council on Alcoholism & Drug Dependence (NCAAD)- Maryland Chapter
    - Proposed Revision of the Dangerousness Standard: We support the recommendation clarified through regulation, rather than statute, the definition of "danger" for purposes of detention for psychiatric evaluation and involuntary admission to a psychiatric facility. We also support the decision to exclude "psychiatric deterioration" in the proposed definition.
    - Training: NCADD-Maryland supports the report's recommendations for training that were made years ago in a similar workgroup's report in 2014, but not yet implemented.
    - Data Collection and Monitoring: NCADD-Maryland also supports the recommendation to gather additional data elements about civil commitment. We encourage the collection and analysis of this data prior to any substantive policy change.

- On Our Own Maryland: We strongly support the following recommendations made in the report.
    - Restrict Involuntary Treatment to Recent, Relevant and Reasonable Threats to Safety: The goal of emergency behavioral health crisis response services should be to support the safety, autonomy, well-being and recovery of the individual in crisis. We urge BHA to uphold the report's recommendation to exclude the nebulous "psychiatric deterioration" clause from the involuntary treatment standards.
    - Without Statewide Training Requirements, Nothing will Change: The decision to use an involuntary intervention should only come after extensive consideration of all other voluntary options and the potential consequences for the person in crisis. We applaud the Report's echoing of the recommendations for training that were provided seven years ago in a similar workgroup in 2014, but not yet carried through to implementation.
    - Without Data Analysis, Equity Cannot be Evaluated: Given the theme of your most recent Annual Conference, Health Disparities, Racial Equity and Stigma in Behavioral Healthcare, we are optimistic that BHA will embrace the recommendations to collect and analyze statewide data on the utilization and outcomes of the involuntary commitment process…
    - Regulation Invites Expertise and Efficiency: The process of eliminating unnecessary use of involuntary treatment and improving efficiency and outcomes in cases where such extreme measures are deemed necessary, will be an iterative one. We therefore agree that the most appropriate and practical venue for any further delineation of "dangerousness standard" is through regulations and not the legislative process.

- Dr. Erik Roskes, General and Forensic Psychiatrist, Personal Opinion
    - I write in partial support and partial opposition to the draft of the Involuntary Commitment Stakeholders' Workgroup Report.
    - I fully support the goals of the workgroup, which is to ensure that people with serious and acute mental health problems have ready and quick access to acute care when needed. However, there is insufficient evidence that our current statute fails to fulfil this goal.
    - The first recommendation should be the development and implementation of a data collection process whereby MDH and stakeholders can learn about how this system works statewide. Only if the results of this data analysis indicate that there is a systemic problem resulting in an unacceptable number of false negatives (people who should have been involuntarily treated by those who were not) can we know what fixes might be needed.
    - If MDH does develop a data collection process, as it should, this will need to include data regarding all the steps in the involuntary process including: emergency petitions, certification process and civil commitment hearing process.

- Treatment Advocacy Center
    - The draft report mischaracterizes the views of the workgroup members (such as myself) who called for psychiatric deterioration to be included within the definition of dangerousness. Repeatedly, the report asserts that some members proposed a commitment criterion which "would not include an element of danger." Since "danger to life or safety of the individual" is the term to be defined here, it would be absurd to allow a meaning that could apply to individuals who pose no such danger. But in fact the workgroup members urging inclusion of psychiatric deterioration did not suggest this. Instead we argued explicitly that an individual at risk of psychiatric deterioration in the absence of timely treatment represents a danger to their own life or safety.

- Since no member of the workgroup has called for the civil commitment of non-dangerous individuals, I am hesitant to draw too much attention to the draft report's erroneous claim that the Supreme Court in O'Connor v Donaldson held civil commitment of non-dangerous individuals to be unconstitutional. This misstatement matters only to the extent that DOH refuses to accept that individuals at risk of serious psychiatric deterioration are "dangerous" to themselves; if DOH were to accept the broader conception of "danger" outlined in the prior bullet point, a mistaken view that O'Connor prohibits civil commitment of non-dangerous individuals would be immaterial. But in light of DOH's apparently narrower view of what it means to be "dangerous," it seems important to set the record on O'Connor straight.
- The SAMHSA "Checklist for Policymakers and Practitioners" included in the report is not relevant to the question at hand, which is how Maryland should define dangerousness. The checklist lists several elements that the author considers important to include in a balanced civil commitment law. While all of these listed elements are indeed important, none of them have anything to do with how a state defines dangerousness.
- The draft report mischaracterizes the Treatment Advocacy Center's Grading the States report, and misleadingly explains away Maryland's "F" grade. It is not true that Grading the States "examin[es] the number of public psychiatric beds, number of people incarcerated with mental health issues and opportunities for diversion" in each state. In fact, Grading the States is narrowly focused solely on the quality of each state's involuntary treatment laws. It does not claim to grade the states on anything else. And it is misleading for the report to assert that Maryland's "F" grade is attributable to the state's lack of an outpatient commitment law.
- The draft report gives short shrift to the important question of whether dangerousness should be defined in statute or regulation. It does not engage at all with the arguments put forth by workgroup members as to why a legislative remedy is necessary to change practices on the ground.

Conclusion

The Involuntary Commitment Workgroup explored many facets of the complex issues related to involuntary commitment. Stakeholders were not able to reach consensus on modifying the definition, or including psychiatric deterioration without an element of danger to the dangerousness definition. The Stakeholders propose the following three recommendations:

(1) Refine the definition of the dangerousness standard in regulations;
(2) Provide comprehensive training around the dangerousness standard; and
(3) Gather additional data elements about civil commitment.

The draft Involuntary Commitment report was disseminated to Stakeholders for their feedback and comments which has been incorporated into the Report. The report is currently being disseminated to solicit public input. The final report will be submitted to the Lt. Governor's Commission to Study Mental and Behavioral Health by September 30, 2021 for further direction.

Appendices & Links

1. Report of the Outpatient Services Programs Stakeholder Workgroup Maryland Department of Health and Mental Hygiene December 10, 2014 Senate Bill 882, Chapter 352 and House Bill 1267, Chapter 353 of the Acts of 2014. Report available on BHA website.
2. Substance Abuse Mental Health Services Administration (SAMHSA), Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice. https://www.samhsa.gov/sites/default/files/civil-commitment-continuum-of-care_041919_508.pdf
3. Treatment Advocacy Center. Grading the States. An Analysis of Involuntary Psychiatric Treatment Laws- September 2020. https://www.treatmentadvocacycenter.org/grading-the-statesMental Health America. Ranking the States, 2020. https://www.mhanational.org/issues/ranking-states
4. Involuntary Commitment Meeting Minutes: March 3, 2021, March 17, 2021, April 7, 2021, and April 20, 2021.
5. Schizophrenia and Related Disorders Alliance of America. Personal statements (See April 7 minutes).
6. Appelbaum, Paul. (1997). Almost a Revolution: An International Perspective on the Law of Involuntary Commitment. http://jaapl.org/content/jaapl/25/2/135.full.pdf
7. Senate Bill 882/House Bill 1267 (2014) Summary. https://legiscan.com/MD/text/HB1267/2014
8. Sommer Knight, M.Sc., G. Eric Jarvis, M.D., M.Sc., Andrew G. Ryder, Ph.D., Myrna Lashley, Ph.D., Cecile Rousseau, M.D., M.Sc. (2021). *Ethnoracial Differences in Coercive Referral and Intervention Among Patients With First Episode Psychosis.* Retrieved July 21, 2021. https://doi.org/10.1176/appi.ps.202000715
9. Mckenzie K. J. (2014). How does untreated psychosis lead to neurological damage? *Canadian journal of psychiatry. Revue canadienne de psychiatrie*, *59*(10), 511–512. https://doi.org/10.1177/070674371405901002.
10. Martone, Gerald. April 2020. *Is Psychosis Toxic to the Brain?* Current Psychiatry. https://cdn.mdedge.com/files/s3fs-public/CP01904012.PDF. Retrieved July 21.2021.
11. Schizophrenia and Related Disorders Alliance of America. Comments on Proposed New Danger Standard Definition, April 16, 2021.
12. Executive Order 01.01.2019.06 . (2019). Establishment of the Commission to Study Mental and Behavioral Health in Maryland. https://governor.maryland.gov/wpcontent/uploads/2019/05/EO-01.01.2019.06-Commission-to-Study-Mental-and-Behavorial-Health-in-Maryland.pdf
13. Written Feedback to the July 2021 Draft Involuntary Commitment Report.

Maryland
DEPARTMENT OF HEALTH
Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Dennis R. Schrader, Acting Secretary

Behavioral Health Administration
Aliya Jones, M.D., MBA
Deputy Secretary Behavioral Health
55 Wade Ave., Dix Bldg., SGHC
Catonsville, MD 21228

Involuntary Commitment Meeting Minutes
March 3, 2021

Members Present: Marian Bland, Heidi Bunes, Evelyn Burton, Malika Curry, Risa Davis, Anne Geddes, Eleanor Dayhoff-Brannigan, Emily Datnoff, Erin Dorrien, Mona Figueroa, Dr. Aliya Jones, Erin Knight, Joana Joasil, Sharon Lipford, Dawn Luedtke, Phyllis McCann, Kirsten Robb-McGrath, Dan Martin, Christian Miele, Dr. Scott Moran, Dr. Steve Whitefield, Trina Ja'far, Kate Wyer

I. **Greetings**
Marian Bland, Director of Division of Clinical Services, Adults and Older called to order the first Involuntary Commitment Stakeholders Workgroup at 2:00 p.m.

II. **Welcome & Workgroup Purpose**
Dr. Aliya Jones, Deputy Secretary, Behavioral Health Administration
In most behavioral health systems, there are people with severe illnesses that are prone to repeated hospitalization, come into contact with the criminal justice system and struggle to get the treatment they need. Many states use some form of civil commitment to serve as a safety net when a person, due to their illness, is not able to maintain basic survival skills for self-care. Despite the clear need for medical intervention, providing treatment to persons in extreme situations is not an easy task and hospitalization is often a critical first step in initiating psychiatric care. Over the last several years, states have become more specific on defining dangerousness. In Maryland, there is unclear language in the statutes and regulations which has led to wide interpretation of the law.

The Lt. Governor has asked BHA to examine the definitions of Involuntary Commitment in Maryland and better define harm to self/others and grave disability. Through the

Stakeholder workgroup, we will have discussions to better define language of civil commitment. We want to have statutes, regulations and a process that balances when a person needs hospitalization against their will while ensuring personal autonomy and care in the least restrictive manner. Today, we are here to listen to your thoughts, to have a shared discussion, to learn and better define the definition of harm to self and grave disability. Together we can bring these issues to light and move civil commitment in Maryland in the direction that better serves consumers and communities.

III. National Advocacy Organizations & Rankings
Sharon Lipford, Program Administrator, Behavioral Health Administration

There are two national advocacy organizations that bring diverse perspectives on behavioral health treatment and services:

Treatment Advocacy Center (TAC) a national nonprofit organization dedicated to eliminating barriers to the timely and effective treatment of severe mental illness.

Mental Health America (MHA) is a community-based nonprofit dedicated to addressing the needs of those living with mental illness and promoting the overall mental health of all.

The TAC report examines laws across the country for involuntary treatment. Ten states received an A and eight states received an F. Maryland was one of the states to receive an F. TAC looks at public psychiatric beds, number of people incarcerated with mental health issues and opportunities for diversion. The TAC report advocates for more clearly defined criteria for involuntary commitment and supports outpatient treatment.

MHA's report looks at 15 indicators for youth and adults to assess the comprehensiveness of the behavioral health treatment system. They advocate for policy, programming, and analysis. In their national report card, MHA gave Maryland an A. Minnesota ranked high on both the TAC and MHA reports which might be used as a resource.

IV. Overview of Involuntary Commitment Statute and Definitions
Eleanor Dayhoff-Brannigan, Assistant Attorney General, Office of the Attorney General
There is interest in updating the definition of "danger to self or others" in the regulation to more clearly include language that requires the Administrative Law Judge or judge to include the possibility or probability of self-neglect in the analysis.

Involuntary Admission Overview:

- A clinician or peace officer completes an emergency petition which doesn't have to be reviewed by a judge. The individual is directly taken to an emergency department.

- Involuntary Admission to a psychiatric facility can occur when an "interested person" fills out an Emergency Psychiatric Evaluation (EPE) form and requests that an individual be committed.

- A judge reviews the EPE form and determines whether the individual should be admitted for an emergency evaluation.

- After the emergency evaluation, the hospital determines whether to file an application for involuntary admission (IVA) to the hospital.

- The Office of Administrative Hearing holds an Involuntary hearing and determines whether the individual should be involuntarily committed.

- Involuntary admissions also occur every six months if an individual needs to remain committed and can be filed by the treatment team or facility where the individual is receiving treatment.

- Involuntary admission procedures are both in statute (Health General 10-616) and Regulation (10.21.01 et. seq.)

Component Parts of an Inpatient Commitment Standard
https://www.samhsa.gov/sites/default/files/civil-commitment-continuum-of-care.pdf

Minnesota Statute:
"Danger to self or others" includes:

- a failure to obtain necessary food, clothing, shelter, or medical care as a result of the impairment;
- an inability for reasons other than indigence to obtain necessary food, clothing, shelter, or medical care as a result of the impairment and it is more probable than not that the person will suffer substantial harm, significant psychiatric deterioration or debilitation, or serious illness, unless appropriate treatment and services are provided;
- a recent attempt or threat to physically harm self or others; or
- recent and volitional conduct involving significant damage to substantial property.
- A person does not pose a risk of harm due to mental illness under this section if the person's impairment is solely due to:
  (1) epilepsy;
  (2) developmental disability;
  (3) brief periods of intoxication caused by alcohol, drugs, or other mind-altering substances; or
  (4) dependence upon or addiction to any alcohol, drugs, or other mind-altering substances

Michigan Statute:

MICH. COMP. LAWS § 330.1401(1).

As used in this chapter, "person requiring treatment" means (a), (b), (c), or (d):

(a) An individual who has mental illness, and who as a result of that mental illness can reasonably be expected within the near future to intentionally or unintentionally seriously physically injure himself, herself, or another individual, and who has engaged in an act or acts or made significant threats that are substantially supportive of the expectation.

(b) An individual who has mental illness, and who as a result of that mental illness is unable to attend to those of his or her basic physical needs such as food, clothing, or shelter that must be attended to in order for the individual to avoid serious harm in the near future, and who has demonstrated that inability by failing to attend to those basic physical needs.

(c) An individual who has mental illness, whose judgment is so impaired by that mental illness that he or she is unable to understand his or her need for treatment, and whose impaired judgment, on the basis of competent clinical opinion, presents a substantial risk of significant physical or mental harm to the individual in the near future or presents a substantial risk of physical harm to others in the near future.

(a) An individual who has mental illness, whose understanding of the need for treatment is impaired to the point that he or she is unlikely to voluntarily participate in or adhere to treatment that has been determined necessary to prevent a relapse or harmful deterioration of his or her condition, and whose noncompliance with treatment has been a factor in the individual's placement in a psychiatric hospital, prison, or jail at least 2 times within the last 48 months or whose noncompliance with treatment has been a factor in the individual's committing 1 or more acts, attempts, or threats of serious violent behavior within the last 48 months. An individual under this subdivision is only eligible to receive assisted outpatient treatment.

HB 928 / SB 1344
Proposed Definition of Dangerousness
"Danger to the life or safety of the individual or of others" means a substantial risk, in consideration of the individual's current condition and, if available, personal and medical history, that the individual will:

(1) cause bodily harm to the individual or another individual; or

(2) be unable, except for reasons of indigence , to provide for the individual's basic needs, including food, clothing, health, or safety; or

(3) suffer substantial deterioration of the individual's judgment, reasoning, or ability to control behavior, provided that the individual is currently unable to make a rational and informed decision as to whether to submit to treatment.

Further clarification includes:
"(3) The individual [presents] IS REASONABLY EXPECTED, IF NOT HOSPITALIZED, TO PRESENT a danger to the life or safety of the individual or of others;"

V. **Maryland Department of Disabilities – Youth & Families Subcommittee Workgroup**
Christian Miele, Deputy Secretary, Maryland Department of Disabilities and Dawn Luedtke

Our charge is to identify mental health personnel and resource needs in each jurisdiction, determine best practices and identify successful initiatives. To influence policy, the workgroup would provide recommendations to the subcommittee. If the subcommittee wants to make a recommendation it is sent to the full commission and then to the Governor.

In 2003 the words related to imminent danger were removed from the statute. It was believed that this change would create flexibility with law enforcement doing the petitions and taking people to treatment but that didn't happen. Law enforcement seems to view the emergency petition as a last resort probably because of the probable cause standard.

VI. **Maryland's Robust Community Behavioral Health**
Marian Bland, Director of Division of Clinical Services, Adults and Older Adults
Maryland has a comprehensive, well developed behavioral health system in Maryland. Services include:

- Assertive Community Treatment programs (evidenced-based)- There are currently 24 ACT Teams and 22 Mobile Treatment Teams in Maryland
- Comprehensive, statewide network of outpatient clinics
- Crisis Services -hotlines, mobile crisis teams, walk-in/urgent care, stabilization/crisisresidential beds
- Crisis Intervention Teams (CIT) – law enforcement response (all jurisdictions receive funding)
- Detention Center Programs – jail and reentry
- Forensic Assertive Community Treatment in Baltimore City
- Mental Health Court Programs
- Outpatient Commitment Pilot in Baltimore City
- Peer Support Programs – WRAP, Psychiatric Advance Directives

VII. **Discussion & Next Steps**
Marian Bland, Director of Division of Clinical Services, Adults and Older Adults
Stakeholders discussed the Involuntary Commitment process and commented on various aspects of the revising the definition of dangerousness. Comments/Discussion included:

- It seems like Minnesota is viewed as the gold standard. Is there any data on how it was implemented and what types of groups were targeted? Minnesota's population is different from Maryland and some of the language may target people we don't need to target, including those with past incarcerations, vulnerable populations, and people of color.

- The Michigan statute has tight language that is tied to the mental health disorder whereas HB 928 doesn't.

- The imminent danger part of the Maryland statute that was re,moved is still a barrier for families to get treatment for their loved ones. Unless the person is totally debilitated for several days, the mobile crisis teams won't even come out. It's important to clarify that danger doesn't need to be imminent.

- The current dangerousness standard could be a driver to placing people into situations of homelessness and incarceration.

- We need to be careful that stigma, discrimination, ignorance and racism can come into play when it comes to one person making a snap assessment especially for young men with black or brown skin. There needs to be education and training to teach decision making.

- ACT teams can create strong relationships based on mutual respect and trust. What type of help is a person getting from a stranger that shows up and makes choices about where you spend the next 6 months of your life?

- When we talk about treatment what are we really saying? Does it mean that people will be forced to take medication? Medication may help some people but it is not a silver bullet. We need to be aware that there are more options that can be used to help someone feel in control. We don't want to take away someone's due process if they are refusing medications.

- The new statute opens the door for a lot of involuntary commitments.

- Getting people into hospitals doesn't help them resolve psychiatric psychosis. There needs to be more outpatient treatment.

- Choices should be included into our system.

- The clinical review process is cumbersome, we may have to look at that process as well. When someone is in a facility and refuses medication the appeal process can take 15-21 days. That is a barrier for getting people the help they need. It is a civil rights and due process issue.

- Like including language regarding the inability to provide food or shelter but this can result in individuals being hospitalized indefinitely.

- This discussion is important to families who cannot get their loved ones in treatment when they need it. Many times those who need involuntary commitment don't recognize they have a mental illness and they are experiencing active psychosis.

- There were questions about the number of people served in Baltimore's Outpatient Civil Commitment Program and whether BHA could invite BHSB to

provide and update on the Outpatient Civil Commitment Program? BHA will invite Baltimore City's OCC to present at a future meeting on the program's progress and challenges.

Dr. Jones provided closing remarks. Our goal by the last stakeholder workgroup meeting is to put forward a recommendation in the best interest of those who may be put in the situation of being involuntarily committed and helping people get what they need.

VIII. Next Meetings:
Marian shared the dates of the next meetings:

- March 17, 2021 1:00 - 2:30 PM (2nd meeting)
- April 7, 2021 2:00 - 3:30 PM (3rd meeting)
- April 20, 2021 11:00 AM - 12:30 PM (4th meeting, if needed)

Meeting adjourned at 3:30 p.m.

Maryland
DEPARTMENT OF HEALTH
Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Dennis R. Schrader, Acting Secretary

Involuntary Commitment Stakeholders' Workgroup
March 17, 2021
Minutes

Attendees
Marian Bland, Michelle Fleming, Anne Geddes, Brande Ward, Brian Stettin, Caren Howard, Carol McCabe, Dan Martin, Darren McGregor, Dawn Luedke, Debbie Plotnick, Eleanor Dayhoff-Brannigan, Eric Roskes, Erin Dorien, Erin Knight, Kate Wyer, Katie Dilley, Katie Rouse, Katie Dille, Kirsten Robb-McGrath, Malika Curry, Moira Cyphers, Phyllis McCann, Regina Morales, Risa Davis, Steve Johnson, Scott Moran, Sharon Lipford, Susan Steinberg, Steve Whitefield

1. **Welcome and Purpose/Goals of Stakeholder's Workgroup Reviewed - zMarian Bland**

   Marian shared the goals of the meeting for March 17, 2021 and were the following:

   Goal 1: Continue review of best practices.

   Goal 2: Hear from individuals with lived experience.

   Goal 3: Define danger to self and grave disability.

2. **March 3, 2021 Minutes were Reviewed - Marian Bland**

   Katie Rouse was added as an attendee from last meeting.

3. **Review of Stakeholder Comments - Marian Bland**

   Marian reviewed the comments from the stakeholders meeting held on March 3, 2021. Comments are reflected in the March 3, 2021 minutes.

4. **Review Discussion/Information about Populations - Eleanor Dayhoff**

   Eleanor provided feedback from the March 3 meeting reporting on the populations of race by state. At the last meeting we discussed language from different states and there were questions regarding the populations between the states.

   - Minnesota - 82% white
   - Michigan - 74.8 % white
   - West Virginia - 92% white
   - Illinois - 60% white and 23% non-English speaking
   - Maryland - 50.2% white

Maryland's population is most similar to Illinois.

Most states have a definition of dangerousness that includes some form of neglect. The major concern is regarding population and bias. How much does racial bias and other biases impact involuntary commitment? There is some merit to having a timeline in the definition of danger to self and others. Prior violence for a person with mental health issues is the highest predictor for future violence.

Maryland is not considering the language from Michigan statute which requires a set number of acts to happen within a set time frame in order to consider involuntary commitment.

Comment: The proposed legislation is trying to solve a resource problem. People wait in the ER for hours and sometimes weeks for a bed when they meet civil commitment criteria. This law will not solve that problem.

Comment: The more you try to spell out who gets civilly committed the more restrictive the process becomes.

Comment: It is inexcusable that parents are told to call back when their child is dangerous. The issue is that people aren't able to get help earlier.

5. Persons with Lived Experiences - Consumer Quality Team, Kate Wyer, Senior Director

Kate provided an overview/comments from people interviewed through the CQT program regarding the Outpatient Civil Commitment Program. Specifically, comments from people with lived experience include:

- "This program has been helpful in getting me on track."
- "This program helped me and saved my life."
- "The counselor is helping me get a place to live."
- "It's going good, the counselor makes sure I have food, medication and a roof over my head."

The quality team is staffed with people who have lived experience. There is a resource called Open Dialogue for families and the peer community. It was developed to help people in crisis situations. There will be a two-day training in May.
https://dialoguerevolution.com/training/opening-dialogues

Steve Johnson from Behavioral Health System Baltimore (BHSB) will present on the Outpatient Civil Commitment Pilot Program (OCC) pilot program at a later date (April 20, 2021 meeting)

6. SAMHSA Checklist (PowerPoint) - Sharon Lipford

SAMHSA developed a report called Civil Commitment and the Mental Health Continuum of Care: Historical Trends and Principles for Law and Practice. SAMHSA created a checklist to help policy makers and practitioners identify several elements for civil commitment. As we move forward redefining the Maryland statute, we plan to use the SAMHSA best practices as a template.

7. Review- West Virginia Statute and Revisions - Maryland's Involuntary Commitment Definition - Eleanor Dayhoff- Brannigan

Eleanor Dayhoff-Brannigan reviewed the West Virginia statute. Eminent danger is more short term and foreseeable danger is not.
Question: Is there any data on involuntary commitments among Indigenous/Native Population?

Unfortunately, BHA does not have an answer at this time. However, we will research the topic and share any data with the group.

Comment: Maryland's statute hasn't required imminent danger since 2003. We don't have any time frames included in our statute right now.

Comment: That's a good thing. I would hate to see us move there.

Comment: Just because someone doesn't take their medication, it doesn't indicate that they will be dangerous. It is more likely that they need engagement.

Comment: Clinicians are notoriously bad for predicting dangerousness. We need to be very clear that our ability to see someone's dangerousness is very limited.

Comment: The current definition of dangerousness affords doctors and law enforcement the ability to need for emergency petitions.

Comment: There were an estimated 8,000 emergency petitions last year. Less than 350 were released by judges because they didn't meet the dangerousness standard.

Comment: The dangerousness standard is for involuntary commitment and emergency petitions which means police and lay persons will have to interpret it. If clinicians struggle, law enforcement will not be able to determine based on psychiatric deterioration if someone is going to be a danger in the foreseeable future.

Comment: It's very telling that we frame the conversation around danger and not safety. Ultimately, we want people to be safe. What is the experience of a person going through this and sitting in the waiting room for hours?

Comment: I have concerns about caring for self the way it is written in the West Virginia stature. It is written as "or" and not "and."

8. ChatBox - Discussion/Comments - All

Comment: The comment that HB 1344 does not link the danger standard to having a mental illness is not accurate. Also the comment about the target population applies only to outpatient commitment.

Comment: What about NJ? Also a fairly close match to MD in terms of demographic makeup.

Comment: Prior violence for a person with serious mental illness is the highest predictor of future violence when psychotic. History is vital.

Comment: Isn't the question with respect to prior criminal record is whether it's criminal record in general (not necessarily correlative) or conviction of a crime of violence?

Comment: What are the Stats on Indigenous/American Indian Populations?

Comment: I am curious whether anyone has reviewed research on the impact of statutory changes on civil commitment rates or decisions.

Comment: To be clear, the standards in Michigan and elsewhere consider a certain number of incidents in a certain period of time are standards for outpatient commitment only. That would not make sense as an inpatient standard. Dr. Roskes, there is an unfortunate dearth of research on that question.

Comment: Correct.

Comment: MHA has also found that the criteria does NOT matter.

Comment: This is the TAC roundup of state's IVA laws: https://www.treatmentadvocacycenter.org/storage/documents/state-standards/state-standards-for-civil-commitment.pdf.

Comment: The current standard in 10-617 does not require imminence. I am going to die in the foreseeable future. Is that what we mean?

Comment: Carroll McCabe: Our office represents over 8,000 people. The interpretation of the definition of dangerousness is in an extremely broad way. It's not just physical danger of others but to self because people don't take their medications or care for themselves. The refusal of medications, lack of insight shouldn't drive this [issue]. We see people who are being emergency petitioned. Hopkins releases over 50% from the emergency department because they don't need inpatient psychiatric care. I don't see the need for change of the dangerousness definition. Nobody is talking about collateral consequences.

Comment: I concur with Scott Moran's statements. Our ability to predict dangerousness in the very near term (minutes-hours) is pretty good. Beyond that, the accuracy of our predictions falls off very quickly.

Comment: MSP obtained data from OAH indicating that 90% of those patients taken to hearing are retained at the hearing, in about 800 hearings per month.

Comment: The current standard results in a very narrow interpretation of imminent danger of suicidal or homicidal because they are not familiar with court precedent. The law needs to reflect the broader standard. Only those who meet the narrow standard even get to the commitment hearing. ER doctors interpret danger as imminent according to Delegate Morheim, an ER doctor. Very serious consequences to denial of treatment: suicide, incarceration, homelessness, violence.

Comment: It's about being safe. Emotionally, physically, essentially. What is missing, is that everything has consequences. What is the experience of a person who goes through the process? Sitting in the ED escalates feelings of panic, fear, paranoia. While conversation focuses on specific sets of folks, the standards apply across the state. Many more people, due to COVID, have lots of folks not getting what they need in the moment and being pushed away out of fear of completely losing their life. What we need to look at is safety and not always the conversation on how soon a person is going to be dangerous.

Comment: Thank you Carroll for bringing up the collateral damage from involuntary commitment. This issue keeps veterans, police and others from reaching out or accepting help.

Comment: Again: if people misinterpret the standard of "danger" which is what the statue says as "imminent danger" which is not what it says, and thereby improperly not committing people that should be committed, that is a TRAINING issue, and will not be resolved by changing the statute.

9. Meeting Recap and Next Steps - Marian Bland

Marian stated that the Outpatient Civil Commitment Program will be invited to present at a future meeting. The next Involuntary Commitment meeting will be held on April 7, 2021. The time may need to be changed because it conflicts with BHA's 988 meeting as noted by Dan Martin Marian acknowledged the comments and questions included in the chat box and informed the group the information will be included in the minutes and discussed at the next meeting. The revised definition will be sent out to the group prior to the next meeting for review. The document referenced by Dr. Roskes *Study to Change Civil Commitment* will also be sent out.

Maryland
DEPARTMENT OF HEALTH

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Dennis R. Schrader, Secretary

Behavioral Health Administration
Aliya Jones, M.D., MBA
Deputy Secretary Behavioral Health
55 Wade Ave., Dix Bldg., SGHC
Catonsville, MD 21228

Involuntary Commitment Stakeholders' Workgroup
April 7, 2021
Minutes

Attendees
Anne Geddes, Brande Ward (Yahtiley Phoenix), Brian Stettin, Carroll McCabe, Dan Martin, Dawn Luedtke, Phyllis McCann, Sharon Lipford, Susan Steinberg, Eleanor Dayhoff- Brannigan, Dr. Erik Roskes, Erin Dorrien, Erin Knight, Evelyn Burton, Jennifer Redding, Risa Davis, Steve Johnson, Kate Farinholt, Katie Rouse, Kirsten Robb-McGrath, Marian Bland, Malika Curry, Moira Cyphers, Mona Figueroa, Dr. Scott Moran, Dr. Steven Whitefield, Trina Ja'far.

I. **Welcome and Introductions:** Ms. Marian Bland

II. **Review of March 17, 2021 Minutes and Meeting Recap:** Marian Bland
The minutes were reviewed and accepted. The purpose of the Involuntary Commitment meeting is to continue to review best practices; hear from family members and individuals with lived experiences; and continue to discuss the definition of danger to self and grave disability.

III. **Community Member Presentations:**
Brande Ward (Yahtiley Phoenix), Peer Recovery Specialist, Maryland Peer Advisory Council, Cherokee Nation Eastern Band (Descendant)
"There is a lack of classification by race and treatment isn't culturally appropriate. There are 7,000 indigenous native people living in Baltimore City (2010 Census) and there aren't any stats. Treatment is deplorable and there are no conversations or advocacy for indigenous people. When I was hospitalized, I didn't have a say in my treatment plan. My treatment plan wasn't discussed with me, I wasn't allowed to go outside and connecting with nature is a part of my culture. Culture is critical to treatment".

Ann Geddes, Policy Director, Maryland Coalition for Families
There are very different opinions about involuntary commitment. What families agree on is that they want their loved ones to have easy access to quality treatment and services. We believe that this is where our focus should be, building out comprehensive services and supports for mental health illness. We must acknowledge that involuntary commitment is traumatizing and can have long term negative consequences which can result in aversion to treatment. My

family's personal experience with involuntary commitment is that it didn't help to facilitate recovery, it impeded it.

Evelyn Burton, Advocacy Chair, Maryland Chapter of Schizophrenia and Related Disorder Alliance of America

Ms. Burton provided statements from community members.
Comments on Maryland's Danger Standard by Kelly Proctor, Howard Co. 4/7/2021

Five years ago, my then 20-year-old son was diagnosed with Bipolar disorder, acute psychosis, and schizoaffective disorder. During his year and a half psychosis, our family went from being afraid for my son to being afraid of him. Calling for assistance turned out to be very stressful because my husband and I were constantly asked if my son had assaulted us. I am outraged that being attacked by my son is the standard that Maryland has set to provide my son assistance. It became clear that Maryland laws are reactive and not proactive in helping families in a mental health crisis. Currently, Maryland law does not consider property destruction from a violent outburst as a sign of psychiatric deterioration and does not seem to understand that psychosis does not just go away on its own. Our family was often in danger, sleeping in shifts and carrying pepper spray. My husband and I were scared of the consequences of filing for an emergency petition while living with someone so unstable.

Today, my husband and I remain hyper-vigilant in our son's interactions, always looking for signs that he is a danger to himself or others. To date, as a caregiver, it is my job to identify and manage the severity of a psychotic episode since the current law does not provide support or help. Although a mental illness diagnosis in a family is life-changing, it should not be a sentence for a lifetime of fear.

Maryland needs to recognize that property destruction is one of the signs of imminent danger in a psychotic episode. This law allows the providers of care to file for an emergency petition before a tragedy occurs. Families, like mine, should not have to continue to live with trauma and constant fear waiting for harm to occur before evaluation and treatment are available.

Comments on the BHA Proposed Danger Standard by Karen Logan

The proposed BHA danger standard for emergency evaluation and involuntary hospital commitment would NOT have prevented the tragic deaths of two sheriffs and the incarceration of my son, because it does not clearly include "serious psychiatric deterioration" as one of the criteria.

FIVE DAYS! FIVE DAYS! That was the time from the first clear signs of any mental illness, to severe paranoid fears resulting in the deaths of two young sheriffs. Before the fifth day there was no evidence of substantial risk of harm, death, or bodily injury, and then it was too late.

DAY 1: We recognized the symptoms of irrational behavior, agitation, hallucinations, delusions, and paranoid fears, since we have relatives with schizophrenia and bipolar disorder.

DAY 2: My son agreed to go to the ER for an evaluation. The psychiatrist said he needed to be admitted immediately for treatment, but psychiatric deterioration did not meet the criteria for involuntary admission. My son told his father that the psychiatrist had strange eyes and he "was one of those people" trying to get him, so he refused admission.

DAY 3 and 4: His psychosis worsened. He refused outpatient treatment.

DAY 5: My son's wife and I filed an emergency petition. The judge was unwilling to agree based on the psychiatric deterioration. Finally, when we told him my son's recent statements about not being around much longer, the judge considered them a possible threat of harm, and agreed. Unfortunately, my son's paranoia was so severe by then, it resulted in the deaths of the two sheriffs who served the petition.

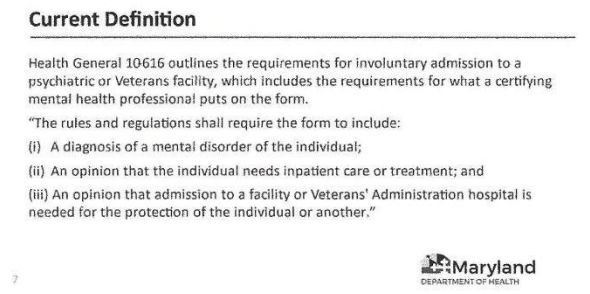
Please include psychiatric deterioration in your definition of danger. This is vital so that physicians, police, and judges, will allow emergency petitions and involuntary hospital admissions in time to prevent more tragic deaths, incarcerations, and broken families.

Statement on the BHA Proposed Danger Standard by Charles Ippolito, 4-7-21
I am the parent of a 50-year-old son who suffers from mental illness. Many of you may have read our story in the June 2014 Washington Post article entitled "The Man in the House". Ref link:http://m.washingtonpost.com/national/behind-the-yellow-door-a-mans-mental-illness-worsens/2014/06/28/28bdfa9c-fbb5-11e3-b1f4-8e77c632c07b_story.html . The proposed danger standard would NOT have helped me to get an evaluation or hospital treatment for my son because it does not include the criteria of a substantial risk of psychiatric deterioration. My son has schizoaffective disorder, and isolated himself in his house for over 3 years, was psychotic, unable to coherently communicate with anyone, including his family and children, and was clearly suffering psychiatric deterioration, believed there was nothing wrong with him and adamantly refused treatment. His family moved out of the house, his wife divorced him, he lost his six-figure professional job, could no longer work or manage his financial affairs, his only contact with his 3 young children was occasionally watching them play on skype, the house where he lived is in foreclosed on and his car was repossessed. He became homeless. However he never actually threatened to harm or caused harm to himself or others, or injured anyone, or was unable to care for himself, so I would not have met the proposed standard. For my son to get the treatment he needed, the law to clearly state that one criterion for emergency evaluation and involuntary hospitalization is a "substantial risk of psychiatric deterioration." Allowing a person to mentally deteriorate and remain psychotic for over three years is inhumane and in no one's best interest, not the state and not the person. Our whole family continues to suffer. Please, please help us by adding the criteria of "substantial risk of psychiatric deterioration" to the danger standard so there will be no question in the minds of peace officers, judges, and mental health professionals that those like my son are eligible for emergency evaluation and involuntary hospital treatment.

Comments on the BHA Proposed Danger Standard by Liz Montaner, 4/7/21
I am the mother of a 36-year-old son diagnosed with schizophrenia. The current BHA draft standards for the definition of dangerousness would not have helped facilitate treatment for my son after his first psychotic break. This is because it does not include any criteria for significant psychiatric deterioration. It would not have eliminated the need for us to ask him to leave home and make him homeless in a vulnerable psychotic condition. After graduating from college, my

son began showing signs of psychosis. Unfortunately, he did not believe he was ill. He had a neurological deficit called anosognosia which prevented him from understanding that many of his thoughts were not reality based. He saw no reason for any psychiatric treatment and refused it. He did not meet the standards of the current law and he would not have met the proposed danger standard since there was no substantial risk of harm to self or others or of grave disability at that time, only psychiatric deterioration. We made the extremely difficult decision to make him homeless, because we believed it was the only way to have a shot at treatment.
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. Please clarify Maryland's danger standard by including significant psychiatric deterioration so that future Maryland families can seek treatment sooner which will improve the long-term outcomes of their loved ones.

IV. **Revision- Maryland's Involuntary Commitment Definition:** Dr. Steven Whitefield
Dr. Whitefield provided a review of the current definition and discussed proposed changes.



Current Definition

Health General 10-616 outlines the requirements for involuntary admission to a psychiatric or Veterans facility, which includes the requirements for what a certifying mental health professional puts on the form.

"The rules and regulations shall require the form to include:

(i) A diagnosis of a mental disorder of the individual;

(ii) An opinion that the individual needs inpatient care or treatment; and

(iii) An opinion that admission to a facility or Veterans' Administration hospital is needed for the protection of the individual or another."

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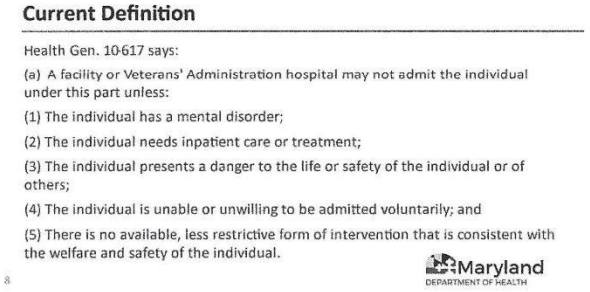

Current Definition

Health Gen. 10-617 says:

(a) A facility or Veterans' Administration hospital may not admit the individual under this part unless:

(1) The individual has a mental disorder;

(2) The individual needs inpatient care or treatment;

(3) The individual presents a danger to the life or safety of the individual or of others;

(4) The individual is unable or unwilling to be admitted voluntarily; and

(5) There is no available, less restrictive form of intervention that is consistent with the welfare and safety of the individual.

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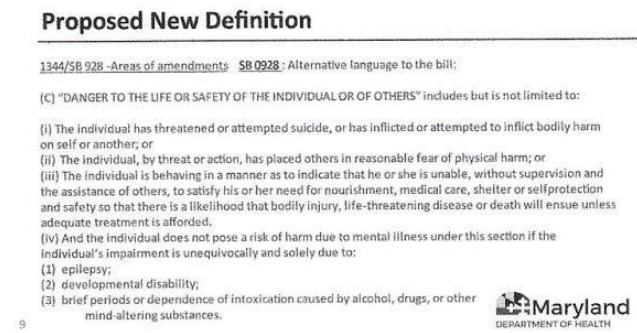

V. Stakeholder Discussion & Feedback:

1. *Comment:* I have concerns from a patient's right perspective. The language is entirely retrospective. There's nothing that says that we are trying to identify the danger that the person is likely to present in the foreseeable future. It's a terrible missed opportunity to not include language like psychiatric deterioration as a basis for involuntary commitment. The likelihood that someone could cause harm to their mind is a danger in itself.

2. *Comment:* The "or" at the end of each semicolon should be "and." There is no temporal relationship in the language for the standard which is extremely concerning. The language is so broad that it will push people away.

3. *Comment:* It's important to remember all the criteria. Just because somebody has attempted suicide, it doesn't make them eligible for involuntary commitment.

4. *Comment:* Roman Numeral III is written in such a way that it describes people that are living in the community successfully. This is not the first time that we, as a community, have discussed the dangerous standard. There was a process a number of years ago where there was a significant amount of work was done and meetings around efforts to make some changes to the wording of the dangerous standard. There was proposed language that the stakeholders were in agreement with and I don't think it went anywhere after it was proposed. Can we revisit that language?

5. *Comment:* The predictions on future danger are notoriously unreliable even for trained professionals. We have seen studies that show they are slightly more reliable than chance. This is not going to be interpreted by just mental health professionals. It will be interpreted by police officers and lay people. If mental health professionals struggle with determining dangerousness, I think it's reasonable to assume that people who aren't trained in mental health will struggle. Roman Numeral III doesn't do a good enough job tying the inability to care for oneself to the mental illness regardless of the qualifier at the end. We strongly object to the inclusion of psychiatric deterioration consideration. Just because someone is at risk for worsening symptoms doesn't mean they will become a danger to themselves or to others. Including psychiatric deterioration could create a vastly over broad group of people that will be subjected to involuntary commitment.

6. *Comment:* NAMI supports clear language to define danger appropriately and I think that the proposed expanded definition is a strong start.

7. *Comment:* Where the crisis situations mentioned is a result of not receiving services in the community that are culturally competent and culturally specialized. We should be focusing on creating services that are preventive, supportive and less intensive. Hospitalization is not a stop gap. There has to be a conversation about how a person can be supported when they leave the hospital. We are making a lot of educated guesses and predictions that changing the standard will help and the results will be positive or negative. What's the plan for evaluating the impact of the proposed challenges? What data will we be able to look at on a regular basis that accounts for equity and bias so that we can tell whether or not the changes have made any impact?

8. *Comment:* Dr. Whitfield mentioned that the current standard is short and broad and I think that's the key point. The current standard allows clinicians at the point of service to make determinations based on broad language. It's actually the most permissible language that we have in the country and it should remain untouched. As I have said in the last 3 rounds of this conversation over the last decade, the problem is resources. We need resources in the community which include a broad spectrum of services that's readily available to people in the community for people when they want them. This includes not just clinical services but peer run services and support services that we are under-funding and under-providing in the state. To reiterate, we should be making decisions based on data and not anecdotes.

9. *Comment:* I would really be interested in seeing the language from 2014. In particular, the danger to self and to others. Including reasonable fear of physical harm is important. It's inappropriate that someone so ill must reach the point of harm to themselves or others before treatment is provided. The process of waiting for someone to declare that they want to harm themselves or decompensate, is in and of itself perpetuating trauma and harm. Where's the state's responsibility and accountability in protecting this population and preventing them from having to get to that place before they get treatment?

10. *Comment:* Are we here to talk about system change or the danger standards and involuntary commitment standard? This keeps coming up and being an issue because the law isn't working. It's really hard to get a group like this to reach a consensus without taking action. Are we looking at regs? Are we looking at a bill or just going to have more meetings and just say there's no agreement and then the subject gets dropped?

11. *Comment:* This particular workgroup was asked to look at the danger to self and grave disability. There is a commission studying mental and behavioral health and there is also a system of care workgroup meeting to discuss system changes.

12. *Comment:* I participated in the meetings in 2013 and 2014 and there wasn't a unanimous agreement on what was reached for psychiatric deterioration in that proposal. In terms of predicting dangerousness, those studies primarily occur when referred to violent dangerousness and that may be difficult to predict but if someone stops eating, they will have serious repercussions. Future risk is something that doctors can assess.

13. *Comment:* Is there a time limit on the history of threatening or attempted suicide or bodily harm? If not, it would be helpful to add language to clarify.

14. *Comment:* Section (iv) number (iii), indicates to me that someone who has a chronic drug or alcohol problem can be subject to involuntary commitment in a psychiatric hospital.

15. *Comment:* The intent is to exclude someone who has a diagnosis of SUD (substance use disorder).

16. *Comment:* Problem with number one, judges will not admit information that is not relevant.

VI. **Review of Stakeholder Comments from Chat Box:** Note-chats regarding the quality of WIFI, joining/leaving the meeting were not included.

1. *Comment:* In this definition, where would Indigenous/Native People be included? Response: Data for the Indigenous/Native population regarding involuntary commitment is not collected.

2. *Comment*: Stakeholder provided the name of a book. Katie, can you repeat the name of the book again? The Body Keeps the Score: https//www.ncbi.nlm.nih/gov/pmc/articles/PMC4414784/.

3. *Comment:* If there was a time limit on the history of threatening or attempted suicide or bodily harm, would that be helpful or not? Or adding language that clarifies that it should be recent?

4. *Comment:* The reason this keeps coming up is because we don't take on those systems limitations. Until there are adequate resources, tweaking the statute will make little difference. Read the Appelbaum article.

5. *Comment:* There should be a temporal relationship between the criteria for the standard to fence in how it is applied so that it's related to current status.

6. *Comment*: You cannot isolate this issue from the broader system in which this issue exists.

7. *Comment:* Would the issue of 'interpretation' be addressed by changing a definition? Or only by requiring a standard training for all folks/roles involved in implementing the EP/IVA process? It would be interesting to see what the impact would be if BHA instituted a bi or tri-annual training requirement sort of like CPR certification.

8. *Comment:* From an MPS perspective: the more you create a list, even if it says "not limited to", the more you risk those trying to execute the law will view it as an exhaustive list, not as a list of potential suggestions that is incomplete and allows for others. If we think that people have trouble interpreting the current statute, which, if true, means training is needed, wait till we make it more complicated.

9. *Comment:* Everyone keeps talking about HB 1344/SB 928 and neither got out of committee.

10. *Comment*: Agree with Katie. Regardless of the definition, it will still be subject to interpretation. Consistency requires training.

11. *Comment:* The Office of the Public Defender (OPD) has represented more than 30,000 individuals at involuntary civil commitment hearings since I have been Chief of the Mental Health Division in 2016. The Maryland Court of Appeals and the Administrative Law Judges who hear these cases have broadly interpreted the current dangerousness standard. The Maryland Court of Appeals and every Administrative Law Judge has interpreted dangerous to include the behavior described in the proposed definition a(i), (ii) and (iii).

12. *Comment*: Would the providers agree to additional training? Would they pay for the CEs or the state? Seems like a fight over training requirements would forestall any kind of progress rather than a statute change.

13. *Comment:* 10-708 is not germane to this discussion.

14. *Comment:* The Supreme Court and Maryland law require that each criterion for involuntary commitment be proved by clear and convincing evidence. The Supreme Court also requires proof by clear and convincing evidence that a person's dangerousness is derivative of their mental illness.

15. *Comment:* Moira- with the wonders of technology, I wonder if it could just be a free 1-hr webinar, held 4x/year.

16. *Comment*: Correct. 10-708 is not applicable to this definition.

17. *Comment:* I'm not saying it's a bad idea, Katie just that figuring out the logistics of that and getting various groups of providers all to agree and then figuring out who monitors how the training is administered, how the module is developed, whether the providers occupational boards need to be involved and whether or not there are penalties for compliance...like we could have a whole work group on that.

18. *Comment*: I do as well. I'd like to suggest time limits on oral comments to give everyone a chance to participate.

19. *Comment: We* should not be legislating by anecdote. We need data.

20. *Comment:* I hear you, Moira! It would be a puzzle for sure. It's just a little surprising to me that there isn't a standard training available for such an impactful action that so many clinicians, LEOs, etc. can be reasonably expected to face at some point in their career.

21. *Comment:* I respect all the work BHA is putting into these issues and we were asked to respond to their proposed changes to the law so it's a bit unfair to say you can't separate this issue out from systemic problems when that's exactly what we were asked to do. No one is denying this is larger than a legislative change or pretending that this will solve all our problems.

VII. **Next Steps:** Marian Bland

BHA will review all the feedback discussed and will make changes to the proposed definition based on today's discussion. BHA will resend to the group a copy of the 2014 report mentioned by several of the members of this group. At the next meeting we will provide NAMI an opportunity to present. We will send out the comments submitted to BHA by NAMI and the Schizophrenia and Related Disorders Alliance of America (SARDAA). We will also see what data is available on Involuntary Commitments and finalize the proposed definition of danger to self and others.

The next meeting will be held: April 20, 2021 | 11 a.m. to 12:30 p.m. (4th meeting)

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Involuntary Commitment Stakeholders' Workgroup
April 20, 2021
Minutes

Opening and Welcome
Marian Bland, Director of Division of Clinical Services, Adults and Older Adults
Behavioral Health Administration

Attendees - Marian Bland, Brian Stettin, Dr. Erik Roskes, Evelyn Burton, Steve Johnson, John Crouch, Dr. Steve Whitefield, Sharon Lipford, Katie Rouse, Dan Martin, Carroll McCabe, Kate Farinholt, Dawn Luedtke, Mona Figueroa, Regina Morales, Andrea Brown, Moira Cyphers.

Welcome and Review of minutes
Marian Bland, Director of Division of Clinical Services, Adults and Older Adults
Behavioral Health Administration

Ms. Bland welcomed stakeholders to the meeting. She asked stakeholders to review the minutes. Ms. Burton requested the following revisions to the 4/7/21 minutes:

1. Change the sentence on Pg. 2 to reflect that the statement is from a family member and not from Ms. Burton.
2. Include the comments from the three additional families.
3. Include comments regarding the definition of harm standard.

The written comments from families and the comments regarding the definition of harm documents submitted by Evelyn Burton will be sent to the group as an attachment with this week's meeting materials.

Overview of Agenda
Marian Bland, Director of Division of Clinical Services, Adults and Older Adults
Behavioral Health Administration

Ms. Bland reviewed the meeting agenda.

Review HB 1267
Marian Bland, Director of Division of Clinical Services, Adults and Older Adults
Behavioral Health Administration

Ms. Bland provided a review of HB 1267.

HB 1267 Background

Pursuant to Chapters 352 and 353 of the Acts of 2014, the *Department of Health and Mental Hygiene* submitted a report to the Legislature on the Outpatient Services Programs Stakeholder Workgroup. The report included proposals to:

- Establish an outpatient civil commitment program in Maryland;
- Expand access to voluntary outpatient mental health services;
- Evaluate the dangerousness standard for involuntary admissions and emergency evaluations.

7 Maryland DEPARTMENT OF HEALTH

HB 1267 Recommendations

- The Department promulgate regulations defining dangerousness to promote consistent application of the standard throughout the healthcare system;
- The Department should develop and implement a training program for healthcare professionals regarding the dangerousness standard as it relates to conducting emergency evaluations and treatment of individuals in crisis. It was recommended that training be extended beyond the emergency room to Administrative Law Judges, the Office of the Public Defender, consumers and family members to ensure consistent application of the standard statewide.
- Panel concluded that a gravely disabled standard was not needed to address inconsistencies in involuntary admission practices.

8 Maryland DEPARTMENT OF HEALTH

HB 1267 Recommendations

- Proposed Definition of Dangerousness Consistent with the Continuity of Care Advisory Panel's recommendation, the Department proposes the following definition of dangerousness to promulgate in regulations:

"Danger to the life or safety of the individual or of others" means, in consideration of the individual's current condition and, if available, personal and medical history, that:

(1) There is a substantial risk that the individual will cause harm to the person or others if admission is not ordered; or

(2) The individual so lacks the ability to care for himself or herself that there is a substantial risk of death or serious bodily injury if admission is not ordered."

9 Maryland DEPARTMENT OF HEALTH

One of the recommendations discussed included training. This recommendation will be included as well as a recommendation from this workgroup as well.

Data Review
Carroll McCabe, Chief Attorney, Mental Health Division
Maryland Office of the Public Defender

Ms. McCabe provided an overview of Civil Commitments from the Maryland Office of the Public Defender.

Status	Totals	Comments
Total cases in 2020	9, 047	
Dispositions	8, 769	The difference between total cases and dispositions is a result of the number of people who are picked up in the emergency room and discharged before the hearing docket is scheduled.
Discharged	2,528	
Voluntary	3, 041	
Never appeared on docket	990	
Administrative Law Judge Hearing	790	
Released	224	Some people were released because of procedural errors, the hospital didn't prove the patient had a mental illness, was found not to be dangerous by ALJ or released to less restrictive alternatives.
Retained in hospital	550	
Discharged after being postponed	74	
Cases postponed	875	

Special Emergency Petitions by Race	
Asian	3%
Black	54%
Hispanic/Latino	4%
White	37%
Other or unknown	2%

Ms. McCabe reported that of the clients who are self-represented, the vast majority come into the hospitals on emergency petitions. The final number isn't available at this time.

Ms. McCabe reported that the system is working. There are anecdotes where people have had difficulty getting an emergency petition for a family member but that is the minority of cases. The issue is a training issue and that's what the Office sees. Judges are not releasing dangerous people to the streets and hospitals aren't discharging dangerous people to the streets. Recurring issues are not the result of the definition of dangerousness. Maryland has the most liberal definition in the country. If there are police officers who aren't completing emergency petitions on people who need them, that is a training issue. We had over 9,000

people come through the Office last year and only 224 were released. We have noticed anecdotally that there is a higher likelihood that there will be an emergency petition if you are black. Statistics show that in terms of individuals retained:

- 200 African Americans
- 14 Asians
- 2 Hispanics
- 127 Whites

Statistics show that African Americans are more likely to have an emergency petition and if they go to a hearing, they are more likely to be retained. We are starting to keep additional data this year that will be shared next year. There is another data point that we track and that is the number of hours spent in the emergency room. For a six-month review of data by age indicates:

- 533 ages 65 and older
- 53 over the age of 55
- 148 ages 36-45
- 259 ages 21-35

Comment: "Less than 10% of the cases, emergency petition or certified, are taken to a hearing. Most people are released or sign a voluntary commitment before they get to hearing and of those that come to a hearing, less than a third are released by the ALJ (administrative law judge). Most of them are technical releases and not merits. This underscores the need for training to assure that clinicians are following appropriate procedures and the need for adequate resources".

Comment: "Maryland does not have a definition of danger. The term is left undefined. The law talks about danger to self or others but it is not defined. Maryland is one of four states that doesn't provide a definition at all. So, while that is true that it leaves it open to compassionate progressive definition that encompasses all the areas it also leaves it open to a very narrow restrictive definition. It's the inconsistency and the lack of predictability across the state that leads to the need for us to have a definition. As useful as the data is, we must keep in mind that it does not tell the entire story as to the need for a definition of danger. When we are looking at the cases that make it to court that's downstream in the process. Most of us believe the problem is more upstream because law enforcement is making the determination that a person is not a danger to themselves or others. For determinations that are made in the emergency room, this indicates a case should not come to court because a person doesn't meet the definition as it is understood. You are not getting the total picture from the data that Carroll presented as to why many of us believe there is a need for change here".

Comment: "I am interested in the data that showed the disparity in the emergency petitions with respect to African Americans and the perception that certain behaviors are dangerous and why that may be. Knowing that there is data to be collected now, based on legislative changes, related to various factors impacting access to health care services. This includes mental and behavioral health care services and is broken out by race and ethnicity. Is it an issue of implicit bias of an earlier intervention and resources for a particular community, or is it a combination of

both? My guess is that based on the data that exists presently, it's impossible to draw that conclusion. Would that be accurate"?

Comment: "Clearly all of us and the state are willing to dedicate some time and resources to this very important issue. It's surprising to me and I will agree with Brian on this, we are not seeing the whole picture. How many emergency petitions were presented to judges that weren't granted and under what reasons? Where are all of these documents? Are they in the medical files of the person? Are they actually filed with the court system? If so, the court should be able to produce information about how many petitions were filed and for what reasons? I really want to ask that before we try to make a change that's going to be very impactful based on stories. The stories are important but haven't been validated against other pieces of data. Would the state be willing to invest a little bit of time into data analytics to collect the data related to this issue and analyze it? Facebook can figure out what kind of tee shirt I am likely to buy. Surely, it's an Excel spreadsheet and some pivot tables. It's not super complicated math on analyzing this information. I also want to reiterate that back in 2014 everybody agreed that the issue here is training. It's people not understanding what the current law is and not applying it correctly. In this meeting, it seems like one thing that we all can agree on is that the issue is training. So why not put our time, effort and resources into trying to find a solution to what we all agree is training and see what happens from that? Maybe that will clarify a lot of difficult situations and issues or gather more specific feedback about where there is a misunderstanding".

Comment: "It's very clear that training is an issue. It was a recommendation in 2014 and it is definitely a recommendation now as well. In reference to the data, we agree that there is more information that needs to be attained in terms of data. We are grateful to Carroll for presenting the data and there is more work that definitely needs to be done gathering better data. If we don't have the data maybe it's time to make recommendations that we need to start collecting it. We want to see the impact and the full picture as well. I definitely agree with the comments that this is just a piece of the data, but it's not the full picture, and that training is definitely important".

Comment: "I wanted to add that I did get one number from the court that includes the number of emergency petitions that they actually issued. In 2020 the court issued 3,799 emergency petitions".

Comment: "I found it enlightening to read the testimony from Dr. Israel who is at Shady Grove Behavioral Health Hospital, regarding HB 33 in terms of his experience in taking people to hearings. He said that " As a psychiatrist who has practiced in outpatient and inpatient settings for 30 years, in response to my request for input from an inpatient psychiatrist working at Shady Grove Hospital, the law needs to be changed. The judges do not take into account the patient's ability to care for him/herself. My colleagues and I are furious about this egregious practice. For example, a patient who shortly before admission drank cat vomit and was discharged from the hearing. In another case, a person with schizophrenia would forget she left the stove on overnight. When her family would try to reason with her, she would become paranoid, enraged, and would barricade herself in her room. Yet again it was decided in a hearing that this behavior didn't rise to the level of dangerousness required by the current law. Based on what I see of patients discharged from inpatient units, I fear that community

inpatient psychiatrists have become so demoralized by the process that they take it upon themselves to discharge patients that they think are unlikely to be committed. This is given that judges tend to interpret the statute so narrowly, why would they want to subject themselves to a protracted futile process. Finally, I wonder how uninterrupted inpatient treatment would affect the readmission rate? Would patients possibly stay out of the hospital longer reducing some of the demand for inpatient beds?

I have talked to other psychiatrists at other hospitals that have similar concerns about the narrow interpretation and also that the public defenders try to get the judges to agree. In terms of training, I think that I am wholeheartedly in favor of training. Who is going to decide on the training since there is no definition? If we don't have a definition, it's hard to have consistent training. I would really appreciate it if Carroll could share the data with us."

Comment: "We will get the data from Carroll and be included in the minutes"?
Response: "Yes, this information will be sent out to stakeholders".

Comment: "I just want to comment on Brian's point that the hearing is the end of a long process, that's absolutely correct. The problem with collecting data, and I am not arguing that we shouldn't try but the problem with collecting data on emergency petitions, but they are not centralized. Carroll pointed out that there are about 9,000 cases of which they have data and about 33,000 that the court has issued. Obviously, there are a lot of emergency petitions that don't get to court. An emergency petition that I would sign would never get to court. I am a physician licensed to EP people and give the ED to the police officer and they would pick up the patient and take them to the hospital. Presumably, the hospital would take it to the public defender which is supposed to happen but it will never get to court. So, the problem with the EP currently, is that there's no centralized mechanism for collecting that data. I don't know if it is actually doable without collecting data directly from the hospital. Now we are treading into unfunded territory. If we are going to do training in 24 jurisdictions , who's paying for it and how are we getting officers of the streets and physicians from their clinics to go to the training ? I am not arguing against training. I think the problem that Evelyn points out is that psychiatrists complain that the public defenders are doing their jobs and assiduously representing their clients. That's the job of the public defenders. The job of the physician is to make a case. Psychiatrists, as a rule, aren't particularly well-trained to testify. I am. I've done a lot of it but a lot of psychiatrists have not. When I have seen cases that are released it is usually because the hospital didn't make a strong case. Most cases are not released on merit, they are released on technicalities because the document wasn't completed properly or because somebody waited too long to get evaluated or because someone waited too long to get a bed. The timeline and the statutes are pretty stringent. We are more forgiving than most states that require six hours instead of 30. If we don't meet those timelines because there are no beds and I have seen cases where people are in the ER for hours, days, and sometimes weeks. That's the problem of not having the definition of dangerousness or including what got the person into the hospital. Centralized data on EPs is a problem. The only central point is the hearing which Carroll's office has access to and OH has access. The data may not be imperfect but it's what we got. With regard to 2014, I was in the department until 2017 and I don't recall anything happening during 2014 – 2017 to implement those recommendations".

Community Member Experiences
Kate Farinholt, Executive Director, NAMI

Front end data is really important and we don't have it. Anecdotes happen to be another piece. Also, training is not worthless, but training without a direct reference to a clear and consistent definition is somewhat problematic.

Ms. Farinholt read stories from people with lived experiences:

1. "During my dark years of deep depression, I was diagnosed with PTSD and depression. My life was facing decline. I lost my children. I was anorexic, homeless, just going to the ER periodically, and then being released. I became vehemently and clearly suicidal. After many years of decline, my family was finally able to have me involuntarily committed to the hospital. I was able to live independently, however I was still plagued with debilitating, intrusive memories, suicidal thoughts, and anger at my family. My daughter and I attended the NAMI program where I witnessed the love and dedication of family members. I understood that my family's emergency petition was an act of love. I began to reconnect with my family and began the journey of recovery. I have learned not to engage in frustration, anger and blame. I learned to forgive myself and my family for doing the only thing they could to save my life. By letting go of anger, bitterness and resentments, I found it possible to work through the pain and the healing. I have reinvested in my life because of the involuntary commitment and NAMI programs. I have learned that I must protect my recovery by continuing to acquire new coping skills and changing my normal pattern of behavior of reacting . As a result, I have not been hospitalized in ten years".

2. "My recent hospitalization was sudden and unexpected. I was threatening suicide and self-harm. I had a long history of self-harm. I was using alcohol to cope with an increasing amount of stress, and increased isolation from the pandemic drastically escalated. Mobile crisis units were closed for the day and I was taken to the emergency room in handcuffs due to protocols. After hours of isolation, panic and being overwhelmed with shame, I was able to speak to the psychiatrists for an evaluation. I was given a choice to go voluntarily or involuntarily. The nurse told me that if I didn't sign the admission paperwork, that I would probably be involuntarily committed so the end result would be the same. I reasoned that the sooner I complied, the sooner I could go home. I agreed to be transferred to an inpatient psychiatric hospital and I was glad I did. I was able to accept my mental illness and I found comradery, acceptance, and understanding from other patients. I learned and developed coping strategies to cope with my PTSD. I was able to begin the gradual process of recovery though the emergency room admission was not something that I would ever want to experience again. My hospitalization was a very positive and healthy experience".

3. This is the recent experience of a family member who writes, "My son was in his forties when he died. He cycled in and out of mania and depression for many years. He had never accepted his diagnosis or treatment and he disappeared from our lives for many years saying that we were evil for trying to get him psychiatric help. Recently, his

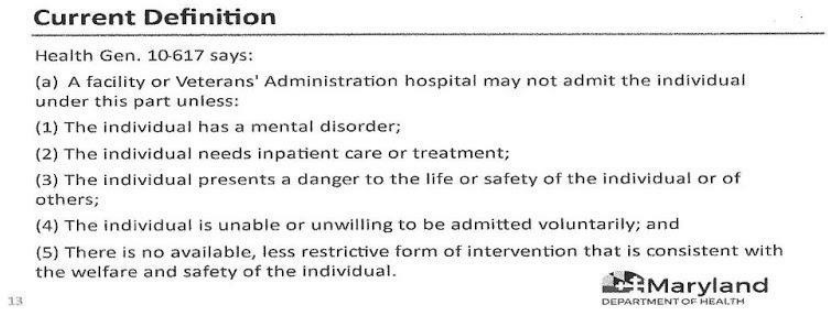
landlord tried to find us. He called because my son had not answered his door or phone for weeks. When they went in to check to see if he was alive, they discovered that he was bed ridden. When we rushed to his address, we found an emaciated, bed-ridden, listless, and unrecognizable man with bones sticking out. It was clear that my son had stopped eating for probably weeks and he was refusing water. He had ordered cases of whiskey weeks before and had drunk them all. He could not get himself out of bed and refused medical treatment. He asked me to leave because he said that I wanted to do him harm. Instead, I called around to find out what to do. A few hours later I called for crisis services to come and help. I was told that my son had to ask for help for himself then I was told to call the police. Very kind trained police officers came but said that because he was not harmful to himself, they would not take him involuntarily to the hospital. They said that I could try to get a court order if I wanted but I would have to wait until the court was open. They gave me no instructions and left. Some days later he finally agreed to go to the hospital to get checked. He was taken out of the house in an ambulance because he couldn't walk. By the time he got to the hospital voluntarily he had gotten worse. Several days later he died of kidney failure. My son killed himself, slowly, yes, but he was not in his right mind and he needed an intervention".

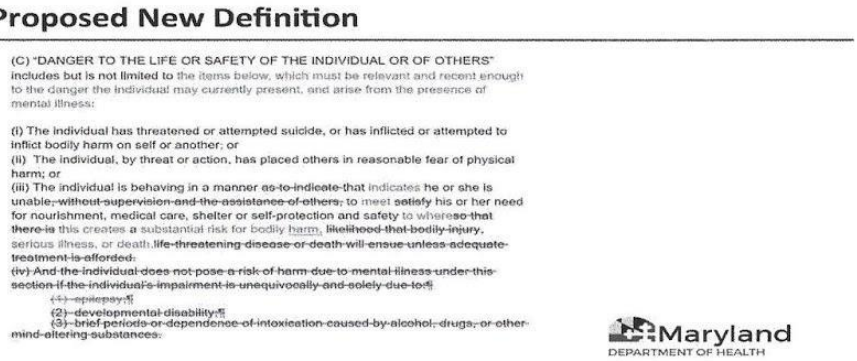
These are just stories but I wanted to share them. Two of the stories are from consumers/ peers and one story is from a family member.

Comment: Thank you Kate. We really appreciate those stories. We want to take into account the data and the experiences as we continue this discussion.

Revision- Maryland's Involuntary Commitment Definition
Dr. Steven Whitefield, Medical Director, Behavioral Health Administration

Dr. Whitefield shared the current definition of Health General 10-617 and presented a proposed new definition.





Dr. Whitefield reported that the first sentence attempts to add clarity that the episode of danger to life or safety is currently present and arises from a person's mental illness. There was discussion about inserting language defining length of time (how recent) the danger is. At the last meeting, it was discussed that a period of 4-6 months is typically what judges consider as recent. Section (iii) removed diagnoses that can lead to certification for dangerousness. There was a change made from "likelihood to substantial risk". Bodily injury was changed to "bodily harm". These are the changes made since the last meeting.

Comment: I have three non-substantive changes. In the opening text, I would refer to the list below as circumstances instead of items. Where it says "arise from the presence of mental illness", I would say" arise as a result of mental illness". In number three, where it says "created a substantial risk", I would change that to "such as to create a substantial risk". I would like to thank the department for their work and effort . The substantive issue is that we still aren't acknowledging psychiatric deterioration and the risk of psychiatric deterioration itself as a basis for intervention. I could cite half the states currently who make it possible to have someone hospitalized based on the basis of psychiatric deterioration. The need for it is very clear from the science we have on how important it is to intervene in a timely fashion to maximize a person's recovery. We know that the longer the duration of untreated psychosis the lower a person's prospects are for recovery. Studies have shown the link between psychosis and brain damage. That ought to be a reason to intervene.

Comment: What we struggle with is that there are a lot of folks out there that just narrow it down to psychosis. How do you measure and quantify deterioration and how it impacts the long-term course? There would be a lot of folks potentially hospitalized.

Comment: I really appreciate the effort and thought you all are putting into this document. As I said before, we would be strongly opposed to putting psychiatric deterioration in the definition. Just because a person's mental health may be worsening it doesn't make them a danger nor does it mean that involuntary admission is the clinically appropriate level of care. Adding language to include psychiatric deterioration could create a vastly overbroad group of people to involuntarily committed. Almost everyone with a mental health disorder could be considered as a risk for some deterioration in the future. I don't think putting substantial in

front of it solves anything. If you need something clear to have training on , one person's determination of substantialness is pretty subjective.

Comment: Are people comfortable with this definition as a recommendation ?

Comment: The first step is identifying there is a mental disorder and the second step is applying the current standard or the standard here to the case. I am a little surprised that we haven't started with that definition.

Comment: I am a little surprised that there is nothing in the definition that SAMSHA recommended which states "an individual being at risk in the foreseeable future" . This definition doesn't really address the future, it mostly addresses past behavior. In your definition, it speaks of bodily harm. The brain is part of the body but that's not clear in this definition. Remaining psychotic can harm your brain. It also doesn't specifically say psychiatric illness. I am pleading with you to put something in there that includes people who are chronically psychotic, or temporarily psychotic.

Comment: We will make notes and report the areas where there is no consensus from these meetings.

Comment: We will include the pros and cons of no-changes to the statute.

Comment: It's unconstitutional to hospitalize someone just because they have a mental illness or just because they are psychotic. The supreme court has been crystal clear that a person has to be dangerous and the dangerousness has to be a derivative of the mental illness. This statute would also seem to violate O'Conner vs Donaldson.

Comment: I believe that the issue of considering psychiatric deterioration or mental deterioration is really better addressed through talking more about how we make our system more easily accessible, addressing areas of discontinuity in our system. There is a significant lack of assertive outreach and engagement service which is needed to help maintain continuity. It's an issue of system accountability. We need to be accountable to the people and the families that we serve. More work needs to be done in those areas and that could help to solve many of the issues we see here today related to this conversation.

Outpatient Civil Commitment Program
Steve Johnson, Vice President of Programs, Behavioral Health Systems Baltimore
John Crouch, Outpatient Civil Commitment Program Monitor Behavioral Health Systems Baltimore

The Outpatient Civil Commitment (OCC) is a service delivery model that requires an individual who meets certain criteria to adhere to a mental health treatment regimen in the community for a defined period of time in lieu of inpatient hospitalization.

2016
- OCC proposal approved by SAMHSA

2017

- HB 1383 Behavioral Health Administration – Outpatient Civil Commitment Pilot Program
- Promulgation of regulations and two public comment periods
- Program Start in October

2018

- Returned funding to SAMHSA, which paused program
- Program restarted in October

2019

- Regulation change in September to expand program eligibility

2021

- Additional regulation changes proposed to BHA

Ongoing

Monthly stakeholder meetings conducted to review programmatic updates and strategies to grow and enhance the program.

OCC Partners

Behavioral Health Administration
Behavioral Health System Baltimore
Office of Administrative Hearings
LifeBridge Health
Disability Rights Maryland
On Our Own of Maryland
National Alliance on Mental Illness Maryland
Mental Health Association of Maryland
Maryland Hospital Association

Goals of OCC

- Reduce inpatient hospitalizations
- Increase connection to outpatient behavioral health services
- Realize cost savings to the public behavioral health system
- Improve program participants' health outcomes and quality of life

ELIGIBILITY CHECKLIST

- ☐ Are an adult diagnosed with a mental health disorder
- ☐ Live in Baltimore City or are homeless and looking for housing in the City
- ☐ Have a history of refusing, not following through with, or not fully engaging with community mental health services

For Voluntary Referral:	For Involuntary Referral:
☐ Agree to be referred to OCC	☐ Do not agree to be referred to OCC
☐ *Are currently hospitalized in an inpatient psychiatric hospital *and*	☐ Are currently retained in an inpatient psychiatric hospital *and*
☐ *Have been hospitalized in an inpatient psychiatric hospital at least one other time within the past 12 months (*New)	☐ Have been retained in an inpatient psychiatric hospital at least one other time within the past 12 months

PROGRAM DATA

Fiscal Year	Number of Referrals	Voluntarily Enrolled	Involuntarily Enrolled
FY18	10	3	3
FY19	8	3	0
FY20	7	4	0
FY21	6	1	0

- 31 referrals/ 14 participants enrolled
- Out of 17 referrals not enrolled:
  - 7 were due to eligibility criteria not being met
  - 5 were discharged prior to OCC hearing
  - 3 moved out of Baltimore City at discharge from hospital
  - 1 transitioned to a state hospital
  - 1 withdrew their referral (voluntary admission)
- 11 of the 14 participants connected with behavioral health services

PARTICIPANT FEEDBACK

- "[The Peer Recovery Specialists have] been helpful. They helped me get shoes. I think it's beautiful."
- "They're angels. [The Peer Recovery Specialists] are godsends. I see them almost every day. I get a lot of moral support."
- "The loving care I've gotten from [the Peer Recovery Specialists] has been the best part of the program. They don't try to force nothing."
- "It's excellent. [The Peer Recovery Specialist] is excellent. He helps with housing and jobs and finding places to go. He helps with food, clothing, shoes, and personal items that I'm supposed to have."
- "It's going pretty good. It's going excellent. [The Peer Recovery Specialist] helps me out tremendously. He helps me with everything; he makes sure I have my medicine, a roof over my head, and food. He's a great counselor."

Source: Statement from participants as reflected in Consumer Quality Team reports

Program Values

- Peer-support is central component
- Consumer's voice and choice
- Stakeholder group support and collaboration
- Working to ensure system accountability

Lessons Learned

- Systems change is difficult
- Consumer's voice and choice
- People in Baltimore fit the target population and we aren't serving them
- Ongoing outreach and education needed

PROPOSED REGULATION CHANGES

- Expanding residency requirement to include surrounding zip codes outside of Baltimore City.
- Ensuring prior commitment in a State Hospital does not prevent OCC eligibility.
- Accepting referrals directly from State Hospitals that may include involuntary admissions as part of a conditional release order
- Establishing bridge subsidies and voucher program in partnership with the Housing Authority of Baltimore City to support stabile housing options for OCC participants.
- Including certain number of ED visits in eligibility criteria, which would apply to voluntary participants.
- Eliminating ALJ endorsement for individuals entering the program voluntarily who are not retained at the hospital.

OCC is an alternative to inpatient treatment and patients are committed to this program similar to the six-month commitment to inpatient treatment. OCC strives to help people whose needs aren't being met well by the system and are experiencing repeated psychiatric hospitalizations and instability in their lives. The goal is to meet the person's needs better and to stabilize them. This initiative is a peer supported service that can operate concurrently or not concurrently with other services in the behavioral health system. Access to legal services is also a part of the grant and legal services are provided by Terry Mason.

Summary of Chat Discussion

Comment: Less than 10% of the cases EP'd/certified are taken to hearing. Most ppl are released or sign a voluntary petition before they get to a hearing. Of those who come to a hearing, less than a third are released by the ALJ, and most of them (I suspect based on my experience) are technical releases, not released on the merits. That underscores the need for training (to ensure that clinicians follow appropriate procedures), and the need for adequate resources (which would reduce time in ERs waiting for a bed).
Comment: What training programs were rolled out after the 2014 report?

Comment: Yes, the recommendations from 2014 on training were very strong. Would be good to know if any of it got off the ground.

Comment: The recommendations were strong. But what actually happened? Nothing, I think.

Comment: Well that is significant. It would be good to really know the answer and then develop a 12–18-month action plan for training across all 24 jurisdictions with measurable outcomes and deliverables. I know that Sheriff Popkin tracked the training they did on ERPO just to have it, but that was useful in understanding knowledge gaps and reach. The same should be done here.

Comment: But isn't this a legal order, not a clinical order?

Comment: Just to respond to Evelyn's comments relating to Dr. Israel's experience. His experience with ALJ's interpretation of the dangerousness standard is not what we in the OPD see in 33 hospitals across the State every day. On a daily basis, in multiple hospitals our clients are retained at hearing because they cannot care for themselves. I had a client involuntarily committed last week because she is a diabetic and stopped taking insulin. She believed she was being poisoned.

Comment: Thank you, Kate. Those are powerful experiences.

Comment: Katie, I appreciate your vulnerability, transparency, and humanness.

Comment: Health Gen 10-101 defines "Mental Disorder", not "mental illness. Suggest you revert to that definition.

Comment: With respect to a lack of definition of dangerousness, the Maryland Court of Appeals broadly interpreted dangerousness in the case of In Re. JCN> In that case, a PhD student at an Ivy League college was writing manic letters to professors and others in her profession. She was not taking thyroid medication and there was a concern that she might drive a car that she purchased (she had a club foot).

The Supreme Court in O'Connor v Donaldson stated: "where state mental hospital's superintendent, as an agent of the state, knowingly confine a mental patient who was not dangerous and who was capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends, superintendent violated patient's constitutional right to liberty".

Comment: Mental Disorder- (i) "Mental disorder" means a behavioral or emotional illness that results from a psychiatric disorder. (2) "Mental disorder" includes a mental illness that so substantially impairs the mental or emotional functioning of an individual as to make care or treatment necessary or advisable for the welfare or property of another. (3) "Mental disorder" does not include an intellectual disorder.

Comment: People without psychiatric issues make "irrational" decisions about medical care all the time.

Comment: Psychiatric Services just published an interesting article that included that 'past history' consideration: https://ps.psychiatriconline.org/doi/10.1176/appi.ps.202000427.

Comment: Training, training, training. No clinician makes a decision without accounting for past history. If ALJs don't use that information, that would be a training issue.

Comment: One take away from my stories is that these people had to wait until things were extreme- and physical. I would like at least another day to review and respond to Dr. Whitefield's language. I apologize.

Comment: ALJs consider a patient's medical history all the time. It is a factor in hundreds of cases in hospitals across the State. In fact, I have never had an ALJ refuse to consider a client's relevant past medical/psychiatric history.

Comment: Regarding the language re: ability to remain in the community with assistance (paraphrase) from caregivers...should the level of assistance needed be specific. The level of care required may be 24/7 and it may not be realistic or possible for a caregiver to provide the level of supervision or assistance needed.

Comment: Data on OCC suggests that my prediction was correct, all those years ago. But, very glad to see the positive feedback regarding peer specialists.

Comment: Here is another article from Dr. Morris on the issue of the difficulty of getting data on civil commitment. https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.202000212

Comment: Applaud OCC. Unfortunate that there is such low enrollment. We support all effective interventions that support someone in the community and avoid commitment.

Comment: BHSB/BHA need to be commended for trying to get this pilot to work and always including all viewpoints. Lots of creative thinking and collaboration behind the scenes. Tough to see hospitals not taking advantage of OCC.

Comment: Yes, we are certainly disappointed with the #s served and want to count on all of you to be ambassadors for this program. Some of you already are and my thanks.

Comment: Thanks for herding the cats, Marian.

Comment: Thanks Marian and the BHA team.

Closing
Marian Bland, Director of Division of Clinical Services, Adults and Older Adults
Behavioral Health Administration

Marian thanked all of the stakeholders for taking so much time to participate in the workgroup. Next steps include sending out the minutes and developing a draft proposal. Stakeholders will have an opportunity to comment on the report and changes to the definition of dangerousness.

Schizophrenia and Related Disorders Alliance of America (SARDAA)
Comments on Proposed New Danger Standard Definition

SARDAA
Maryland Chapter

Schizophrenia and Related Disorders Alliance of America
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COMMENTS ON THE PROPOOSED NEW (4-16-21) DANGER STANDARD DEFINITION OF THE MARYLAND BEHAVIORAL HEALTH ADMMINISTRATION By Evelyn Burton, Advocacy Chair

We greatly appreciate that some of our prior suggestions have been incorporated into the proposed new definition. However, the revised proposed language still does not clearly address some of the major problems with the current standard.

1. Clarification needed that danger applies to the future and need not be "present" or "imminent".

The 2020 Report of the Commission to Study Mental and Behavioral Health in Maryland singled this out as a major problem with the current interpretation of the danger standard. It stated, "The currently widely used standard of "immediacy" is insufficient."

At the first meeting of the BHA stakeholder's meeting, the department committed to following the guidance of the SAMHSA recommendations for inpatient Commitment standards. These recommendations address future risk of harm: ""Without commitment…the individual will be at significant risk, in the foreseeable future, of behaving in a way actively or passively that brings harm to the person or others."

The Proposed New Definition relies on current or imminent risk rather than risk in the foreseeable future. Section (C)(iii) still requires that the individual is already unable to meet his or her basic needs. This very much sounds like imminent risk of harm as is frequently required today. See Pogliano and McIver Testimony). As was pointed out by the Maryland Psychiatric Society in their testimony on SB928, "few people with mental illness are entirely "unable" to provide for their basic needs, so this criterion would never be met by any patient." To be in accordance with the SAMHSA recommendation, we suggest the definition read: "The individual is behaving in a manner, either actively or passively, that indicates, in the foreseeable future, that the individual WILL BE substantially impaired in the individual's ability to meet his or her need for…" Alternatively, the words "reasonably expected" as used in SB928 could be retained as follows: "The individual IS REASONABLY EXPECED, IF NOT HOSPITALIZED, TO PRESENT a danger to the life or safety of the individual or of others." And change "unable" to "substantially impaired in the individual's ability…".

2. 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

The New Proposed Definition in section (C)(iii) still totally ignores this SAMHSA recommendation. It does not make clear that "medical care" should include psychiatric care, "bodily harm" should include harm to the brain and "illness" should include psychiatric deterioration" or deterioration in the ability "to exercise self-control, judgement, and discretion in the conduct of his or her daily activities. SAMHSA recognizes that besides physical harm, significant losses can occur when one becomes psychotic, including family, children, home, job, assets and belongings. Therefore, SAMHSA recommends that harms include "other major loss".

This omission in the proposed danger standard of psychiatric deterioration, fails to take into account known scientific knowledge. Extensive research has shown and SAMSHA has acknowledged that psychosis itself causes 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 worsening long-term outcomes and less recovery.[3] Psychosis needs to be treated like the medical emergency that it is. and treatment provided promptly, even when the individual cannot comprehend that they are ill and need treatment.[4] By ignoring this research as well as research showing that some with schizophrenia and bipolar as a result of their illness, lack the ability to recognize they are ill and need treatment[5], the Department is in effect denying treatment to those whose only symptom is psychosis, thereby harming their brain, diminishing their chance of recovery.

Inclusion of psychiatric deterioration language is essential if we want to be able to provide treatment early enough to prevent the tragedies of murder and violence (see Logan, Boardman, Granados Testimonies), suicides and suicide attempts (see Russell, Hill, Weinberg Testimonies), homelessness (see Montaner, Z.Smith, Custer, Diaz, Kelley, Connors Testimony), child abandonment & trauma (see Connors, Ippolito, Henderson, Ranney Testimonies) and incarceration (See Logan, Boardman, Custer, Diaz, Kelley, Mann, K Smith, Kneller) Not just families but individuals with serious mental illness want early treatment when they are unable to recognize the need, in order to prevent psychiatric deterioration and the tragic consequences of non-treatment (see Eichenberger, Mann, Moran Testimony).

3. Statement needed to require that "in all determinations of danger standard criteria that consideration should be given to the individual's current condition and, if available, personal and medical history". It is vitally important that those making danger determinations not be limited in the information they can consider. Both for violence to others and self, prior violence and non-adherence to medication are high risk factors and should not be ignored.[6] 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 are told personal and medical history cannot be considered and they wait in fear for a recurrence of violence when a loved one is deteriorating. (See Granados and Boardman Testimony)

We would like to better understand the concerns of BHA regarding HB1344. The Department testimony said they did not support the bill because it was "very broad and does not provide enough safeguards to prevent unnecessary commitments, including situations when hospitalization is not the least restrictive setting in which the individual could receive treatment." Apparently, the author of this testimony was unfamiliar with the other 4 current statutory requirements for involuntary hospitalization that must be met in addition to the danger standard. Two of these other requirements specifically prevent involuntary hospitalization for those who do not need that level of care. They are: "The individual needs inpatient care or treatment." and " There is no available, less restrictive form of intervention that is consistent with the welfare and safety of the individual." HB1344 did not change these requirements.

We found it informative that Dr. Israel's testimony described the current narrow interpretation of the danger standard and lack of consideration of personal and medical history, as a major barriers to treatment at the commitment hearing level. He is a psychiatrist who has practiced both in outpatient and inpatient settings in Maryland for 30 years. He stated: "In response to my request for input, an inpatient psychiatrist working at Shady Grove Hospital's busy psychiatric hospital said, "The law needs to be changed. The judges do not take into account the patient's inability to care for self… My colleagues and I are furious about this egregious practice." For example, a patient who shortly before admission had drunk cat vomit was discharged from hearing. In another case, a patient with schizophrenia, because of her disorganized thinking, would forget that she'd left the stove on all night. When her family would try to reason with her, she' would become paranoid and enraged and barricade herself in her room. Yet again, it was decided in the hearing that even this behavior did not rise to the level of dangerousness required by the current law. Based on what I see of patients being

discharged from inpatient units, I fear that community inpatient psychiatrists have become so demoralized by the process that they take it on themselves to discharge patients they think are unlikely to be committed. Given that judges tend to interpret the statute so narrowly, why would they want to subject themselves to a protracted, futile process? Finally, I wonder how uninterrupted inpatient treatment would affect the readmission rate. Possibly, patients would stay out of the hospital longer, reducing some of the demand for inpatient beds in the community.

The patient's "personal and medical history" need to be included as an element to be included because the current law requires the patient's release unless danger is demonstrated by "clear at convincing evidence that *at the time of the hearing* (italics mine). Again, a narrow interpretation of this clause has led to many inappropriate discharges of patients who are overtly dangerous prior to admission, remain symptomatic, but are behaviorally contained by the structure of the unit. The judge's consideration of the patterns prior to admission would hopefully promote his making a more clinically informed decision."

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.

[4]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

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

[6] Buchanan, A., et al. (2019, April). Correlates of future violence in people being treated for schizophrenia. *The American Journal of Psychiatry.*

[7]DJ Jaffe, Insane Consequences Prometheus Books 2017 p 33.

Comments from June 24 Involuntary Stakeholders Workgroup Report

Behavioral Health System
Baltimore

July 9, 2021

Aliya C. Jones, M.D.
Deputy Secretary, Behavioral Health
Maryland Department of Health
201 West Preston Street
Baltimore, MD 21201

RE: Involuntary Commitment Stakeholders Workgroup Report

Dear Dr. Jones,

Thank you for the opportunity to provide feedback on the Involuntary Commitment Stakeholders Workgroup Report—June 24,2021. Behavioral Health System Baltimore (BHSB) supports the recommendations included in this report and appreciates collaborative, inclusive process used by the Behavioral Health Administration to develop the report recommendations.

The recommendations support efforts to ensure Marylanders with serious mental illness are receive the appropriate level of care in the least restrictive setting capable of meeting their needs. Specifically, BHSB would like to offer the following feedback:

- **Clarifying the Dangerousness Standard:** BHSB supports the recommendation to promulgate regulations, rather than propose a statutory change, to define "danger" for purposes of detention for psychiatric evaluation and involuntary admission to a psychiatric facility. We also support the decision to exclude "psychiatric deterioration" in the proposed definition. Just because an individual's mental health symptoms may be worsening does not necessarily make them a danger, nor does it mean involuntary hospitalization is the clinically appropriate level of care.
- **Training:** BHSB supports the recommendation to develop a training to promote appropriate and consistent application of the dangerousness standard. However, it is important to note that even with a training, there may always be inconsistencies in how "dangerousness" is interpreted and applied in practice across multiple systems and providers. A widespread training for multiple stakeholders may help to minimize these inconsistencies.
- **Data Collection and Monitoring:** BHSB supports the recommendation to gather additional data about civil commitment. The data elements in the report would provide valuable information to understand the civil commitment process more fully. BHSB believes it is important that the collection and analysis of this data happen prior *to* any substantive policy change.

Thank you again for the opportunity to provide feedback, and for including BHSB in the Involuntary Commitment Stakeholder Workgroup process.

Sincerely,

Adrienne Breidenstine
Vice President, Policy & Communications
Behavioral Health System Baltimore

Emailed Letter

July 16,2021

Good Morning,

Thank you so very much for your interest in understanding my concerns regarding the Stakeholder Workgroup Report. After further consideration, below are some additional thoughts:

Psychiatric Deterioration standard. I went back and reread the slides that were presented in the Workgroup on statutes from West Virginia, Illinois, Minnesota, and Michigan as well as the SAMHSA Inpatient Commitments Checklist. All 4 of these states and the SAMHSA Checklist included psychiatric deterioration standards, however the workgroup never discussed whether the specific language in each were acceptable or not.

None of these 5 sources had any language even vaguely resembling the language for a psychiatric deterioration standard (standard iv) that the Report on page 9 which it says was rejected by the Workgroup. I don't know who crafted that language but it was never presented to the stakeholder group so it is misleading to even include it in the report, let alone say the group rejected it. If the department wants to reject a psychiatric deterioration standard that decision should be attributed to them.

If this is supposed to be a report from the Stakeholders Group, then to be accurate it should only note that there was not agreement on the inclusion of a psychiatric deterioration standard and if desired, list the reasons on both sides without giving weight to either side. If the Department has a position it should be clearly attributed along with their reasons. Also, psych deterioration "without an element of danger" is inaccurate since the proponents consider psych deterioration to be a danger in itself.)

Imminent Danger:
I would just like to point out that all of the 4 states reviewed and the SAMHA guidelines include language to assure that "imminent" danger is **not** required. At several meetings and in my comments I pointed this out but nothing was ever added to clarify this important meaning which was the major concern of the 2020 Commission report (Item 9: "The currently widely used standard of "immediacy" is insufficient.")

SAMHSA: " will be at significant risk" " in the foreseeable future"
Minnesota: "the person will suffer"
Michigan: "can reasonably be expected within the near future"
West Virginia: " Likely to cause"
Illinois: " reasonably expected"

Again, I think it would be more accurate to just say the Stakeholder Group did not agree on inclusion of language to clarify that imminent danger is not required. It should be

mentioned that the "proposed" standard does not include this language. The Department's position, if included, should be clearly attributed to the Department.

Regulation vs Statute: Since Regulation was a recommendation the State Attorney General's advisor to the Department, it should be so stated and a more thorough explanation of the pros and cons that were considered by the Department, especially given that the Commission recommended Statute in its 2020 Report. ("The commission recommends legislation that provides a clearer statutory definition of danger of harm to self or others."

The report should clarify that this was never discussed by the Workgroup members and they made no recommendation. The only mention I could find in the minutes on this topic were on the following pages of the report, all by administration employees:

Pg. 16: Dr. Aliya Jones: "In Maryland, there is unclear language in the statutes and regulations which has led to wide interpretation of the law." (Note: Dr. Aliya Jones stated at the commission meeting of March19, 2021: "The work that the BHA has been doing and what we are looking to do is to change the statute." This is why TAC and SARDAA never brought up the issue

Pg. 17: Eleanor Dayhoff-Brannigan: "There is interest in updating the definition of "danger to self or others" in the regulation..."

Pg. 39: Review of HB1267 Recommendations: by Ms. Bland: "promulgate in regulations"

(Note: TAC and SARDAA never brought up the benefits of Statute over Regs because we were replying on Dr. Jone's statement above & the Commission recommendation.)

In conclusion, I think it is inaccurate to say that all the Workgroup supports the standard listed. If you want to list something, it should be clarified that some groups supported this only if a psychiatric deterioration standard is added as well as language to clarify that the danger need not be imminent.

Please feel free to call or email me anytime to discuss this.
Thank you again so much for your interest in reducing the barriers to care for those with serious mental illness.

Best,
Evelyn Burton

Emailed Letter

Jul 19, 2021

Good morning,

I just wanted to point out that a very simple way to facilitate that those with psychosis will not be denied needed hospital treatment is to simply add the word "mental" between "bodily" and "harm" in section (iii) of the proposed definition. This clearly links psychiatric deterioration to the concept of harm.

If you note, Michigan uses this approach: "An individual who has mental illness, whose judgment is so impaired by that mental illness that he or she is unable to understand his or her need for treatment and whose impaired judgment, on the basis of competent clinical opinion presents a substantial risk of significant physical or **mental harm** to the individual in the near future or presents a substantial risk of physical harm to others in the near future.

I highly recommend that you speak to Brian Stettin who is very familiar with the many ways in which the 23 other states states incorporate this concept into their standard and has extensive experience working with other states to improve their danger standards. He is very willing to work with you to address this need. His cell phone number is 518-817-8493. His email is above.

Thank you again for considering the treatment needs of those with anosognosia who are suffering from psychosis.

Best,
Evelyn Burton

MARYLAND PSYCHIATRIC SOCIETY

July 9, 2021 Feedback to Involuntary Commitment Stakeholders' Workgroup

The Maryland Psychiatric Society appreciates the efforts of the Involuntary Commitment Stakeholders' Workgroup and its June 24, 2021 draft Report Refining the Definition of Dangerousness in Maryland. Our member psychiatrists are integrally involved in caring for people with severe behavioral illnesses and involuntary commitment may be the best course for some of those individuals. We agree that there are times when people are at significant risk to themselves or others, yet they are not retained. This serious problem can lead to reluctance to even begin the emergency petition process or to rely on voluntary commitment (which can result in premature discharge) when there is concern that others may interpret the statute differently. In some very heart wrenching instances, the result is tragic. The workgroup has explored what can be done to improve the outcomes for at risk patients in Maryland and drafted three recommendations.

The Maryland Psychiatric Society supports the recommendation to provide more information and training around the *current* dangerousness standard, which readily accommodates a range of gray area situations involving serious risk to the individual or others. Highly trained forensic psychiatrists generally have success with the current statute, but others with less knowledge and experience would benefit from comprehensive education in applying the law under various scenarios. This recommendation is aimed directly at the problem of understanding, which is at the root of misapplication of the statute.

We also support the recommendation to gather more data about how the current system is working. It appears that the data available are new and being revised based on current priorities. We would welcome an opportunity to partner to design a data system that can shed light on why there are a small number of cases where the system fails an individual so that effective corrective measures can be taken.

Although it is initially appealing, we disagree with the recommendation to refine the dangerousness standard in regulations. This gives the appearance of addressing the conflict between civil liberty and public safety but would not provide a comprehensive solution in our view. Even if the description of "danger to the life or safety" is more detailed and prescriptive there will still be instances when the individual is not retained but should have been.

This report does not address another serious concern, which is inadequate resources for people suffering acute mental health crises. Maryland needs more inpatient beds at both private and state hospitals. This deficiency can lead to individuals being inappropriately released from the emergency department when there is an ambiguous situation and no bed availability. We also need more specialized, high quality, community-based alternatives to hospitalization.

Thank you for the opportunity to provide input. Please email heidi@mdpsych.org with questions.

Sincerely,

Virginia L. Ashley, M.D.
President

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July 12, 2021

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Behavioral Health Administration
Spring Grove Hospital Center
55 Wade Avenue, Dix Building
Catonsville, MD 21228

Re: Involuntary Commitment Stakeholders Workgroup Report

Dear Dr. Jones:

Please accept this letter as the formal comments of the Maryland Coalition of Families (MCF) on the Report of the Involuntary Commitment Stakeholders Workgroup. Thank you for providing stakeholders with the opportunity to offer comments.

MCF provides family peer support and navigation services to families caring for a child, youth or young adult with mental health needs, and to families of any loved one with a substance use or problem gambling issue. As such, we feel well-placed to present a family perspective, one that sometimes differs from the position of other groups that frequently proport to speak for all families.

We support the recommendations of the Workgroup Report, and believe that the process that informed the Report was inclusive, thorough, well-informed, and balanced. We especially appreciated the opportunity to present on the personal experience of one family, who found that involuntary commitment did not promote the recovery of their loved one, but hindered it. This was a cautionary tale as to why we must proceed with great care when looking at expanding the criteria for involuntary commitment.

At MCF we agree with the following recommendations in the Report:

- "Psychiatric deterioration" should not be included in the definition of dangerousness – it is highly subjective and frequently has nothing to do with a risk of danger.
- Comprehensive training around the dangerousness standard should be provided to a wide variety of professionals who might touch an emergency petition (this also was recommended in the Report of the 2014 Workgroup, in which we participated). If training does not help to improve consistency across the state, only then should we further define the standard.

- Data should be collected and continually analyzed, to get a clear idea about the ongoing practice of civil commitment in Maryland, and especially how it may be disproportionately impacting Black Marylanders.
- Dangerousness should be defined in regulation as opposed to statute, so that changes in the dangerousness standard can be made more easily if this is found to be needed after widespread training takes place and after data has been collected and analyzed.

Many family members value self-determination and the ability of an individual to choose from a wide array of quality and readily available behavioral health treatments and community supports. This sentiment was expressed In the 2021 legislative session, when a bill was introduced to apply Maryland's dangerousness statute to individuals with substance use disorders. MCF's substance use staff (family members with a loved one with a substance use problem) vehemently opposed such a change. Instead, they said that what they wanted was for there to be a wide variety of quality treatment services and auxiliary supports, easily accessible on demand for those struggling with a substance use problem.

This is where Maryland should continue to be focusing its efforts – on the expansion of a robust system of care for those with behavioral health needs and their families.

Thank you for the opportunity to comment.

Sincerely,

Ann Geddes
Director of Public Policy

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July 6, 2021

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RE: Involuntary Commitment Stakeholders Workgroup Report

Dr. Jones –

Thank you for the opportunity to provide these comments regarding the June 24 report of the Involuntary Commitment Stakeholders Workgroup. We appreciate the inclusive process used by the Behavioral Health Administration in developing this report and look forward to a continuing collaboration in our collective efforts to ensure Marylanders with serious mental illness are afforded the appropriate level of care in the least restrictive setting capable of meeting their needs.

MHAMD supports the recommendations proposed in the report, as outlined in further detail below.

Revision of the Dangerousness Standard

We support the recommendation to promulgate regulations, rather than propose a statutory amendment, to define "danger" for purposes of detention for psychiatric evaluation and involuntary admission to a psychiatric facility. We also support the decision to exclude "psychiatric deterioration" in the proposed definition. Just because an individual's mental health symptoms may be worsening does not necessarily make them a danger, nor does it mean involuntary hospitalization is the clinically appropriate level of care.

Predictions of future dangerousness are notoriously unreliable. Studies have consistently found that unstructured clinical assessments of future dangerousness are "accurate in no more than one out of three predictions"[1] and only "slightly more reliable than chance."[2] Adding the variable of "deterioration" and extending the potential danger to an unspecified distant future will increase the already high error rates of involuntary detention and commitment.

[1] Monahan, J., *Structured Risk Assessment of Violence*, Textbook of Violence Assessment and Management 17, 20-21 (Simon and Tardiff eds., 2008).
[2] *See, e.g., In re the Detention of D.W., et. al. v. the Department of Social and Health Services*, No. 90110-4 (Supreme Court of Washington, August 7, 2014)

And if trained and experienced mental health professionals would struggle to accurately predict future dangerousness based on psychiatric deterioration, it seems reasonable to assume that law enforcement and lay persons would perform even worse. While police officers may be able to assess, based on direct observation, whether a person is currently acting in a dangerous manner, they have no expertise to form a reasonable basis that someone is experiencing "psychiatric deterioration" which will result in future dangerousness.

With respect to lay persons, a petition for a psychiatric evaluation currently requires a description of the dangerous behavior that is believed related to mental illness, which enables a judge or district court commissioner to determine whether there is an objectively reasonable basis for involuntary detention. This review provides at least some minimum level of due process protection against speculative subjective opinions rendered by non-professionals. Under a "psychiatric deterioration" standard, however, petitions would have to be approved based precisely on such subjective speculation that a person's mental health is declining and that this decline is an inherent danger to self or others.

Training

Regardless of the actual statutory or regulatory language, there will always be inconsistencies in how "dangerousness" is interpreted and applied in practice across multiple systems and actors. Accordingly, to minimize these inconsistencies to the extent possible, MHAMD also supports the recommendation for widespread training on the dangerousness standard for a variety of audiences.

The process by which an individual is subjected to emergency psychiatric evaluation and involuntary admission to a psychiatric facility requires a determination by a variety of individuals as to whether the dangerousness standard has been satisfied. These individuals include law enforcement and other first responders, emergency department staff, inpatient psychiatric clinicians, judges, defense counsel and administrative hearing officers. Training and education regarding the appropriate application of the dangerousness standard at each phase of the involuntary commitment process will help to ensure the standard is applied consistently across the state.

Data Collection and Monitoring

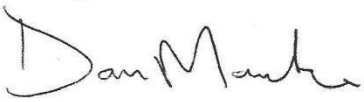
Lastly, MHAMD also supports the recommendation to gather additional data elements about civil commitment. We encourage the collection and analysis of this data *prior to* any substantive policy change. Data presented by the Office of the Public Defender (OPD) shows that nearly 10,000 individuals were subject to involuntary commitment proceedings in 2020. Any changes that may expand this already substantial population of Marylanders subject to a significant limitation of liberty must be informed by robust data collection and analysis across every step in the process.

The OPD data also indicates that Black Marylanders are more likely to be petitioned for an emergency psychiatric evaluation and more likely to be retained at hearing as compared to their white counterparts. This disparity mirrors national disparities related to mental health

diagnosis and inpatient commitment. Black individuals on average are up to four times more likely than whites to receive a schizophrenia diagnosis – even after controlling for all other demographic variables[3] – and more than twice as likely to be involuntarily committed to state psychiatric hospitals.[4] Any revision to Maryland's involuntary commitment process must take these disparities into consideration, and changes must be made with an eye toward reducing inequities in how the process is applied.

Thank you again for allowing the opportunity to provide these comments, and for including MHAMD in the Involuntary Commitment Stakeholder Workgroup process. Please do not hesitate to contact us with any questions.

Sincerely,



Dan Martin
Senior Director of Public Policy

[3] Barnes, A., *Race, schizophrenia, and admission to state psychiatric hospitals* (2004), Administration and Policy in Mental Health, Vol.31, No.3; Barnes, A., *Race and Hospital Diagnosis of schizophrenia and mood disorders* (2008), Social Work, Volume 53, Number 1.

[4] Lewis, A., Davis, K., Zhang, N., *Admissions of African Americans to state psychiatric hospitals*, International Journal of Public Policy (2010), Volume 6, Number 3-4, pp. 219-236; Lawson, W.B., Heplar, H., Holladay,J., Cuffel, B. (1994) *Race as a factor in inpatient and outpatient admissions and diagnosis*, Hospital and community psychiatry, 45, 72-74; Lindsey, K.P.& Paul, G.L. (1989) *Involuntary commitments to public mental institutions*: (2010), Davis (2010).

NAMI Maryland
National Alliance on Mental Illness

July 12, 2021

Involuntary Commitment Workgroup
Maryland Behavioral Health Administration

NAMI Maryland Comments on the Involuntary Commitment Work Group Report

NAMI Maryland strongly supports clear language to define danger appropriately and we appreciate the opportunity to comment on the report. Overall the proposed definition is an improvement and brings a measure of flexibility needed to ensure individuals with severe mental illness are not prevented from accessing treatment. We also applaud the Behavioral Health Administration's commitment to widespread training to ensure proper implementation of the danger standard. The recent date collection efforts are also critically important to help the state understand the circumstances in which the danger standard may be applied and the outcomes of various patient cases. Our comments on the draft report are to reiterate our support for the inclusion of psychiatric deterioration/psychosis as part of the framework for the involuntary admission decision making process.

NAMI MD proposes (in bold):

The Involuntary Commitment Workgroup proposes the following revision to (3) *The individual presents a danger to the life or safety of the individual or of others;* the dangerousness standard, to become the following:

> *(3) 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; or*
>
> ***(iv) The individual has psychosis due to a mental disorder, and the psychosis and the deterioration it has caused severely impair an individual's judgment, reasoning, or ability to control behavior, to where this creates a substantial risk for the emergence in the near future of a danger to the life or safety of the individual or of others.***

Psychiatric Deterioration

NAMI Maryland believes that the sooner an individual has access to medical care, the better off their outcomes are. Specifically including language about psychosis and psychiatric deterioration is important. Chronic psychosis leads to brain deterioration. This consideration is necessary and appropriate as part our danger standard. Without it, the state is unfairly preventing individuals

from accessing treatment as soon as possible and turning a blind eye to those who must decompensate until they have harmed or threatened to harm themselves or others. It is wholly inappropriate that a gravely ill individual must reach the point of self-harm (or to others) before we intervene and treatment is provided. This high threshold may place many individuals and families in direct harm before treatment becomes accessible.

Physical harm should not be the exclusive standard for danger – new language gets this right
NAMI Maryland supports the proposed expanded definition of "danger to the life or safety of the individual or of others." Clear guidance is necessary for the equal application of the statute statewide, thereby reducing barriers to treatment (due in part to varying degrees of interpretation). The proposed definition will provide greater assurances for the health and safety of an individual in crisis and help their family members advocate for treatment on their behalf. In particular, we support the adoption of language that broadens the standard to reflect:

- **Reasonable fear of physical harm to self or others.** When it comes to violence associated with psychosis, the signs of an individual in crisis are unmistakable. Physical harm should be a consideration but not the basis for the definition of danger. That approach ignores what studies show: a history of violence is a likely sign it will occur again. It also perpetuates unsafe, traumatic, and scary situations for individuals with a mental illness and their family members.

Racial injustice in health care
NAMI Maryland supports the additional training proposed by BHA to ensure that changes to the danger standard are fairly applied. All changes regarding involuntary commitment need to **be systematically implemented and resourced.** In addition to greatly increasing access to affordable community-based behavioral health care, removing law enforcement (where possible) from crisis response, and enhanced training for law enforcement, should be a priority in underserved communities. Marylanders need help, not handcuffs. We must ensure that any changes to the involuntary commitment standard are not used as the basis to perpetuate racial injustice in health care. It is our hope that the adoption of broader, more flexible language will lead more Marylanders to treatment, not the criminal justice system. NAMI MD stands ready to assist BHA in achieving these goals.

The proposed changes to our involuntary commitment standard outlined in the June, 2021 draft report would help reduce the revolving door cycle of treatment for individuals who cannot stay on their treatment plans. For the fraction of our population too sick to accept treatment, too sick to advocate for themselves, a clear involuntary commitment standard will ensure that only the individuals who truly need it qualify and will provide a greater measure of certainty for the family members advocating for treatment on behalf of their loved ones.

While we support additional expansions (in bold, above) to the involuntary commitment standard in Maryland, the proposed expansions agreed upon by the work group represent progress and we thank the department for their continued commitment to caring for all Marylanders.

Kathryn S. Farinholt
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NCADD
MARYLAND

July 12, 2021

Aliya Jones, M.D., MBA
Deputy Secretary for Behavioral Health
Behavioral Health Administration
Spring Grove Hospital Center
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Catonsville, MD 21228

RE: Involuntary Commitment Stakeholders Workgroup Report

Dear Dr. Jones:

Thank you for the opportunity to provide comments regarding the June 24th report of the Involuntary Commitment Stakeholders Workgroup. NCADD-Maryland would like to express its support for the recommendations proposed in the report.

Proposed Revision of the Dangerousness Standard

We support the recommendation clarify through regulations, rather than statute, the definition of "danger" for purposes of detention for psychiatric evaluation and involuntary admission to a psychiatric facility. We also support the decision to exclude "psychiatric deterioration" in the proposed definition. Just because an individual's mental health symptoms may be worsening does not necessarily make them a danger, nor does it mean involuntary hospitalization is the clinically appropriate level of care.

Research demonstrates that predictions of future dangerousness are notoriously unreliable. Those clinicians trained and experienced in mental health treatment and interventions struggle to accurately predict future dangerousness based on psychiatric deterioration. To put that judgment in the hands of law enforcement and lay persons would be wholly inappropriate. While police officers may be able to assess, based on direct observation, whether a person is currently acting in a dangerous manner, they have no expertise to form a reasonable basis that someone is experiencing "psychiatric deterioration" which will result in future dangerousness.

Training

NCADD-Maryland supports the report's recommendations for training that were made years ago in a similar workgroup's report in 2014, but not yet implemented. The decision to use an involuntary intervention should only come after extensive consideration of all other voluntary options and the potential consequences for the person in crisis. There must be a statewide training initiative to equip the law enforcement and other relevant professionals with adequate, up-to-date knowledge of the legal, ethical, and health implications of each step of the involuntary

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commitment process. Maryland's Public Behavioral Health System cannot consider itself to be "trauma-informed" without addressing this glaring deficit in protocol and practice.

Data Collection and Monitoring

NCADD-Maryland also supports the recommendation to gather additional data elements about civil commitment. We encourage the collection and analysis of this data *prior to* any substantive policy change. Given the uneven availability of crisis intervention and community-based treatment options throughout the state, and given the statistics that demonstrate a racially disparate impact of commitments, we believe data needs to be detailed, by jurisdiction, including a range of demographics, in order to inform appropriate policy changes.

We again thank you for the opportunity to comment on this important issue and NCADD-Maryland stands ready to assist in this work.

Sincerely,

Nancy Rosen-Cohen

Nancy Rosen-Cohen, Ph.D.
Executive Director

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July 12, 2021

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Re: Comments on BHA Involuntary Commitment Stakeholders' WG Report (June 2021)

Greetings Dr. Jones:

Thank you for the opportunity to provide comments regarding the drafted *Involuntary Commitment Stakeholders' Workgroup Report: Refining the Definition of Dangerousness in Maryland (June 24, 2021)*. On Our Own of Maryland participated in this workgroup, and we commend BHA for facilitating an inclusive process with a diverse group of stakeholders.

There is perhaps no intervention as daunting, or that carries such serious and sometimes life-long consequences, as the prospect of involuntary hospitalization. On behalf of the more than 6,000 people living with behavioral health challenges who participate in our statewide network of peer-run Wellness & Recovery Centers, we are grateful to BHA for proceeding with the utmost care and concern for ensuring equity, promoting recovery, preventing harm, and upholding self-directed choice as you evaluate the current process and potential impacts of changes to the "dangerousness standard" as it applies to involuntary treatment practices.

We strongly support the following recommendations made in the report:

- **Restrict Involuntary Treatment to Recent, Relevant, and Reasonable Threats to Safety:** The goal of emergency behavioral health crisis response services should be to support the safety, autonomy, well-being, and recovery of the individual in crisis. The system of care has several currently used modalities[1] that can effectively meet the needs of persons experiencing an increase in challenging psychiatric symptoms or behaviors. As these engaging, enduring services are widely recognized as the most effective approach - in terms of both personal recovery and services costs - we urge BHA to uphold the report's recommendation to exclude the nebulous 'psychiatric deterioration' clause from the involuntary treatment standards.

[1] e.g. Assertive Community Treatment teams, Wellness & Recovery Centers, Mobile Crisis Teams, Crisis Stabilization programs, etc.

Recovery is not a linear process, and it requires chosen supports to be consistently integrated throughout all aspects of a person's life. The scant and scatter-shot "treatment" delivered during a few days' involuntary hospital stay increases stress and stigma, and has little influence on precipitating and perpetuating factors that will continue a 'crisis cycle' if left unaddressed upon returning home.

Furthermore, when the lived experience of psychiatric crisis includes not just the intensity of emotional and cognitive distress, but also being handcuffed, thrown in a police vehicle, sitting in the emergency room for hours, being locked in a psychiatric unit, and having to prove your credibility to a judge - people will do whatever it takes to avoid the humiliation and trauma of repeating that experience. Involuntary treatment pushes people away from the system of care, and can increase the potential for future interactions with crisis response services to quickly escalate out of fear and panic.

- **Without Statewide Training Requirements, Nothing Will Change:** The decision to use an involuntary intervention should only come after extensive consideration of all other voluntary options and the potential consequences for the person in crisis. It is surprising that despite this decision-making process occurring in the most vulnerable and volatile of circumstances, with the demonstrated potential for deadly harm to come to the person at the hands of untrained law enforcement officers or for significant (re)traumatization in being restrained and detained at the hospital, there exists no statewide training initiative to equip the relevant professionals with adequate, up-to-date knowledge of the legal, ethical, and health implications of each step of the involuntary commitment process. Maryland's Public Behavioral Health System cannot consider itself to be "trauma-informed" without addressing this glaring deficit in protocol and practice. We applaud the Report's echoing of the recommendations for training that were provided seven (7) years ago in a similar workgroup's report in 2014, but not yet carried through to implementation. We would be eager to assist in the integration of peer voice and direct experiences into this training curriculum, at BHA's invitation.

- **Without Data Analysis, Equity Cannot Be Evaluated:** Given the theme of your most recent Annual Conference, *Health Disparities, Racial Equity and Stigma in Behavioral Healthcare*, we are optimistic that BHA will embrace the recommendation to collect and analyze statewide data on the utilization and outcomes of the involuntary commitment process (e.g. Emergency Petitions, Certification reports, Application for Involuntary Admission, Administrative hearing dispositions, etc.), with particular focus on sussing out any disparities based on racial or ethnic identity, suspected or confirmed diagnosis, residency, or petitioner type. This complex project is worthy of time and keen attention.

- **Regulation Invites Expertise and Efficiency:** The process of eliminating unnecessary use of involuntary treatment, and improving efficiency and outcomes in cases where such extreme measures are deemed necessary, will be an iterative one. As BHA implements training and analyzes data, the resulting learnings should be quickly integrated into guiding documents and procedures. We therefore agree that the most appropriate and practical venue for any further delineation of the "dangerousness standard" is through regulations, and not the legislative process.

A psychiatric crisis can be a moment of opportunity, where an active concern for safety leads those involved to find a way to jump the numerous gaps in our system of care and the barriers of stigma to secure emergency treatment that can change the trajectory of one's life. While acute interventions are critically important, we are also reminded that at no time should the protocols related to crisis response services - especially if implemented against the expressed will of the individual - overshadow the Public Behavioral Health System's imperative to invest in the expansion of accessible, recovery-oriented, community-based behavioral health care services that are effectively preventing and diverting crisis situations every day.

Thank you again for your commitment to improving our shared system of care, your compassion and concern for the well-being of peers, and your consideration of our comments (and cautions) today. We are glad for the opportunity to continue working in collaboration with the BHA and all our fellow stakeholders to enhance and advance the state of behavioral healthcare in Maryland.

Sincerely,

Katie Rouse

Katie Rouse
Executive Director

Written Testimony
Erik Roskes, MD
General and Forensic Psychiatrist
Baltimore, Maryland

Note: this statement constitutes my personal opinion and should not be construed as representing the opinion of any of my employers or contractees.

I write in partial support and partial opposition to the draft of the "Involuntary Commitment Stakeholders' Workgroup Report: Refining the Definition of Dangerousness in Maryland". I fully support the goals of the workgroup, which is to ensure that people with serious and acute mental health problems have ready and quick access to acute care when needed. However, there is insufficient evidence that our current statute fails to fulfill this goal.

The current statute, which allows for the involuntary admission of people whose mental illness renders them dangerous to themselves or to others, is broadly worded and readily applicable to a wide variety of presentations before the police, before judges, and before clinicians. That broad wording is a strength of the statute, not a weakness. The Office of the Public Defender presented preliminary data demonstrating that almost 10,000 patients entered the involuntary admission process in 2020. Just 219 people were released at hearing. While I have deep empathy for the tragic stories presented by some of the advocates, those sad anecdotes do not indicate a systemic problem warranting a systemic response – they are outliers, not the norm.

The first recommendation should be the development and implementation of a data collection process, whereby MDH and stakeholders can learn about how this system works statewide. Only if the results of this data analysis indicate that there is a **systemic** problem resulting in an unacceptable number of false negatives (people who should have been involuntarily treated but who were not) can we know what fixes might be needed. As I noted repeatedly during the workgroup discussions, a statutory or regulatory fix may not be needed if

- there are inadequate resources for people suffering acute mental health crises (including both inpatient beds and, importantly, high quality community-based alternatives), or
- the people responsible for executing the law do not understand the law properly.

If MDH does develop a data collection process, as it should, this will need to include data regarding all of the steps in the involuntary treatment process, including data regarding

- Emergency petitions,
- The certification process, and
- The civil commitment (hearing) process.

Only by understanding how each of these steps is executed statewide can we know what intervention to implement. My hypothesis, based on over 25 years of clinical and forensic experience in Maryland, is that training and an improved spectrum of hospital and community-based resources will go a long way toward ensuring that people who need treatment get it, while also ensuring proper protection of the civil liberties of those potentially subject to involuntary treatment.

Thank you for the opportunity to comment.

July 12, 2021

Ms. Marian Bland
Director of Clinical Services
Maryland Department of Health
Behavioral Health Administration

Dear Ms. Bland:

As a member of the Involuntary Commitment Stakeholders' Workgroup, I write to express disappointment with DOH's draft report on the Maryland danger standard distributed to the workgroup on June 28, and to correct several inaccuracies upon which it relies. Specifically:

- The draft report mischaracterizes the views of the workgroup members (such as myself) who called for psychiatric deterioration to be included within the definition of dangerousness. Repeatedly, the report asserts that some members proposed a commitment criterion which "would not include an element of danger."

  Since "danger to life or safety of the individual" is the term to be defined here, it would be absurd to allow a meaning that could apply to individuals who pose no such danger. But in fact the workgroup members urging inclusion of psychiatric deterioration did not suggest this. Instead we argued explicitly that an individual at risk of psychiatric deterioration in the absence of timely treatment *represents a danger to their own life or safety*. We base this argument on copious research demonstrating that extending the duration of untreated psychosis results in physical brain damage and significantly diminishes an individual's prospects for mental health recovery. Our contention was that an individual who suffers such harm due to non-treatment is categorically less equipped to maintain their personal safety and avoid life-threatening hazards than an individual whose brain function was preserved through timely treatment.

  If DOH rejects this line of argument, the report should at least engage with it and explain why it has been found unpersuasive. Instead, the draft report constructs and easily knocks down a "straw man" by framing the case for psychiatric deterioration as untethered to any concern for danger to self or others.

- Since no member of the workgroup has called for the civil commitment of non-dangerous individuals, I am hesitant to draw too much attention to the draft report's erroneous claim that the Supreme Court in *O'Connor v Donaldson* held civil commitment of non-dangerous individuals to be unconstitutional. This misstatement matters only to the extent that DOH refuses to accept that individuals at risk of serious psychiatric deterioration are "dangerous" to themselves; if DOH were to accept the broader conception of "danger" outlined in the prior bullet point, a mistaken view that *O'Connor* prohibits civil commitment of non-dangerous individuals would be immaterial. But in light of DOH's apparently narrower view of what it means to be "dangerous," it seems important to set the record on *O'Connor* straight.

  In summarizing *O'Connor*, the draft report claims that the court "indicated a state should not be able to confine a non-dangerous individual who is capable of surviving safely in freedom." This is incorrect and omits a critical phrase from the court's holding. In fact the O'Connor court held

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that "a State cannot constitutionally confine ***without more*** a non-dangerous individual who is capable of surviving safely in freedom[.]" The phrase "without more" in this carefully constructed sentence is not superfluous verbiage. The *O'Connor* case concerned an individual who had not been convincingly diagnosed with any particular mental illness, who the court found was not being provided with any meaningful treatment while confined in the hospital – facts which played a major role in the court's reasoning. In this context, it is abundantly clear that what the court means by "confine without more" is *confine without doing anything more than confining.* In other words, *O'Connor* addresses when it is permissible for the state to confine a purportedly mentally ill individual *without attempting to provide them with treatment.* The case does not address the question of when the state may confine an individual for the purpose of treating their mental illness. Any doubt about this is settled by footnote 9 of the *O'Connor* decision, where Justice Stewart, writing for the unanimous court, states this explicitly: **"[T]here is no reason now to decide ... whether the State may compulsorily confine a nondangerous, mentally ill individual for the purpose of treatment."**

Accordingly, the draft report grossly misrepresents the *O'Connor* decision. This should be removed from the final report.

- The SAMHSA "Checklist for Policymakers and Practitioners" included in the report is not relevant to the question at hand, which is how Maryland should define dangerousness. The checklist lists several elements that the author considers important to include in a balanced civil commitment law. While all of these listed elements are indeed important, none of them have anything to do with how a state defines dangerousness. The question of what it means to be a danger to self or others is simply not what the SAMHSA checklist was designed to help states grapple with. As such, there is no value in including it in this report. The fact that Maryland's current inpatient commitment law meets all elements of the SAMHSA checklist is nice, but not germane.

- The draft report mischaracterizes the Treatment Advocacy Center's *Grading the States* report, and misleadingly explains away Maryland's "F" grade. It is not true that *Grading the States* "examin[es] the number of public psychiatric beds, number of people incarcerated with mental health issues and opportunities for diversion" in each state. In fact, *Grading the States* is narrowly focused solely on the quality of each state's involuntary treatment laws. It does not claim to grade the states on anything else. And it is misleading for the report to assert that Maryland's "F" grade is attributable to the state's lack of an outpatient commitment law. Putting the outpatient issue aside, Maryland was also given a failing grade (17 out of 50 points) for its *inpatient* commitment laws, largely but not entirely due to its lack of an adequate definition of dangerousness.

- The draft report gives short shrift to the important question of whether dangerousness should be defined in statute or regulation. It does not engage at all with the arguments put forth by workgroup members as to why a legislative remedy is necessary to change practices on the ground. (For example, the argument that certain professions and constituencies relied upon to interpret the civil commitment law are outside of the clinical realm, making them much less likely to take note of and feel bound by a health regulation than they would a state law.) All we are told to justify the recommendation of a regulatory approach is that "if concerns are identified [after

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implementation], regulations can be amended without the passage of new legislation." This justification might be more compelling if Maryland were entering uncharted waters by establishing a definition of danger. In a national environment where nearly every state explicitly defines danger in statute with no apparent trampling of civil liberties, it is hard to imagine why DOH should see such a need for trial and error. And it should be noted that the malleability of the regulatory approach cuts both ways, giving families of individuals with severe mental illness far less peace of mind that Maryland will remain committed in perpetuity to delivering treatment to those who cannot recognize their own desperate need for it.

In light of the foregoing, I urge DOH to reconsider its conclusions and amend the report before finalization to incorporate psychiatric deterioration as a form of danger-to-self and to recommend that the definition of dangerousness be enshrined in Maryland law. Thank you for considering my views.

Sincerely,

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Policy Director

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Involuntary Commitment Stakeholders

Involuntary Commitment Workgroup
Stakeholders – 3.22.21

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