ON OUR OWN OF MARYLAND

onourownmd.org

7310 Esquire Court
Mailbox 14
Elkridge, MD 21075

410.540.9020

WRITTEN TESTIMONY IN OPPOSITION TO SB 707:

Mental Health Law - Danger to the Life or Safety of the Individual or of Others - Definition (Right to Treatment)

Thank you Chair Beidle, Vice-Chair Hayes and committee members for your commitment to improving the quality and accessibility of healthcare services for Marylanders, especially community members who experience significant behavioral health challenges. On Our Own of Maryland (OOOMD) is a nonprofit behavioral health education and advocacy organization, operating for 30+ years by and for people with lived experience of mental health and substance use recovery. In 2025, our network of affiliated, independent Wellness & Recovery Organizations served 10,000 community members living with mental health and substance use challenges, many of whom are uninsured and unhoused.

OOOMD is strongly opposed to SB 707, which would significantly broaden the conditions under which an individual experiencing a mental illness could be Emergency Petitioned (EP) for evaluation and Involuntary Admission (IVA) into a hospital setting ("dangerousness standard"). Broadening the standard does nothing to address the real service gaps that fuel cyclical crises for people with behavioral health needs, and would further muddle an already murky process plagued by misinformation and inconsistent application.

OOOMD was an active participant in the Behavioral Health Administration (BHA)'s *Involuntary Commitment Stakeholders' Workgroup*, which produced a report of recommendations in August 2021. We commend BHA for facilitating a transparent, inclusive process with input from diverse stakeholders. **Notably, the only recommendations widely endorsed by the workgroup were about robust data collection and training surrounding the current Emergency Petition process and its outcomes, neither of which is currently being done to our knowledge.**[1]

Broadening the standard without addressing current confusion and analyzing the effectiveness of current Emergency Petition and Involuntary Admission processes through training and data collection could likely result in:

- Increased law enforcement presence in behavioral health situations, as police officers are required to implement Emergency Petitions.
- Increased numbers of individuals brought involuntarily to Emergency Departments, which already experience high wait times
- Decreased utilization of 988 and other mobile crisis response services, out of fear of involuntary interventions

[1] Maryland Department of Health. Behavioral Health Administration. Involuntary Commitment Stakeholders' Workgroup Final Report (2021). https://health.maryland.gov/bha/Documents/Involuntary%20Commitment%20Stakeholders.Final%20report%208.11.21.docx.pdf

Changes and Concerns about the Proposed Standard

Overly broadening the 'dangerousness standard' will likely invite greater confusion across the three sectors involved in the process – mental health clinicians, law enforcement, and the legal system – who already do not share clear definitions and application of terms in the current standard or awareness of alternative options for crisis deescalation and urgent behavioral health services in communities. We are particularly concerned about how broad language may disincentivize clinicians against exploring voluntary options if there are fears about potential liability if hospitalization is not pursued. Below are person-centered insights on how the proposed language could be misapplied to situations that do not require involuntary intervention:

Inclusion of Bodily Harm to Individuals or Others

Non-Suicidal Self-Injury (ex: superficial cutting) is importantly different from a suicide attempt. Some individuals use NSSI as a coping strategy in the face of overwhelming emotional distress, with no intention for suicide. While wounds should always be assessed and receive appropriate first aid treatment, the mere presence of a self-inflicted injury should not be considered justification for involuntary admission.

Inclusion of Deterioration

The bill would add language for "substantial deterioration of the individual's judgement, reasoning, or ability to control behavior." Experiencing heightened psychiatric symptoms does not automatically predict risk of safety to self or others, and this language would make legitimate disagreements about medication or treatment modalities vulnerable to claims about "judgement" and "reasoning." If involuntary measures become a standard response, it will significantly increase individuals' fear, reluctance, and resistance to seeking help for behavioral health challenges.

Inclusion of Inability to Meet Basic Needs

The proposed standard makes basic needs, such as shelter, clothing, food, medical self-care, etc., a litmus test for involuntary hospitalization. Due to the serious gaps in our health and human services systems, individuals may struggle in these areas primarily because of barriers to consistent and accessible resources, not their behavioral health condition. Narrow eligibility criteria, complicated or inflexible intake and discharge processes, unwelcoming or stigmatizing environments, and past bad experiences all impact whether a person can find and maintain adequate health, housing, wellness and recovery support in the community.

Unmet Needs & Unintended Impact

A rushed evaluation in an Emergency Department and temporary inpatient stay does little to nothing to address the myriad of issues that can create a crisis state, such as:

- Hopelessness
- Unhealed trauma

- Lack of knowledge about self-help strategies
- Few or no supportive relationships
- Limited income and resources
- Legal issues
- Housing instability or homelessness
- Household or job stress
- Lack of recovery support services
- Unavailability or inaccessibility of clinical or healthcare services in the community
- Co-occurring challenges (ex: physical health conditions, other disabilities, substance use, cognitive difficulties)

A behavioral health crisis can be one of the most overwhelming, painful, and stigmatizing experiences in a person's life. When involuntary interventions are forced on people already in distress, it increases panic, retriggers trauma, fractures relationships with service providers, and can create long-term health, economic, and legal consequences for individuals and families:

- Peers lose jobs, housing, and savings when unable to attend work or pay bills as a result of unexpected hospitalization.
- Once labeled with an 'involuntary' status, peers report they experience increased stigma and shame following the experience.[2]
- High-stress experiences worsen mental health symptoms, increase fear and mistrust of the system and can lead to increased rates of suicide or overdose. A 2025 study found that individuals were at significantly higher risk of suicide following involuntary commitment compared to other populations.[3]
- Research has shown that people of color are significantly more likely to be subjected to involuntary commitment.[4,5]

To illustrate the real impact of involuntary interventions, we share the following stories:

- *"I was Emergency Petitioned at 19 years old because I refused to take medication [that caused troubling side effects]. I did not scream, curse, or be disrespectful; I did not threaten to do anything to myself or anyone else. The therapist claimed I would become a 'danger to myself and others,' even though my mood was good for once. The police slammed me into the car door, handcuffed me as tight as possible, groped and laughed at me, as I heard my mother's sobbing and begging behind me. In the hospital, I experienced assault, seclusion, and humiliation. I still have flashbacks, nightmares, and horrible, intrusive memories… it*

[2] Xu Z, Lay B, Oexle N, et al. Involuntary psychiatric hospitalisation, stigma stress and recovery: a 2-year study. Epidemiology and Psychiatric Sciences. 2019;28(4):458-465. doi:10.1017/S2045796018000021

[3] Grossmann, L., Johansson, F., Fazel, S., Kuja-Halkola, R., Bråstad, B., Mataix-Cols, D., & Fernández de la Cruz, L. (2025). Suicide after involuntary psychiatric care: A nationwide cohort study in Sweden. *The Lancet Regional Health – Europe*, *49*, 101504. https://doi.org/10.1016/j.lanepe.2025.101504

[4] Shea, T., Dotson, S., Tyree, G., Ogbu-Nwobodo, L., Beck, S., & Shtasel, D. (2022). Racial and ethnic inequities in inpatient psychiatric civil commitment. *Psychiatric Services*, *73*(12), 1322–1329. https://doi.org/10.1176/appi.ps.202100342

[5] Walker, S., Barnett, P., Srinivasan, R., Abrol, E., & Johnson, S. (2021). Clinical and social factors associated with involuntary psychiatric hospitalization in children and adolescents: A systematic review, meta-analysis, and narrative synthesis. *The Lancet Child & Adolescent Health*, *5*(10), 738–748. https://doi.org/10.1016/S2352-4642(21)00189-4

will likely haunt me for the rest of my life. I have become scared of the police, wary of my neighbors, lost trust in my friends, and I isolate much more now."

- *"I've been receiving psychiatric care since I was 17. There were always times when my ability to make decisions was disregarded. There were multiple occasions where I was forced to remove my clothing in front of male guards and be forcibly medicated, without my consent or my knowledge of what the medication was. [During one hospitalization] they wanted to put me on lithium. I have a pre-existing thyroid condition and my psychiatrist had never prescribed it to me because of this. I declined and reminded them that I was not supposed to take Lithium. Staff informed me that my options were to take Lithium or to do electroshock treatment. I was exhausted… and agreed to take the Lithium. After release, my psychiatrist immediately took me off it because of how it would affect my thyroid."*

- *"The police came to my house [for a wellness check after speaking about suicide to a friend]. They handcuffed me roughly. I had no shoes on when they took me outside to the car. At the hospital, they put me in a small room with two other handcuffed men. I was afraid. The staff ignored us. They strapped me to a stretcher and took me to another hospital. I was in restraints for at least 24, maybe 32 hours. They treated me like I was a criminal or a wild animal. It was horrible and embarrassing."*

Focus on Community Services & Recovery Resources

Involuntary hospitalizations too often produce traumatic experiences which become a turning point of disengagement away from behavioral health services. The high costs of these interventions drain resources away from the effective, agile, community-based recovery support and treatment services that actually help people sustain long-term recovery and wellness. Our behavioral health system has many best practice, evidence-based, and cost-effective services already established. What's needed in Maryland is robust enhancement and expansion of what is already working well:

- Peer Support Services
- Harm Reduction Programs
- Assertive Community Treatment
- Hotlines & Warmlines
- Walk-In / Open Access Clinics
- Urgent Care Centers
- Mobile Crisis/Response Teams
- Crisis Stabilization Programs

While we all work toward a future where involuntary treatment is unnecessary, we support the general goals of making the standards and practices for involuntary commitment more clear, more consistent, and more careful. However, we believe the proposed changes to the regulations will fail to meet needs and have harmful impacts for individuals experiencing behavioral health crises. **We urge an unfavorable report on SB 707. Thank you.**