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Lt. Governor Rutherford K. Boyd
State House
100 State Circle
Annapolis, MD 21401 - 1925

October 1, 2021

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

Dear Lt. Governor Boyd:

I am the Chief of the Mental Health Division (MHD) in the Maryland Public Defender's Office (OPD). The MHD represents individuals in involuntary civil commitment proceedings in over 30 hospitals across the State of Maryland. During 2020, the MHD represented over 9,000 individuals in involuntary civil commitment cases. Our ethical responsibility is to represent our clients' stated interests and to protect their liberty interests. The MHD participated in the Behavioral Health Administrations' Involuntary Commitment Stakeholders' Workgroup and we appreciate BHA for including us in this process. I wanted to forward to the Commission to Study Behavioral and Mental Health in Maryland our comments to the Workgroup report.

We strongly oppose the following recommendation made in the report:

(1) Refine the definition of dangerousness in regulations.

We strongly support the following recommendations made in the report:

(2) Provide comprehensive training around the dangerousness standard; and
(3) Gather additional data elements about civil commitment.

The Supreme Court held in multiple cases that civil commitment for any purpose constitutes a severe deprivation of liberty. In *Vitek v. Jones,* 445 U.S. 480 (1980) the Supreme Court said:

> We have recognized that for the ordinary citizen, commitment to a mental hospital produces a "massive curtailment of liberty." *Humphrey v. Cady,* 405 U.S. 504, 509 (1972), and in consequence "requires due process protection." *Addington v. Texas,* 441 U.S. 425 (1979); *O'Connor v. Donaldson,* 422 U.S. 563, 580 (1975). The loss of liberty produced by an involuntary commitment is more than a loss of freedom from confinement. It is indisputable that commitment to a mental hospital "can engender adverse social consequences to the individual" and that "[w]hether we label this phenomena 'stigma' or choose to call it something else… we recognize that it can occur and that it can have a very significant impact on the individual." *Addington v. Texas, supra* at 425-426. See also *Parham v. J.R.,* 442 U.S. 584, 600 (1979).

It is in consideration of the individual's right to liberty and due process, enshrined in our law by the Supreme Court that we submit the following comments in support of our above-stated positions.

A Brief Overview of involuntary psychiatric commitment in the United States

Involuntary psychiatric commitments in the United States peaked in 1953, with more than 550,000 people in State-run institutions.[1] By 1960, the deinstitutionalization movement was gaining ground due to several factors. First, the deplorable conditions and lack of human rights were brought to light just as the civil rights movement was surging. Second, the advent of Thorazine and other psychiatric medications made community treatment a possibility. Third, the establishment of Medicare and Medicaid brought the expense of running ineffective government institutions to light. At the same time, the "best interest" standard for involuntary care was abandoned in favor of a "dangerousness" standard which we see reflected in every involuntary commitment statute in the USA.

[1] Testa M, West SG. Civil commitment in the United States. *Psychiatry (Edgmont)*. 2010 Oct; 7(10):30-40. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3392176/ and PDF included – it is a brief paper with an excellent description of the movement to the dangerousness standard that is causing many of the issues concerning the stakeholders.

Substantive points support OPD's position that a change in the definition of "dangerousness" will not lead to better, easier or more thorough treatment for individuals and their families.

There is no clear evidence supporting the concept that broadening the definition will aid more individuals. The number of people brought into hospitals involuntarily is large, showing that there is no persistent difficulty in getting people that are in crisis into a facility for care. The facilities are full and the Emergency Room ("ER") holds people for long periods of time while looking for beds. However, of the roughly 9600 people brought into hospitals involuntarily in 2020, less than 2% were released by an Administrative Law Judge ("ALJ") at an involuntary commitment hearing. Statistically, ALJ's are not releasing large numbers of people in Maryland.

The proposed language intermingles the concepts of causation and coincidence. The language would result in inappropriate, one-size-fits-all solutions (ie. institutional forced medical care regardless of complicating factors) for all situations. For example, a person might be schizophrenic and also experiencing housing or food instability. Involuntary hospitalization is not going to resolve this person's issues. The involuntary commitment model is not equipped to provide the solutions to large systemic problems such as limited affordable housing options, lack of community services, the Department of Social Services' inadequate placement options, lack of Partial Hospitalization Programs or rehabilitation placements and limited outpatient resources which all can easily lead to difficult circumstances. There is no medication for homelessness, for example, and making it "dangerous" by definition, as long as the unhoused person is also mentally ill, seems to lead to a situation where a fundamental liberty is being infringed upon due to inadequate social support or limited financial means.

Broadening the definition leads to even more resources spent in unproductive ways. Over-reliance on hospitalization is problematic because forced treatment has not been shown to increase outpatient compliance nor reduce readmission. Over-reliance on hospitalization is very expensive. The use of locked psychiatric units as a primary form of treatment is not supporting a "least-restrictive setting" standard of care and can lead the State of Maryland to be in violation of the mandates of the Americans with Disabilities Act and *Olmstead v. LC,* 527

U.S. 581 (1999). See *United States v. Mississippi,* 400 F. Supp. 3d 546 (S.D. Miss. 2019), where the U.S. District Court judge found that:

> On paper, Mississippi has a mental health system with an array of appropriate community-based services. In practice, however, the mental health system is hospital-centered and has major gaps in its community care. The result is a system that excludes adults with [SMI](“serious mental Illness”) from full integration into the communities in which they live and work, in violation of the Americans with Disabilities Act (ADA). More social supports would be the best use of the State’s dollars and time.

Legal definitions are not a factor in professional judgements made by front-line decision makers.

Changing the law is not likely to substantially affect the decisions and choices made by individuals in the mental health field that are “on the front line” in the intervention and treatment of those with serious mental illnesses, rather it will be to make the defined concept broader and capture more people, despite a racially-biased system that already disproportionately impacts minorities. Adding police that are not medically trained would not be helpful because interactions with the police are unfortunately often dangerous and traumatic. The practice of hand-cuffing and transporting patients as if they were prisoners is traumatic and not therapeutic.

Included with this response are police department policies from three jurisdictions. A comparison of the policies in Baltimore City with policies in Prince Georges and Montgomery counties reveals how additional language can actually become problematic and counter-productive. Danger is something people get without more explanation, but adding paragraphs to convey what one word does adequately creates more confusion, not less. Officer X knows the law changed… but that alone is not going to help him in the moment. With regard to the police and legal language – note the policy from Montgomery County. It was written in 2005. In 2005, the standard was still “imminently” dangerous, but the policy still just says “danger to self or others”. It did not change when the imminent language was dropped in 2013. It may not

change if the language is expanded. This is because definition adjustment really is not going to affect how police decide who goes to the hospital.

The current system works.

The anecdotes presented to the Workgroup indicate the system works to capture the vast number of at-risk, dangerously ill people, yet the families are still not feeling adequately served. The stories are deeply painful, but they are rare and that means the system is collecting many at-risk people prior to public harm occurring.

Racial disparity exists in the involuntary civil commitment process.

Racism in the involuntary civil commitment process is a real concern. The statistics collected by the OPD over the last 6 months prove the disparities amongst racial groups. While the OPD may not get the whole picture, we see a lot and what we see is not equitable. Refining the definition of dangerousness to satisfy individuals and organizations that seek to make more people eligible for involuntary civil commitment will have a disparate impact on people of color.

Missing data points make changing the definition risky and based on anecdotal information.

How many petitions for emergency evaluation("EP's") were issued in the years prior to the removal of "imminent" in 2013, versus afterwards? One comment indicated removal of "imminent" did not change the results. Maybe it did, maybe it didn't – maybe no one noticed, because the police were already not using "imminent" in their policies for handling mental health emergencies. How many EP's were denied by the Courts? How many were issued but not served? What percentage of total EP's were from courts as opposed to ER doctors, outpatient therapists, crisis teams, police etc.? What, if any, statistics exist to support the notion that the change in the definition of dangerousness had an impact in the States that made those changes? Of note, at least 8 ALJ releases in 2020 were for minor children in DSS custody facing warehousing/illegal overstays or were "uncontested" releases at hearing. Where

is the data from other groups to support their claims that making the definition more narrowly defined by including all these specific types of danger helped in some specific way? Shouldn't the burden to show that the new language is needed be on the parties wishing to make a change that could infringe on a vulnerable population's rights?

The State of the Commitment Law.

No new case law has arisen to support a revision of the definitions. The original Maryland definition was more akin to a clear and present imminent danger of bodily harm - precisely to ensure the liberty interests of individuals were scrupulously protected. There is plenty of evidence that judges at all levels take a very expansive view of danger. In *In Re: J.C.N,* 460 Md. 371 (2018), the Court of Appeals found these findings adequate to support commitment (excerpt is heavily edited): The ALJ acknowledged that J.C.N.'s case was "atypical" because it did not involve "one particular incident, or one particular idea of threatening behavior, or being a danger because one is fighting with other individuals, or threatening someone with a weapon, or so forth." Rather, the ALJ's decision was based on "the entire global nature of this case."[...D]elusions included J.C.N.'s belief that she could return to pursue a Ph.D. at Yale; travel around the country and abroad to give talks at various institutions; purchase and drive an automobile; and function normally without taking the medication prescribed to her....Based on those physical limitations, the ALJ further found that it would be "inadvisable at this time" that J.C.N. attempt to drive. Further, in the opinion of Dr. Sidana, J.C.N. "d[id] not believe at all that she [was] manic," which was why she "refused to take her psychiatric medications ... and thyroid medications that were prescribed to her." Dr. Sidana added that J.C.N. failed to understand that she required follow-up treatment and medication to control her thyroid condition, which, in Dr. Sidana's words, was "very detrimental to her medical health." Although some of J.C.N.'s delusions, taken alone or in combination with others, might not suggest that at the time of the hearing J.C.N. posed a danger to herself or others, at least one—the delusion that she could function normally without medication and follow-up treatment—did pose a danger. The ALJ found that J.C.N.'s "lack of judgment, lack of insight, and these issues about finances as well," demonstrated that she did not have "sufficient

judgment" to "maintain [her]self" outside of an institutional setting. Based on that ultimate finding, the ALJ ordered that J.C.N. be involuntarily admitted. The evidence presented at the involuntary admission hearing was such that a reasonable person in the position of the ALJ could accept the evidence as adequately supporting his ultimate finding, by clear and convincing evidence, that at the time of the hearing J.C.N. was a danger to herself or others.

O'Connor v. Donaldson, supra at 563, 575–76, is the landmark mental health civil rights opinion on how a state's commitment laws should be framed to ensure a balance of liberty with the public good. In *O'Connor*, the Supreme Court considered the following issues: May the State confine the mentally ill merely to ensure them a living standard superior to that they enjoy in the private community? That the State has a legitimate interest in providing care and assistance to the unfortunate is well-established. But the mere presence of mental illness does not disqualify a person from preferring his home to the comforts of an institution. Moreover, while the State may arguably confine a person to save him from harm, incarceration is rarely, if ever, a necessary condition for raising the living standards of those capable of surviving safely in freedom, on their own or with the help of family or friends. May the State confine the harmless mentally ill solely to save its citizens from exposure to those whose ways are different? One might as well ask if the State, to avoid public unease, could incarcerate all who are physically unattractive or socially eccentric. Mere public intolerance or animosity cannot constitutionally justify the deprivation of a person's physical liberty. In short, a State cannot constitutionally confine, without more, a non-dangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends.

In Addington v. Texas, supra at 426-427, the Supreme Court explicitly held that loss of liberty by confinement for mental illness requires a showing that the individual suffers from something more serious than is demonstrated by idiosyncratic behavior. The expansion of the dangerousness statute increases the risk that a panoply of idiosyncratic behaviors may fall under the "dangerous" umbrella.

Closer to home, the 4th Circuit Court of Appeals in *Johnson v. Solomon,* 484 F. Supp. 278, 294 (D. Md. 1979) found in favor of involuntarily committed adolescents, and used the findings

to encourage more spending on community supports and services. It is worth reading *Johnson* just to see the lists of appropriate and less restrictive settings the Court endorsed. The Court stated:

> Much of plaintiffs' evidence at trial was intended to demonstrate that many hospitalized class members could be treated in alternative placements less restrictive than a mental hospital. Defendants have, to some extent, admitted this to be the case. Testimony by Dr. Milton Senn showed that some fifty percent of plaintiff class members were inappropriately hospitalized. In particular, Susan E. was admitted to facilitate an abortion, and Dorothy T. was admitted to Crownsville Hospital for evaluation after a fight with her mother. Another class member, Byron W., was admitted to Eastern Shore Hospital over the objections of the hospital staff that hospitalization was inappropriate. The evidence as a whole showed that not only did several hospital treatment teams feel that less restrictive settings were appropriate for several class members, but also that lack of community alternatives in particular meant longer than necessary hospitalization....[The]difficulty lies not only in the request that the State be directed to spend more money on mental health but that the Court mandate fairly precise guidelines so as to implement plaintiffs' theories as to the appropriate therapeutic response. While this Court was willing to venture forth into such areas when the issue concerned the constitutionality of commitment standards, findings, and the right to treatment, to do so in this area would be to overstep not only the sensitive boundaries of federalism but also to risk the danger of codifying through law an aspect of medicine and treatment which is by no means universally accepted.

Regarding allegations in the comments and minutes of the report that doctors or law enforcement officers are too confused, afraid or anxious to commit people in any but the most dramatic circumstance, the Maryland Court in *Bell v. Chance*, 188 A.3d 930,937 (Md. 2018), explicitly supported the freedom to certify and commit. "To encourage the appropriate exercise of that judgment, the Mental Health Law provides immunity from liability for a mental health facility, and its agents and employees, concerning decisions made in connection with the involuntary admission process. HG § 10-618 and 629; Maryland Code, Courts & Judicial Proceedings Article ("CJ"), § 5-623. In particular, an applicant who acts "in good faith and with reasonable grounds" is immune from civil or criminal liability relating to the application for involuntary admission. HG § 10-618(a); CJ § 5-623(b). Similarly, a mental health facility, as well as an agent or employee of a facility that, in good faith and with reasonable grounds, acts in compliance with the provisions of Part III of Subtitle 6 is not civilly or criminally liable for those

actions. HG § 10-618(b)-(c); CJ § 6-623(c)-(d). Further, any petitioner who submits or completes an emergency petition, any peace officer who acts as a custodian of an emergency evaluee, any emergency facility or employee of an emergency facility that acts in compliance with the provisions of part IV of Subtitle 6 is not civilly or criminally liable for those actions.

The Americans with Disabilities Act and *Olmstead* remain the leading federal law on least restrictive settings. In the Americans with Disabilities Act of 1990(ADA), Congress described the isolation and segregation of individuals with disabilities as a serious and pervasive form of discrimination. 42 U.S.C. §§ 12101(a)(2), (5). In *Olmstead,* supra at 587, the Supreme Court stated:

> Specifically, we confront the question whether the proscription of discrimination may require placement of persons with mental disabilities in community settings rather than in institutions. The answer, we hold, is a qualified yes. Such action is in order when the State's treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities.

Expansion of the definition of "danger" risks violating the Olmstead Rule because inpatient locked psychiatric treatment is the most restrictive placement in the civil system. Additionally, to the extent the State of Maryland relies most heavily on involuntary inpatient hospitalization (inpatient beds) as the solution to individuals with serious mental illness, resources will not be allocated or spent to increase community treatment options. Unless the State invests in community services, the State of Maryland could find itself in the same position as a number of other States– defending against an *Olmstead* lawsuit filed by the Department of Justice.

Refining the dangerousness standard will not address the myriad of issues that impact the lives of individuals with serious mental illness.

Refining the definition of dangerousness to potentially expand the number of individuals eligible for involuntary inpatient commitment will not address the many concerns voiced by individuals and organizations supporting this change. The focus of involuntary inpatient

hospitalization is safety and stabilization. According to Maryland Department of Health data reported in 2018, the average length of stay on an inpatient psychiatric unit in a general hospital was 6 days. The average length of stay in a private psychiatric hospital was 11 days. State psychiatric hospitals almost exclusively serve forensic patients and are not typically available to non- forensic patients so their length of stay data has not been included. Unless private inpatient units release patients with discharge plans that are tailored to the patient's specific needs and connects them to robust community services, the released patients will be caught in a vicious circle of re-hospitalizations with little to no improvement in their long term health or quality of life.

Rule-making is not the appropriate legal process for defining the dangerousness standard.

During oral argument in the case of *In Re: J.C.N*, Judge Barbera asked the attorneys from the Maryland Attorney General's Office as well as the hospital whether it would be helpful for the court to provide additional guidance on the definition of dangerousness. Both attorneys said no. They wanted the definition to remain flexible. While the Court broadly interpreted "dangerousness" in reaching its opinion, the Court provided no further guidance. It is reasonable to assume that the Court believed that any change in the definition should be made by Maryland's legislature. In fact, bills that would have changed the definition have been proposed in the legislature but have never passed. Using the rule-making process to effect a change that neither the courts nor the legislature have been willing to make violates the edicts of separation of powers. Such action by the Department would amount to an executive branch agency stepping on the toes of legislators chosen by Maryland's citizens.

The definition of dangerousness impacts a citizen's fundamental right to liberty. Any attempt by the Department to define language in a statute that impacts a fundamental constitutional right through the rule-making process is beyond the scope of the Department's authorizing statute and will surely invite litigation over the issue.

There are serious collateral consequences derivative of an involuntary commitment that weigh heavily against increasing the number of mentally ill individuals eligible for commitment.

There are automatic and potential consequences resulting from an involuntary admission, including a broad range of legal, economic, and social impacts. These include required registration with the Department of Public Safety and the FBI, [2] restrictions against owning and purchasing a firearm under Maryland and federal law,[3] disqualification from certain Legal disabilities as well as social stigma remain…."). employment,[4] and from serving as a guardian or custodian of a child in need of assistance.[5] Additionally, one of the greatest consequences is the "social stigmatization as the result of having been declared in need of mental treatment and committed to a mental institution[.]" *See In re D.W.W.*, 616 P.2d 1149, 1151 (Okla. 1980). *Cf. State v. Marsh*, 337 Md. 528, 536 (1995) ("stigma ... often attaches, however unreasonably, to a

[2] Under the Public Safety Article, mental health facilities are required to report to the Department of Public Safety and Correctional Services and the Federal Bureau of Investigation's National Instant Criminal Background Check System ("NICS Index") the names and identifying information of individuals who have been involuntarily committed. See Md. Code, § 5-133.2(a), § 5-133.2(c) of the Public Safety Article.

[3] Pub. Safety § 5-118(b)(3)(xi), governing applications for firearms, requires that the applicant "has never been involuntarily committed to a facility as defined in § 10-101 of the Health-General Article[.]" Pub. Safety § 5-205(b)(10), which governs the possession of a rifle or shotgun by persons with mental disorders, prohibits such possession if the individual "has been involuntarily committed to a facility as defined in § 10-101 of the Health-General Article[.]" Pub. Safety § 5-133(b)(10) prohibits the possession of regulated firearms by an individual who "has been involuntarily committed to a facility as defined in § 10-101 of the Health-General Article[.]" Similarly, under 18 U.S.C. § 922(d)(4), it is "unlawful for any person to sell or otherwise dispose of any firearm or ammunition to any person knowing or having reasonable cause to believe that such person" "has been adjudicated as a mental defective or has been committed to any mental institution[.]"

[4] In addition to creating an obstacle to a law enforcement career, the inability to possess a gun may preclude work as a private detective or a security guard. Moreover, a person may be denied a private detective identification card if the applicant "[h]as been confined to a mental institution for treatment of a mental disorder[.]" See COMAR 29.04.08.03. Similarly, an applicant to be a security guard may be denied the required certification card issued by the State Police if the applicant "[h]as been confined to a mental institution for treatment of a mental disorder[.]" See COMAR 29.04.01.02.

Federal law may preclude work in certain scientific jobs that require the ability to work with biological agents. See 18 U.S.C. 175(b) (prohibiting a person who "has been committed to a mental institution" from possessing a biological agent). An involuntary admission also may disqualify an individual from federal jobs that require a security clearance. See U.S. Office of Pers. Mgmt., "Questionnaire for National Security Positions," at 89, available at https://www.opm.gov/Forms/pdf_fill/SF86.pdf (last visited Dec. 22, 2018) (requiring an applicant to disclose details of any hospitalization for a mental health condition, including whether the admission was involuntary).

[5] Courts are statutorily required to consider "mental health history" when determining a person's fitness for custody or guardianship of a child in need of assistance. Md. Code, § 3-819.2(f)(2)(iv) of the Courts & Judicial Proceedings Article.

person with a mental disease…"); *Dr. K. v. State Bd. of Physician Quality Assur.*, 98 Md. App. 103, 116 (1993) ("Despite great advances in public consciousness, psychiatric treatment can still carry a stigma in our society."); *Vermont v. Condrick*, 477 A.2d 632, 633 (Vt. 1984) ("even after discharge, the collateral consequences of being found mentally ill may continue to plague a defendant. Legal disabilities as well as social stigma remain…"). The increased burdens caused by involuntary civil commitment last for the committee's lifetime.

Data should inform any decision to change a statute designed to protect the fundamental constitutional right to liberty and public safety.

The MHD provided the Department data we collected over the past year. While that data provides useful information, we suggest that the following additional data be obtained:

1. Number of emergency petitions filed through the court system;
2. Number of emergency petitions granted and not granted through the court system;
3. The total number of emergency petitions completed by mental health treatment professionals and law enforcement;
4. The total number of times mental health professionals or law enforcement officers have refused to complete an emergency petition and the reason why;
5. Number of individuals 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);
6. Number of people who were certified and who subsequently agreed to voluntary treatment while still in the emergency room;
7. The race, gender and age of the subjects of each emergency petition sought in the court or completed by mental health professionals or law enforcement officers;
8. The outcomes in States that made similar changes to the definition of dangerousness in their involuntary commitment statutes;
9. The race, gender and age of the subjects of each emergency petition by disposition;
10. The race, gender and age of the subjects of each emergency petition differentiated by the status of the petitioner.

This data should inform any future changes to involuntary civil commitment law in Maryland. As Dr. Erik Roskes so eloquently stated during one of our meetings, "We should not legislate by anecdote."

Thank you again for your consideration of our comments. We look forward to the opportunity to continue working with the Department and other stakeholders to advance Maryland's mental health delivery system in a way that protects the liberty interests of individuals with mental illness while ensuring the safety of the community.

Sincerely,

Carroll McCabe

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